



Brookhaven Science Associates, LLC.

- Active Employees (excluding IBEW employees hired prior to 8/1/06)
- Non-Medicare Retiree/LTD (excluding IBEW terminated employees between 8/1/2000 and 7/31/06)

EFFECTIVE DATE: January 1, 2010

This document printed in January 2010 takes the place of any documents previously issued to you which described your benefits.

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Brookhaven Science Associates, LLC (BSA) and Vytra Managed Health Systems Inc. (VMHS) have entered into a contractual relationship to provide group health insurance benefits to each Participant, and to the Participant's enrolled Eligible Dependents if the Participant has selected employee plus one or family coverage. This Certificate, including any riders, describes the physician and other Provider, Hospital or other health care institution services that are covered as Plan Benefits.

Types of Providers

A Participant may elect to obtain services from a Participating Provider or from a Non-Participating Provider. The Plan pays a higher level of Plan Benefits, for services obtained from a Participating Provider and for Emergency Services when it was not possible to obtain care from a Participating Provider. A Participating Provider has agreed to accept as payment in full the amount agreed to between the Plan and the Participating Provider. For services covered under this certificate by a Non-Participating Provider, Plan Benefits will be based upon the Usual, Customary and Reasonable Charges and as specified in the Schedule of Plan Benefits.

A Non-Participating Provider may charge for services amounts in excess of the Usual, Customary and Reasonable Charges for determining Plan Benefits; the Participant will be fully responsible for payment of such excess charges. The Schedule of Plan Benefits lists the Co-payment, Coinsurance, Deductible or other payment which is the obligation of a Participant and which will vary depending upon whether a service is obtained from a Participating Provider or a Non-Participating Provider.

Notice Regarding Provider/Pharmacy Directories and Networks

If your Plan utilizes a network of Providers/Pharmacies, you will automatically and without charge, receive a separate listing of Participating Providers/Pharmacies. You may also have access to a list of Providers who participate in the network by visiting www.hipusa.com.

Your Participating Provider/Pharmacy networks consist of a group of local medical practitioners, and Hospitals, of varied specialties as well as general practice or a group of local Pharmacies who are employed by or contracted with VMHS.

Vytra Managed Health Systems' Care Line

VMHS' care line allows you to talk to a health care professional during normal business hours, Monday through Friday, simply by calling the number shown on your identification card.

VMHS' care line personnel can provide you with the names of Participating Providers. If you or your enrolled Eligible Dependents need medical care, you may consult your physician guide which lists the Participating Providers in your area or call VMHS' number for assistance. Whether you obtain the name of a Participating Provider from your physician guide or through the care line, it is recommended that prior to making an appointment you call the provider to confirm that he or she is a current participant in this program.

Vytra Managed Health Systems' Service Area

The VMHS Service Area is defined as the Counties of Nassau, Suffolk, Queens, Richmond, Brooklyn, Manhattan, Bronx, Rockland and Westchester.

Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY BROOKHAVEN SCIENCE ASSOCIATES, LLC. WHICH IS RESPONSIBLE FOR THEIR PAYMENT. VYTRA MANAGED HEALTH SYSTEMS INC. PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT VYTRA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY VYTRA. BECAUSE THE PLAN IS NOT INSURED BY VYTRA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, many of these terms are defined in the Definitions section of your certificate.

Eligibility

Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time or part-time Employee; and
- you normally work at least 20 hours a week.

There is no waiting period for coverage under the Plan.

Dependent Insurance

Your dependents will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent

Eligible Dependents

The following Participants of your family are also eligible for medical plan coverage:

- Your Spouse Your eligible same-sex domestic partner and that partner's eligible child(ren). To be eligible, you must share a committed and exclusive arrangement that meets all of the following criteria:
 - Both the Participant and the domestic partner are eighteen years of age or older and unmarried, and
 - Are of the same sex as each other, and
 - Are not related by blood in any manner that would prohibit legal marriage, and
 - Have assumed mutual obligations for the welfare and support of each other (proof of financial interdependence is required), and
 - Have been sharing a common residence and living together as a couple in the same household, and
 - Are each other's sole domestic partner.
- Children of your eligible domestic partner must meet the criteria for unmarried children indicated below.
- Your unmarried children up to 19 years of age, including adopted children and stepchildren who are dependent upon you for support. Stepchildren must reside with you to be eligible for coverage.
- Your unmarried children who are mentally or physically incapable of earning their own living may be continued beyond age 19 if, within 31 days after they have reached age 19, you submit proof of the child's incapacity. Coverage may be continued for dependents who are over age 19 and who become mentally or physically incapable of earning their own living while covered as an eligible dependent, by submitting proof of the child's incapacity within 31 days after they become incapacitated.
- Your unmarried children age 19 and over who meet the following criteria:
 - The dependent child must be the taxpayer's child, including adopted child or stepchild.
 - The dependent child must have the same principal residence as the taxpayer for more than one-half of the tax year. Children who are away at school will not be excluded by this criterion as long as when they are not at school, they are living with you. Children of parents who are divorced will not be excluded as long as they are living with one of the parents for at least one-half of the tax year. Please note that stepchildren must reside with you to be eligible.
 - The dependent child must not provide more than one-half of his or her own support.
 - For a dependent child who is age 19 or over to be eligible for coverage, he or she must attend an accredited college or university on a full-time basis and also meet the criteria indicated above.
- A dependent child who is covered under a group health insurance plan who (1) is enrolled in a post-secondary educational institution and (2) needs to take a medically necessary leave of absence on account of a serious illness or injury from which the child is suffering may be eligible to retain his/her health care coverage while on the medically necessary leave of absence.

To qualify for the extension of coverage:

- the child must be enrolled as an eligible dependent under the Plan,
- the child must be a full-time student at an accredited college or university immediately before the first day of the medically necessary leave of absence,
- proof of the leave from the educational institution must be provided to the Benefits Office, and
- the child's treating physician must provide certification that the child is suffering from a serious illness or injury that necessitates the leave of absence.

Such coverage can continue until the earlier of:

- one year from the start of the medically necessary leave of absence or
- the date on which such coverage would otherwise be terminated under the terms of the health plan.

In order to be eligible for such benefits, provide proof of the leave from the educational institution and proof of the serious illness from the child's physician to the Benefits Office, Bldg. 400B, within 31 days of the beginning of the medically necessary leave.

Coverage for such unmarried children will end on the earlier of (a) the end of the year of attainment of age 23 or (b) when they no longer meet the criteria indicated above. If they are no longer eligible for coverage because they are no longer attending an accredited college or university on a full-time basis, coverage will end as of the end of month in which he or she is no longer a full-time student.

Note: If an Employee and a Spouse work for BSA, the Spouse may enroll as a Dependent or an Employee; or the Employee and Spouse may enroll separately as Employees. If the Employee and Spouse enroll separately, they may NOT enroll as Dependents on each other's plan. If both parents are covered as Employees, their children may be covered as the Dependents of either, but not of both. Participants of the IBEW Union who had dual coverage prior to January 1, 2006 are excluded.

Cost of the Plan

Employee Coverage. This plan is offered to you as an Employee. To be insured, you will have to pay part of the cost.

Dependent Coverage. For your Dependents to be insured, you will have to pay part of the cost of Dependent insurance.

Effective Date

Employee Coverage

You will become insured on the date you elect the insurance by signing an approved payroll deduction form, but no earlier than the date you become eligible. You will not be denied enrollment for medical insurance due to your health status.

You will become insured on your first day of eligibility, following your election, if you are in Active service on the date, or if you are not in Active service on that date due to your health status.

You will not be enrolled for medical insurance if you do not enroll within 30 days from the date you become eligible, unless you qualify under the section of the certificate entitled "Special Enrollment Rights".

Dependent Coverage

Coverage for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the day you become eligible for Dependent coverage. All of your Eligible Dependents will be included.

Your Dependents will be covered only if you are covered.

You will not be eligible to enroll your Dependents if you do not enroll them within 30 days from the date you initially become eligible, unless you have a change in status event that is a "Qualifying Event."

Any Dependent child born while you are enrolled in this Plan will be covered for medical benefits on the date of his birth if you elect Dependent medical coverage no later than 30 days after his birth. If you do not elect to insure your newborn child within such 30 days, coverage for that child will end on the 30th day. No benefits for expenses incurred beyond the 30th day will be payable.

Mid-Year Changes

The benefit elections you make when you enroll in the Plan will be in effect for the entire calendar year (or portion of the calendar year that remains, if you are a new Employee), unless you experience a Change in Status. You will *not* be able to change your coverage elections unless you file a written request for a change with your Benefits Office within 30 days of any of the following Change in Status events:

Change in Status

If one or more of the following Changes in Status occur, you may revoke your old election during the year and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences which qualify as a Change in Status include the events described below, as well as any other events which the Plan Administrator determines are permitted under subsequent IRS regulations:

- a change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your Spouse);
- a change in the number of your dependents for tax purposes (such as the birth of a child, adoption or placement for adoption of a dependent, or death of a dependent);

- any of the following events that change the employment status of you, your Spouse, or your dependent that affects benefit eligibility under a cafeteria plan (including this Plan) or other Employee benefit plan of yours, your Spouse, or your dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching between salaried and hourly-paid, union and non-union, or part-time and full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular Employee benefit;
- an event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit; or
- a change in your, your Spouse's or your dependent's place of residence.

If a Change in Status occurs, you must inform the Plan Administrator and complete a payroll deduction form within 30 days of the occurrence. Your coverage change will be effective on the date you notify the Plan Administrator. However, if your Change in Status is a birth, adoption, or placement for adoption of a dependent child, coverage will be retroactively provided to the date of the event.

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and corresponds with a Change in Status. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Dependent Eligibility.* For a Change in Status involving your (a) divorce, annulment or legal separation from your Spouse, (b) the death of your Spouse or your dependent, or (c) your dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than (a) your Spouse involved in the divorce, annulment, or legal separation, (b) your deceased Spouse or dependent, or (c) your dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or dependent. However, if you, your Spouse, or a dependent elect COBRA continuation coverage under the Employer's plan, you may be able to increase your contribution to pay for such coverage.
- *Gain of Coverage Eligibility Under Another Employer's plan.* For a Change in Status in which you, your Spouse, or your dependent gain eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your dependent's employment status, your election to cease or decrease coverage for that individual under the plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

Special Enrollment Rights

If you declined enrollment in medical coverage for yourself or your Spouse or eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period, you may be able to elect medical coverage under the plan for yourself, your Spouse and your eligible dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Certain Judgments and Orders. If a judgment, decree or order, including a Qualified Medical Child Support Order (QMSCO), resulting from a divorce, separation, annulment or custody change requires your dependent child (including a foster child who is your tax dependent) to be covered under this Plan, you may change your election to provide coverage for the dependent child. If the order requires that another individual (such as your former Spouse) cover the dependent child, you may change your election to revoke coverage for the dependent child.

Entitlement to Medicare or Medicaid

If you, your Spouse, or a dependent actually enroll in Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a dependent who has been enrolled in Medicare or Medicaid loses eligibility for same, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

Based on the provisions of the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA), Employees and Dependents that are eligible but not enrolled in the Plan may enroll for coverage if they notify the Plan Administrator within 60 days if one of the following conditions is met:

- The Employee or Dependent loses eligibility and is terminated from Medicaid or CHIP coverage; or
- The Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

Change in Coverage or Cost of Coverage

If the Plan Administrator notifies you that the cost of your coverage under the plan significantly increases during the Plan Year or there is a significant curtailment of coverage mid-year, you will have the opportunity to stop or change your coverage as permitted by the Plan Administrator.

You must notify the Benefits Office in writing within the applicable period. If you notify the medical program directly, we may be unable to make the change until the next Open Enrollment period.

Open Enrollment

The Open Enrollment period is held once a year, usually in the Fall. During an Open Enrollment period, you may change medical and/or dental programs, drop coverage(s), and/or add or drop dependents from your coverage(s). The elections you make during an Open Enrollment period will be effective January 1 of the following calendar year. Information will be provided in advance to all Employees and eligible Retirees of the Open Enrollment period.

Medical Benefits

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the number shown on the back of your identification card.

This Schedule of Plan Benefits is intended primarily to specify:

- (i) any limitations on number of visits, days of inpatient coverage, visit or other coverage limitation or limitations on the amount paid as Plan Benefits for a particular medical, health or Hospital services.
- (ii) the amount of any Co-payment, Coinsurance, Deductible or other payment that is the responsibility of a Participant.

Services under this Certificate are covered at two levels. These levels consist of:

“Participating Provider” -these Providers have agreed with the Plan to accept the amount agreed to between the Plan and the Participating Providers as payment in full. The Participant is only responsible for any Co-payment, or Deductible. Refer to the attached Schedule of Plan Benefits for Co-payment or Deductible amounts for specific services.

“Non-Participating Provider”

For Plan Benefits from a Non-Participating Provider, VMHS will pay the Participant as follows:

- (i) For Doctor services, including an office visit, a home visit, immunizations and surgical services, VMHS will pay 70% of the eligible expense based on the Usual, Customary and Reasonable Charges. The Participant will be responsible for the 30% Coinsurance. Also, the Participant must pay the amount of the charge in excess of the Usual, Customary and Reasonable Charge. Refer to the attached Schedule of Plan Benefits for specific Physician services; and
- (ii) For Hospital services, the Plan will pay 70% of the eligible expenses based on the Usual, Customary and Reasonable Charges. The Participant will be responsible for the 30% Coinsurance. Also, the Participant must pay the amount of the charge in excess of the Usual, Customary and Reasonable Charge. Refer to the attached Schedule of Plan Benefits for specific Hospital services.

Medical, Health or Hospital Services must be determined to be Medically Necessary by the Plan to be covered as Plan Benefits.

Annual Deductible

The Participant is responsible for payment for the first \$2,000 per Participant per calendar year of eligible expenses, based on the Usual, Customary and Reasonable Charges, as the Individual Deductible for Plan Benefits from a Non-Participating Provider. Two Participants must satisfy the Individual Deductible of \$2,000 in order to meet the Family Deductible of \$4,000.

Coinsurance

The Participant is responsible for 30% of Usual, Customary and Reasonable Charges for Plan Benefits from a Non-Participating Provider up to Maximum Coinsurance Amount.

Drug Deductible

The Participant is responsible for payment for the first \$100 per Participant per calendar year of eligible expenses as the Individual Deductible for Prescription Drug Services. Three Participants must satisfy the Individual Deductible of \$100 in order to meet the Family Deductible of \$300.

Maximum Coinsurance Amount

The Maximum Coinsurance per Participant per Calendar Year for Medically Necessary Plan Benefits from a Non-Participating Provider obtained in compliance with Pre-Certification requirements shall be \$5,000 after which the Plan will pay 100% of the eligible expenses based on the Usual, Customary and Reasonable Charges for Doctor’s services and for Hospital Services. Two Participants must satisfy the individual coinsurance maximum of \$5,000 in order to meet the family coinsurance maximum of \$10,000 after which the Plan will pay 100% of the eligible charges based on the Usual, Customary and Reasonable Charges for

Physician services and for Hospital services provided thereafter to the Participant and each Participant's enrolled Eligible Dependent.

Limitations on Number of Days or Visits

Any visit or day of coverage or payment provided as Plan Benefits from a Participating Provider will be counted in determining the number of visits, days of inpatient coverage, and/or maximum dollar amount of coverage to which a Participant may be entitled to as Plan Benefits from a Non-Participating Provider. Any visit or day of coverage or payment provided as Plan Benefits from a Non-Participating Provider will be counted in determining the number of visits, days of inpatient coverage, and/or maximum dollar amount of coverage to which a Participant may be entitled to as Plan Benefits from a Participating Provider under this agreement.

Pre-Certification

Pre-Certification is required for Hospital Confinements. Failure to Pre-Certify will result in a \$250 penalty and a 50% reduction in benefits for any days not approved per admission.

The Lifetime Maximum Plan Benefit for a Participant and a Participant's enrolled Eligible Dependents under this Plan, is unlimited.

Schedule of Plan Benefits

The Schedule of Plan Benefits summarizes the benefits for medical and Pharmacy coverage under the Plan. For each medical or Pharmacy service covered under this Plan, the Schedule of Plan Benefits specifies the amount of any Co-payment, Coinsurance, Deductible or other payment that is the responsibility of the Participant. The Schedule of Plan Benefits also specifies any visit or other coverage limitation, or limitation on the amount of Plan Benefits for a particular medical or Pharmacy service. (For some services the amount of Coinsurance or Co-payment will vary based upon the number of visits or inpatient days of services.)

THE EXCLUSIONS IN THE SECTION FOLLOWING THE TABLE APPLY TO – AND SUPERCEDE – ALL OF THE BENEFITS DESCRIBED IN THE TABLE.

Inpatient Benefits	Participating Provider	Non-Participating Provider
Pre-Certification is required for Plan Benefits to be at the maximum benefit level.		
Inpatient Hospital Services	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Inpatient Mental Health	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Inpatient Alcohol and Substance Abuse Detoxification - Includes diagnosis, detoxification and evaluation of acute conditions related to abuse of or addiction to alcohol or substance abuse.	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Inpatient Rehabilitation Services Services which, in the judgment of the Participant's Physician, can be expected to result in significant clinical improvement of the Participant's condition through therapy.	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Skilled Nursing Services – 45 days of care per Participant per calendar year, combined in and out of network, following a stay of at least three consecutive days in duration in a Hospital.	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.

Outpatient Benefits	Participating Provider	Non-Participating Provider
Ambulatory Surgery Center or Same Day Hospital Surgery	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Preadmission Testing	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Outpatient Alcohol and Substance Abuse	Covered in full after a \$30 Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Short-Term Outpatient Rehabilitation Services - treatment for illness or injury which in the judgment of the Participant's Doctor can be expected to result in significant clinical improvement of the Participant's condition through Short-Term therapy. Maximum Benefit: 60 consecutive days combined in and out of network per injury/illness. Includes Physical Therapy, Speech Therapy and Occupational Therapy.	Covered in full after a \$30 Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.

Emergency Services	Participating Provider	Non-Participating Provider
Emergency Services – Provided for Emergency care within 72 hours of accident or within 24 hours of onset of illness requiring emergency room use.	Covered in full after a \$50 Co-payment (waived if admitted)	Covered after a \$50 Co-payment (waived if admitted) for Emergency Services; Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges for non-emergency services.
Emergency Transportation – In emergencies	Covered in full	Covered in full
Urgi-Center	Covered after a \$20 Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.

Services of a Physician or Other Provider	Participating Provider	Non-Participating Provider
Office Visits	Covered in full after \$20 PCP/\$30 Specialist Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Allergy Treatment	Covered in full after \$30 Specialist Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Surgery/Anesthesia	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Maternity Care – Pre-Certification is required for Plan Benefits from a Non-Participating Provider to be at the maximum benefit level.	Covered in full after \$20PCP/\$30 Specialist Co-payment for initial visit to confirm pregnancy	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Hospital Visit – Up to 365 daily visits per Participant per calendar year	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
In-Hospital Consultation – Up to one per admission	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Initial Newborn Child Examination	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Outpatient Mental Health Services –	Covered in full after \$30 Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Lab and Pathology Services At an Outpatient Hospital Facility	Covered in full after \$30 Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
At all other facilities	Covered in full	
Electrocardiogram and Electroencephalogram	Covered in full after \$20 PCP/\$30 Specialist Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Radiology, X-Rays and Other Imaging; Ultrasound	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.

Services of a Physician or Other Provider Cont'd.	Participating Provider	Non-Participating Provider
Hemodialysis – Services of a Physician	Covered in full after \$20 PCP/\$30 Specialist Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Chemotherapy – Services of a Physician	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.

Preventative Care	Participating Provider	Non-Participating Provider
Visit for Well Child Care – In Accordance with prevailing clinical Standards of the Academy of Pediatrics: Age 0 – 2 7 visits Age 3 – 5 1 visit annually Age 6 – 12 1 visit every other year Age 13 – 18 1 visit every 3 years Anything visits in excess of above Schedule.	Covered in full Covered in full after \$20 PCP/\$30 Specialist Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Immunizations	Covered in full Co-payment applies if an office visit is not charged.	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Routine Annual Physical Exam – One per calendar year.	Covered in full after \$20 PCP/\$30 Specialist Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Cervical Cytology – One annual cervical cytology screening for women Age 18 and older as part of well exam.	Covered in full after \$20 PCP/\$30 Specialist Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Prostate Specific Antigen (PSA)	Covered in full after \$20 PCP/\$30 Specialist Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Mammograms – Covered periodically according to age and risk guidelines: Age 35 - 39 baseline Age 40 - 49 1 every 2 years Age 50 and over 1 every year More often if medically necessary.	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.

Home Health, Infusion Therapy Services, Hospice And Other Services	Participating Provider	Non-Participating Provider
Pre-Certification is required for Plan Benefits to be at the maximum benefit level.		
Home Health Services – Up to 40 visits per Participant per calendar year, combined in and out of network.	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Infusion Therapy Services - Pre-Certification required for Plan Benefits to be at the maximum benefit level.	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Hospice Services – Up to 210 days for Hospice Care Services and up to five visits for bereavement counseling services.	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.

Other Benefits	Participating Provider	Non-Participating Provider
Acupuncture	Covered in full after \$30 Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Cardiac Rehabilitation Services – Up to 12 consecutive weeks per Participant	Covered in full after \$30 Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Chiropractic Care	Covered in full after \$30 Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Durable Medical Equipment	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Infertility – Medically necessary services to determine and treat the diagnosis of infertility for adult females age 21 through 44 (until 45 th birthday)	Covered in full after \$30 Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
<p>Infertility includes diagnosis, drugs, and surgical repair of medical problems. The diagnostic tests and procedures that are necessary to determine infertility or that are necessary in connection with any surgical or medical treatments or prescription drug coverage.</p> <p>Coverage does not include the diagnosis and treatment of infertility in connection with:</p> <ul style="list-style-type: none"> In vitro fertilization (IVF) Gamete intrafallopian tube transfers (GIFT) Zygote intrafallopian tube transfers (ZIFT) Reversal of elective sterilizations (Reanistimosos) Sex change procedures Cloning or medical or surgical services or procedures that are deemed to be Experimental Infertility drugs during IVF cycles Blood work during IVF cycles Ultrasounds during IVF cycles 		
Insulin, Diabetes Supplies and Diabetes Equipment	Covered after \$20 Co-payment for each order or prescription for Insulin, Diabetes Supplies and for each item of diabetes equipment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Obesity – Subject to any limitations shown in the “Exclusions” section of this certificate. Medical Necessity and Prior authorization required visits and bariatric surgery.	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Organ Transplant – Prior authorization required.	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Pain Management Treatment Services – Acute and chronic conditions are covered. Prior authorization required.	Covered in full after \$30 Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Private Duty Nursing – Subject to Medical Necessity. Prior authorization required.	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Prosthetic Appliance	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
TMJ – Subject to medical review.	Covered in full	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.
Vision Care – Davis Vision Network Out of network coverage for medical diagnosis only.	Covered in full after \$30 Co-payment	Subject to Deductible and Coinsurance; Covered up to Usual, Customary and Reasonable Charges.

Prescription Drug Benefits	Participating Provider	Non-Participating Provider
<p>Prescription Drug Services - Covered only as Plan Benefits from a Participating Pharmacy or a Participating Mail Order Pharmacy</p> <p>* Subject to \$100 per Individual Deductible and \$300 Family Deductible.</p>	<p>From a Participating Pharmacy: (30 day supply) <u>Generic Drugs</u> Covered after \$10 Co-payment*</p> <p><u>Formulary Brand Name Drugs</u> Covered after \$25 Co-payment*</p> <p><u>Non-Formulary Brand Name Drugs</u> Covered after \$40 Co-payment*</p> <p>From a Participating Mail Order Pharmacy: (90 day supply) <u>Generic Drugs</u> Covered after \$20 Co-payment*</p> <p><u>Formulary Brand Name Drugs</u> Covered after \$50 Co-payment*</p> <p><u>Non-Formulary Brand Name Drugs</u> Covered after \$80 Co-payment*</p>	<p>Must use in-network only</p> <p>Must use in-network only</p>

Exclusions

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an illness or injury which is due to war, declared or undeclared.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Care or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Any services and supplies for or in connection with Experimental, Investigational or unproven services. Experimental, Investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or the subject of review or approval by an Institutional Review Board for the proposed use.
- Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Acupressure; Craniosacral/cranial therapy; Dance therapy, movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 12 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35–39 with comorbidities. The following are specifically excluded: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.

- Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
- Reversal of male and female voluntary sterilization procedures.
- Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Plan.
- Non-medical counseling or ancillary services, including, but not limited to Custodial Care, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back to school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services" or "Reconstructive Surgery following Mastectomy".
- Private hospital rooms and/or private duty nursing except as provided in the "Home Health Services" covered expenses section.
- Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
- Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures.
- Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
- Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy, except as provided in "Covered Expenses".
- All non-prescription drugs, and Investigational and Experimental drugs, except as provided in "Covered Expenses".
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Participantship costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
- Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail & Internet consultations and telemedicine.
- Massage therapy

Acts of Third Parties (Subrogation)

This provision applies whenever someone else (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you for an illness or injury suffered by you or your dependent(s) that is covered by this Plan. In that case, you must reimburse the plan for any benefits it paid relating to that illness or injury, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized). The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees incurred in obtaining the compensation unless separately agreed to, in writing, by the Plan Administrator in the exercise of its sole discretion.

Benefits relating to such illness or injury will not be payable by the plan until you sign and return a statement, provided by the plan, acknowledging your obligation to reimburse the plan under this provision. (That obligation will arise upon the payment of any plan benefits relating to the illness or injury, whether or not you sign such a statement.)

Coordination of Benefits

If you are covered by more than one group medical plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans, as shown below. These coordination provisions apply separately to each *beneficiary*, per *calendar year*. Any coverage you have for medical benefits will be coordinated as shown below.

"Other Plan" is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

"Principal Plan" is the plan which will have its benefits determined first.

"This Plan" is that portion of this Plan which provides benefits subject to this provision.

Effect on Benefits

1. If this Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If this Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.
3. The benefits of this Plan will never be greater than the sum of the benefits that would have been paid if you were covered under this Plan only.

Order of Benefits Determination

The following rules determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.
2. A plan which covers you as an Employee pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active Employee, but (b) before the plan which covers you as a retired Employee.

For example: You are covered as a retired Employee under this plan and eligible for Medicare (Medicare would normally pay first). You are also covered as a dependent of an active Employee under another plan (in which case Medicare would pay second). In this situation, the plan which covers you as a dependent will pay first and the plan which covers you as a retired Employee would pay last.

3. For a dependent *child* covered under plans of two parents, the plan of the parent whose birthday falls earlier in the *calendar year* pays before the plan of the parent whose birthday falls later in the *calendar year*. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

Exception to rule 3: For a dependent *child* of parents who are divorced or separated, the following rules will be used in place of Rule 3:

- a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.
 - b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
 - i. The plan which covers that *child* as a dependent of the parent with custody.
 - ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).
 - iii. The plan which covers that *child* as a dependent of the parent without custody.
 - iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).
 - c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.
4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the Order of Benefit Determination provisions of this Plan, this rule will not apply.
6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

Our Rights under this Provision

Responsibility For Timely Notice. We are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value. If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

Facility of Payment. If payments which should have been made under this Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under this Plan, and such payment will fully satisfy our liability under this provision.

Right of Recovery. If payments made under this Plan exceed the maximum payment necessary to satisfy the intent of this provision, we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

Termination of Insurance – Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the date your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Leave of Absence

If your Active Service ends due to an approved leave of absence, your insurance will end of the earlier of:

- the date your employment ends.
- the date your leave of absence ends if you do not return to active employment.
- the date for which the required payment has not been made.
- the date you are no longer in a Class of Eligible Employees.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date your Employer cancels the insurance or stops paying for you.

Medicare Eligibility

Your benefits under this Plan will end on the date you become eligible for Medicare benefits, if you are not in Active Service..

Retirees

All employees who are participating in the Medical Plan and who terminate employment after attaining age 55 and have a combination of age and years of Continuous Service immediately prior to retirement (10 years minimum, or for employees hired prior to January 1, 2001, 5 years minimum) that total 70 years or more may participate in the Medical Plan with their covered dependents by paying the required retiree premiums. For example: An employee age 55 would be eligible for retiree medical coverage after 15 years of Continuous Service. A 62 year old employee would be eligible after 10 years of Continuous Service, if hired on or after January 1, 2001. A 62 year old employee would be eligible after 8 years of Continuous Service, if hired before January 1, 2001.

In determining eligibility for retiree medical coverage, employees who are hired by the Laboratory in connection with the National Synchrotron Light Source II ("NSLSII") project may receive credit for their service with their prior employer in calculating their years of Continuous Service. This prior service credit applies to (a) employees permanently hired by the Laboratory on or after October 1, 2005 to work on the NSLSII project, or (b) Spouses of employees permanently hired by the Laboratory on or after October 1, 2005 to work on the NSLSII project, if the Spouse is permanently hired by the Laboratory on or after October 1, 2005, even if the Spouse is not hired to work on the NSLSII project. The prior service credit applies only to service with a laboratory operated under a contract with the Department of Energy, and only if the employee or Spouse was employed by that laboratory immediately before he or she was hired by the Laboratory. For example, if an employee is hired by the Laboratory to work on the NSLSII project on January 1, 2006, and before being hired by the Laboratory was employed with another laboratory operated by an entity under a contract with the Department of Energy since January 1, 2000, the employee will have six years of Continuous Service when he or she begins at the Laboratory.

Also, employees who are participating in the Medical Plan and who terminate employment after completing 35 years of Continuous Service may participate in the Medical Plan with their covered dependents by paying the required retiree premiums.

In addition, when Long Term Disability (LTD) Plan benefits cease for a participant who was receiving such benefits, the following criteria apply in determining retiree medical benefits eligibility, if participating in the Medical Plan. Use Continuous Service prior to commencement of LTD Plan benefits and age at the time the LTD Plan benefits cease.

Retirees otherwise eligible who are subsequently employed elsewhere or have coverage available through their Spouse's employer may suspend their retiree medical coverage through the Laboratory. It may only be reinstated during an Open Enrollment Period (effective January 1 of the following calendar year) or when a Qualifying Event occurs.

As of January 1, 2007, eligible employees in the positions indicated below who are participating in the Medical Plan and who terminate employment after attaining age 50 and have 25 years or more of Continuous Service may participate in the Medical Plan with their covered dependents by paying the required retiree premiums. If Continuous Service is at least 20 years but less than 25 years and all other criteria indicated above are met, such eligible employees may participate in the Medical Plan by paying the COBRA cost of the plan until their age plus Continuous Service immediately prior to retirement plus their age total 75 years or more (at which time they can continue coverage by paying the required retiree premium). For the purpose of this paragraph, positions eligible for such coverage include Fire Chief, Deputy Fire Chief, Fire Captain, Police Chief, Police Captain, Police Lieutenant and Police Security Training Instructor.

If you die while your benefits are in a suspended status, your eligible dependents may also reinstate coverage during an Open Enrollment Period or when a Qualifying Event occurs.

Termination of Insurance – Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your coverage ceases.
- the date you cease to be eligible for Dependent coverage.
- the last day for which you have made any required contribution for the coverage.
- the date Dependent coverage is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

Notice of Federal Requirements

Coverage for Reconstructive Surgery Following Mastectomy

When a person insured for benefits under this certificate who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- treatment of physical complications in all stages of mastectomy, including lymphedema; and
- mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

If you have any questions about your benefits under this Plan, please call the number on your ID card or contact your employer.

Newborn Mothers Health Protection Act (NHMPA)

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

Qualified Medical Child Support Orders (QMCSO)

If qualified medical child support court order (QMCSO) issued in a divorce or legal separation proceeding requires you to provide health coverage to a child who is not in your custody, you may do so. To be considered qualified, a medical child support order must include:

- name and last known address of the parent who is covered under this Plan;
- name and last known address of each child to be covered under this Plan;
- type of coverage to be provided to each child; and
- period of time the coverage is to be provided.

QMCSOs should be sent to the plan administrator. Upon receipt, the Plan Administrator will notify you and describe the plan's procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the plan. As a beneficiary covered under the plan, your child will be entitled to information that the plan provides to other beneficiaries under ERISA's reporting and disclosure rules.

Family Medical Leave Act (FMLA)

If you take a leave of absence for your own serious health condition or to care for family Participant with a serious health condition or to care for newborn or adopted child, you may be able to continue your health coverage under the Plan. If you drop your health coverage during the leave, you can also have your health coverage reinstated on the date you return to work, assuming you pay any contributions required for the coverage.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment in regard to military leaves of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any life, short-term or long-term disability or accidental death & dismemberment coverage.

A. Continuation of Coverage:

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependent as follows:

You may continue benefits, by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to apply or return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

B. Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave because you do not elect COBRA at the expiration of your military leave and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if, (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a pre-existing condition limitation (PCL) or waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

Rights under ERISA

As a participant in BSA Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your Enrollment Date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Right to Receive a Certificate of Health Coverage

If your coverage under this plan stops, you and your covered dependents will receive a certificate that shows your period of coverage under the Plan. You may need to furnish the certificate if you become eligible under another group health plan if it excludes coverage for certain medical conditions that you have before you enroll. You may also need the certificate to buy, for yourself or your family, an individual insurance policy that does not exclude coverage for medical conditions that are present before you enroll. You and your dependents may also request a certificate within 24 months of losing coverage under this Plan.

Coverage and Claims Procedures

Coverage

All claims for benefits under the plan are processed by VMHS under an ASO contract.

Claims procedures

Claims for benefits under the plan must be filed with VMHS. As part of the claims administration process, VMHS will:

- process claims for benefits due under the Plan;
- provide written explanations of the reasons for denied claims;
- handle claimant requests for reviews of denied claims; and
- make the final decision on denied claims.

Under the Employee Retirement Income Security Act (ERISA) of 1974, you have the right to appeal a denied claim in accordance with the claims procedures described in this Summary Plan Description.

Claims Review Chart		
Type of Claim	Steps to Take	
URGENT HEALTH CARE CLAIM		
<p>Claims for conditions that could jeopardize life, health, or ability to regain maximum function, or would subject you to severe pain.</p> <p>The reasonable layperson standard is used for these claims, except that if a physician determines the condition is urgent, the Plan must accept the physician's determination.</p>	Step 1:	The Plan has 72 hours after receiving your initial claim to approve or deny the claim.
	Step 2:	If denied, you have 180 days after receiving the claim denial to appeal the Plan's decision.
	Step 3:	The Plan has 72 hours after receiving your appeal to notify you of its appeal decision.
	IF YOUR CLAIM IS IMPROPER OR INCOMPLETE	
	Step 1:	The Plan has 24 hours after receiving your initial claim to notify you that your claim is improper or incomplete.
	Step 2:	You have 48 hours after receiving notice from the Plan to correct or complete your claim.
	Step 3:	The Plan has 48 hours to notify you if your claim is approved or denied. The Plan must do so within the earlier of 48 hours of: Receiving your completed claim, or Your deadline to complete the claim.
	Step 4:	If denied, you have 180 days after receiving the claim denial to appeal the Plan's decision.
PRE-SERVICE HEALTH CLAIM		
<p>Group health claims where treatment must be pre-certified before it is performed.</p>	Step 1:	The Plan has 15 days after receiving your initial claim to notify you if your claim is approved or denied.
	Step 2:	You have 180 days after receiving the claim denial to appeal the Plan's decision.
	Step 3:	The Plan has 30 days after receiving your appeal to notify you of the appeal decision. If the Plan allows two levels of appeal, it has 15 days after receiving your appeal to notify you of its decision. Both levels of appeal must be completed within the 30-day deadline.
	IF YOUR CLAIM IS IMPROPER OR INCOMPLETE	
	Step 1:	The Plan has 5 days after receiving your initial claim to notify you that your claim is an improper claim.
	Step 2:	The Plan has 15 days after receiving your claim to notify you of its decision to approve or deny the claim. If the Plan needs more information and provides an extension notice during the initial 15-day period, the Plan has 30 days after receiving the claim to notify you of its decision. (The time the plan waits for claimant information is not counted in totals.)
	Step 3:	You have 45 days after receiving the extension notice to provide additional information or complete the claim.
	Step 4:	If your claim is denied, you have 180 days after receiving the claim denial to appeal the Plan's decision.
Step 5:	The Plan has 30 days after receiving your appeal (15 days if the Plan allows two levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 30-day deadline.	
POST-SERVICE HEALTH CLAIM		
<p>Group health claims where you request reimbursement after treatment has been performed.</p>	Step 1:	The Plan has 30 days after receiving your initial claim to notify you if your claim is denied.
	Step 2:	If your claim is denied, you have 180 days after receiving the claim denial to appeal the Plan's decision.
	Step 3:	The Plan has 60 days after receiving your appeal (30 days if the Plan allows two levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 60-day deadline.
	IF THE PLAN NEEDS FURTHER INFORMATION OR AN EXTENSION	

Claims Review Chart	
Type of Claim	Steps to Take
	<p>Step 1: The Plan has 30 days after receiving the initial claim to notify you if your claim is denied. If the Plan needs more information and provides an extension notice during the initial 30-day period, the Plan has 45 days after receiving the claim to notify you if your claim is denied. (The time the plan waits for claimant information is not counted in totals.)</p>
	<p>Step 2: You have 45 days after receiving the extension notice to provide additional information or complete your claim.</p>
	<p>Step 3: If your claim is denied, you have 180 days after receiving the claim denial to appeal the Plan's decision.</p>
	<p>Step 4: The Plan has 60 days after receiving your appeal (30 days if the Plan allows two levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 60-day deadline.</p>

Claim Denials

If your claim for benefits is wholly or partially denied, any notice of adverse benefit determination under the Plan will:

- state the specific reasons for the determination;
- reference specific plan provisions on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court;
- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- if the denial is based on medical necessity or Experimental treatment, provide an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical condition (or state that such information will be provided free of charge upon request);
- for urgent care claims, the denial notice will include a description of the expedited review process applicable to such claims. This denial may be given orally, provided that a written or electronic notification is furnished to you no later than 3 days after the oral notification.

Appeals

If you believe your claim was denied in error, you may appeal this decision to the plan. You have 180 days after receiving the claim denial to appeal the Plan's decision. You may submit written comments, documents, or other information in support of your appeal and have access, upon request, to all relevant documents free of charge. The review of the claim denial will take into account all new information, whether or not presented or available at the initial claim review, and will not be influenced by the initial claim decision.

A different person than the one who made the initial claim determination will conduct the appeal review and such person will not work under the original decision maker's authority. If your claim was denied on the grounds of medical judgment, the Plan will consult with a health professional with appropriate training and experience. This health care professional will not be the individual who was consulted during the initial determination or work under their authority. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, we will provide you with the names of each such expert, regardless of whether the advice was relied upon.

If your claim involves urgent care, a request for an expedited appeal may be submitted orally or in writing and all necessary information shall be transmitted between the Plan and you by telephone, fax, or other similar method.

If your appeal is denied, the denial notice will contain the following information:

- the specific reasons for the appeal determination;
- a reference to the specific plan provisions on which the determination was based;
- a statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all document, records, or other information relevant to the determination;
- a statement describing any voluntary appeal procedures offered by the plan and your right to obtain information about these procedures;
- a statement describing your right to bring a civil lawsuit under federal law;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- if the denial is based on medical necessity or Experimental treatment, an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical condition (or state that such information will be provided free of charge upon request);

- a statement that “You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.”

The appeal determination notice may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Medicare Election at Age 65.

If you remain actively employed after reaching age 65, you or your Spouse who is over age 65 may choose to remain covered under this Plan without reduction for Medicare benefits or you may choose to designate Medicare as the primary payor of benefits. If you choose to remain covered under this Plan, this Plan will be the primary payor of benefits and Medicare will be secondary. If you choose Medicare as primary, coverage under this Plan will end. If you do not specifically choose one of the options, this Plan will continue to be primary. If you are under age 65 and your Spouse is over age 65, your Spouse can make his or her own choice.

COBRA

Introduction

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This section generally explains COBRA continuation coverage, when it may become available to you, your Spouse and your dependent children, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other Participants of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your Spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose coverage under the Plan because either one of the following events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your Spouse dies,
- Your Spouse’s hours of employment are reduced;
- Your Spouse’s employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-Employee dies;
- The parent-Employee’s hours of employment are reduced;
- The parent-Employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “dependent child.”

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide this notice in writing along with a copy of the Social Security Administration Determination within sixty (60) days from the date of the Determination to the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any dependent children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the Spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If your dependent children attain the age of nineteen (19), or twenty-three (23) if full-time students, or recover from a disability while you are eligible to participate in the Plan or after you have elected continuation coverage, they are eligible to continue to participate in the Plan at their own expense with identical benefits for thirty-six (36) months from the date their eligibility under the Plan ceases.

If you have elected Family Participant, any child who is born to or placed for adoption with you during the period of continuation coverage is eligible to participate in the Plan.

Notice

You, your Spouse or dependent children must notify the Plan Administrator of divorce, separation, disability, a change in dependent status or that a child has been born to or placed for adoption with you within sixty (60) days after the later of 1) the date of the event 2) the date of the loss of coverage, 3) the date of the determination from the Social Security Administration of disability or 4) the date on which you are informed through this summary plan description or a general notice of the responsibility to provide notice and the Plan's procedures for providing notice, whichever is later, in order for your Spouse or dependent children to be offered separate applicable continuation coverage or you, your Spouse, or dependent children to receive extended disability continuation coverage.

If you, your Spouse or dependent children are on extended continuation coverage for disability and receive a final determination from the Social Security Administration that there is no longer a disability under Titles II or XVI of the Social Security Act, the person on extended continuation coverage must notify the Plan Administrator within thirty (30) days of the final determination.

The Employer will notify the Plan Administrator within thirty (30) days of the death, termination, reduction of hours or Medicare eligibility of an Employee. Within fourteen (14) days (or longer time period under Section 2590.606-4 if applicable) of receiving notice from you or your employer, the Plan Administrator must notify qualified persons of their rights to continuation coverage by mail to their last known address.

Election

Eligible persons will have sixty (60) days from 1) the date when eligibility under the Plan ceases or 2) receipt of notice of rights to continuation coverage, from the Plan Administrator, whichever is later, to elect continuation coverage at their own expense.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as

a plan sponsored by your Spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Cost

Persons electing continuation coverage shall be charged by the employer an amount not to exceed the premium for similarly situated persons. The Employer may also charge an administrative fee of up to two percent (2%) of the premium. Payment may be made in monthly or quarterly installments calculated in advance for twelve (12) month periods. If a person is on extended continuation coverage for disability, the employer is entitled to charge for coverage after eighteen (18) months an amount not to exceed one hundred and fifty percent (150%) of the premium for similarly situated persons. If persons are required to pay for the period of continuation coverage between when coverage ceases under the Plan and the date of election of continuation coverage, such premiums shall be paid within forty-five (45) days of the election.

Termination

Continuation coverage may be terminated before the eighteen (18), twenty-nine (29), or thirty-six (36) month period if:

- a. persons electing continuation coverage
 - 1) join another medical plan, which does not have limitations and exclusions for pre-existing conditions as an employee, Spouse or dependent child.
or
 - 2) are entitled to Medicare benefits.
- b. on the month that begins more than thirty (30) days after the date of final determination by the Social Security Administration that a person on extended continuation coverage is no longer disabled under Titles II or XVI of the Social Security Act.
- c. premiums are not paid by or for persons electing coverage.
- d. employer discontinues all health plans available to the Employee.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family Participants. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Identification Information

Plan name:	Brookhaven Science Associates, LLC Welfare Plan
Plan number:	501
Type of plan:	The group health plan provides comprehensive medical benefits and is considered a "welfare benefit plan" under ERISA.
Type of funding:	The plan is self-insured by Brookhaven Science Associates, LLC and unfunded.
Type of administration:	Vytra Managed Health Systems Inc. provides claims administration and other services through an ASO contract. Benefits are not insured by Vytra Managed Health Systems, Inc.
Claims administrator:	Vytra Managed Health Systems Inc. 395 North Service Road Melville, NY 11747 (631) 694-6565
Plan year:	The Plan Year begins on January 1st and ends on December 31st. The Plan's financial records are based on the Plan Year.
Plan administrator:	Brookhaven Science Associates, LLC PO Box 5000, Building 400B Upton, NY 11973 (800) 353-5321
Trustee	A list of any Trustee of the plan, which includes name, title and address, is available upon request to the Plan Administrator.
Employer who sponsors the plan:	Employer named above
Employer's EIN (Employer Identification Number):	113409315
Agent for service of legal process:	Employer named above
Plan establishment:	Brookhaven Science Associates, LLC established the group health plan for the exclusive benefit of its eligible employees on January 1, 2005. The effective date of this Summary Plan Description describing benefits under the Plan is January 1, 2010.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This document is intended to satisfy HIPAA's notice requirement with respect to all health information created, received, or maintained by the BSA Comprehensive Welfare Benefits Plan group health plan (the "Plan"), as sponsored by BSA (the "Company").

The Plan needs to create, receive, and maintain records that contain health information about you to administer the Plan and provide you with health care benefits. This notice describes the Plan's health information privacy policy with respect to your Medical, Prescription Drug, Dental, Vision, and Health Care Flexible Spending Arrangement (FSA) benefits. The notice tells you the ways the Plan may use and disclose health information about you, describes your rights, and the obligations the Plan has regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your health care providers.

Brookhaven Science Associates' Pledge Regarding Health Information Privacy

The privacy policy and practices of the Plan protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws. Effective January 1, 2010, the use or disclosure of protected health information that is Genetic Information about an individual for underwriting purposes shall not be a permitted use or disclosure. The term "underwriting purposes" includes determining eligibility or benefits, computation of premium or contribution amounts, the application of any preexisting condition exclusion, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

Privacy Obligations of the Plan

The Plan is required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of the Plan's legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

How the Plan May Use and Disclose Health Information About You

The following are the different ways the Plan may use and disclose your PHI:

- **For Treatment**
The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.
- **For Payment**
The Plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.
- **For Health Care Operations**
The Plan may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the Plan's participants receive their health benefits. For example, the Plan may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the Plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Plan may also combine health information about many Plan participants and disclose it to the Company in summary fashion so it can decide what coverages the Plan should provide. The Plan may remove information that identifies you from health information disclosed to the Company so it may be used without the Company learning who the specific participants are.
- **To the Company**
The Plan may disclose your PHI to designated Company personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to the Company's Privacy Officer ("the Plan Administrator") and/or the Participants of the Company's Benefits Department. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other Company employee or department and (2) will not be used by the Company for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Company.

- **To a Business Associate**
Certain services are provided to the Plan by third party administrators known as "business associates." For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require its business associates, through contract, to appropriately safeguard your health information.
- **Treatment Alternatives**
The Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services**
The Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.
- **Individual Involved in Your Care or Payment of Your Care**
The Plan may disclose PHI to a close friend or family Participant involved in or who helps pay for your health care. The Plan may also advise a family Participant or close friend about your condition, your location (for example, that you are in the hospital), or death.
- **As Required by Law**
The Plan will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

Special Use and Disclosure Situations

The Plan may also use or disclose your PHI under the following circumstances:

- **Lawsuits and Disputes**
If you become involved in a lawsuit or other legal action, the Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.
- **Law Enforcement**
The Plan may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.
- **Workers' Compensation**
The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws other similar programs.
- **Military and Veterans**
If you are or become a Participant of the U.S. armed forces, the Plan may release medical information about you as deemed necessary by military command authorities.
- **To Avert Serious Threat to Health or Safety**
The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.
- **Public Health Risks**
The Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.
- **Health Oversight Activities**
The Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.
- **Research**
Under certain circumstances, the Plan may use and disclose your PHI for medical research purposes.
- **National Security, Intelligence Activities, and Protective Services**
The Plan may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence, and other national security activities authorized by law and (2) to enable them to provide protection to the Participants of the U.S. government or foreign heads of state, or to conduct special investigations.

- **Organ and Tissue Donation**
If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank to facilitate organ or tissue donation and transplantation.
- **Coroners, Medical Examiners, and Funerals Directors**
The Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

Your Rights Regarding Health Information About You

Your rights regarding the health information the Plan maintains about you are as follows:

- **Right to Inspect and Copy**
You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.

To inspect and copy health information maintained by the Plan, submit your request in writing to the Plan Administrator. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.
- **Right to Amend**
If you feel that health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, send a detailed request in writing to the Plan Administrator. You must provide the reason(s) to support your request. The Plan may deny your request if you ask the Plan to amend health information that was: accurate and complete, not created by the Plan; not part of the health information kept by or for the Plan; or not information that you would be permitted to inspect and copy.
- **Right to An Accounting of Disclosures**
You have the right to request an “accounting of disclosures.” This is a list of disclosures of your PHI that the Plan has made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; or in certain other situations. To request an accounting of disclosures, submit your request in writing to the Plan Administrator. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.
- **Right to Request Restrictions**
You have the right to request a restriction on the health information the Plan uses or disclosures about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family Participant or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had.

To request restrictions, make your request in writing to the Plan Administrator. You must advise us: (1) what information you want to limit; (2) whether you want to limit the Plan’s use, disclosure, or both; and (3) to whom you want the limit(s) to apply.

Note: The Plan is not required to agree to your request.
- **Right to Request Confidential Communications**
You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan send you explanation of benefits (EOB) forms about your benefit claims to a specified address.

To request confidential communications, make your request in writing to the Plan Administrator. The Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of this Notice**
You have the right to a paper copy of this notice. You may write to the Plan Administrator to request a written copy of this notice at any time.

Changes to this Notice

The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future. The Plan will post a copy of the current notice in the Company’s Benefits Office at all times.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Plan Administrator at the address listed below. Alternatively, you may complain to the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission complained of occurred.

Note: *You will not be penalized or retaliated against for filing a complaint.*

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclosure your PHI for the reasons covered by your written authorization; however, the Plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information

If you have any questions about this notice, please contact:

Brookhaven Science Associates, LLC
PO Box 5000, Building 400B
Upton, NY 11973
(800) 353-5321

Notice Effective Date: January 1, 2010

Definitions

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer.

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time or part-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business;
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan. For the purposes of determining our payment, the total value of Allowable Expense as provided under This Plan and all Other Plans will not exceed the greater of: (1) the amount which the *claims administrator* would determine to be eligible expense, if you were covered under This Plan only; or (2) the amount any Other Plan would determine to be eligible expenses in the absence of other coverage.

Ambulatory Surgery Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Benefits Office can be reached by writing to Brookhaven National Laboratory, Building 400B, Upton, NY 11973 Attn: Benefits Office or by calling 631-344-2877, 631-344-5126 or 800-353-5321.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

CHIP means coverage under the Children's Health Insurance Program, a state program designed to provide health care coverage for uninsured children and some adults.

Claims Administrator means the entity designated by the Plan Administrator to handle claims under the Plan.

Class of Eligible Employees means all regular employees who work at least 20 hours per week.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Co-payments are expenses to be paid by you or your enrolled Eligible Dependent for the services received. Co-payments are in addition to any Coinsurance.

Coinsurance is the percentage of the claim after reasonable and customary that you are responsible to pay.

Covered Person is an Employee, Retiree or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO participation, an individual health insurance policy, Medicaid or Medicare. Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Deductible is the amount that you must pay for covered medical expenses each calendar year before benefits will be paid under the Major Medical portion of the Plan. There is no deductible for benefits paid through the Preferred Provider portion of the Plan.

Domestic Partner means an individual with whom you must share a committed and exclusive arrangement that meets all of the following criteria:

- Both the Participant and the Domestic Partner are eighteen years of age or older and unmarried (or are legally married to each other), and
- Are of the same sex as each other, and
- Are not related by blood in any manner that would prohibit legal marriage, and
- Have assumed mutual obligations for the welfare and support of each other (proof of financial interdependence is required), and
- Have been sharing a common residence and living together as a couple in the same household, and

- Are each other's sole Domestic Partner.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Eligible Dependent means your Spouse, your Domestic Partner and your unmarried children who meet the requirements set forth in the section entitled "Eligible Dependents."

Emergency means a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship. See Active Employee.

Employer is Brookhaven Science Associates, LLC (BSA).

Enrollment Date is the first day of coverage.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the Experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means “genetic information” as defined in 45 C.F.R. Section 160.103.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- an outpatient in a Hospital because of surgery;
- receiving emergency care in a Hospital for: (a) an Injury, on his first visit as an outpatient within 72 hours after the Injury is received; or (b) a sudden and unexpected Sickness within 12 hours after the Sickness begins, if lack of such care would cause his condition to worsen seriously; or
- Partially Confined for treatment of mental illness, alcohol or drug abuse or other related illness. Two days of being Partially Confined will be equal to one day of being Confined in a Hospital. The term Partially Confined means continually treated for at least 3 hours but not more than 12 hours in any 24-hour period.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means incapable of producing offspring.

Injury means an accidental physical injury to the body caused by unexpected external means.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Non-Participating Provider is a provider that does not participate in the Plans contracted network.

Open Enrollment means the period of time, held once a year, typically in the Fall, during which you may change your medical and/or dental programs, drop coverage(s), and/or add or drop Dependents from your coverage(s) for the following Plan Year. The Plan Administrator will notify you of the applicable Open Enrollment period.

Orthotics is an external device that is not surgically implanted that replaces a body part or the function of a body part and is customized to the patient. This includes an addition or alteration to a shoe, and orthopedic shoes. Orthotics does not include a brace requested for support or protection of a body part for the purpose of sports.

Out of Pocket Maximum is the amount that you must pay for covered medical expenses each calendar year before benefits will be paid at 100% of the Reasonable & Customary fee under the Major Medical portion of the Plan. There is no out of pocket maximum for benefits paid through the Preferred Provider portion of the Plan.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Participant includes any Employee, Retiree or enrolled Eligible Dependent who is covered under this Plan.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Brookhaven Science Associates, LLC Welfare Plan, which is a benefits plan for certain Employees, Retirees and Eligible Dependents of Brookhaven Science Associates, LLC and is described in this document.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Preferred Provider is a provider that is either a facility or physician that participates with the Plan contracted network.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectible insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Primary Care Physician (PCP) means a Physician who is engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

Rehabilitation Services are services which, in the judgment of the Participant's Physician, can be expected to result in significant clinical improvement of the Participant's condition through Short-Term Therapy. Rehabilitation Services do not include Rehabilitation Services for conditions relating to psychiatric care or abuse or addiction to alcohol or substance abuse.

Retired Employee is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Short Term Therapy constitutes a period of 60 days/visits per Participant per calendar year for each physical therapy; occupational therapy; and speech and hearing therapy for treatment of illness or injury which in the judgment of the Participant's Provider can be expected to result in significant clinical improvement of the Participant's condition.

Sickness is a person's illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse means the person of the opposite sex to whom you are legally married.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Urgent care is the delivery of ambulatory care in a facility dedicated to the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.

Urgent Care Center (Urgi-center) is an ambulatory care facility dedicated to the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.

Usual, Reasonable and Customary Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is less than the Reasonable and Customary Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Reasonable and Customary.

Vytra Managed Health Systems, Inc. (VMHS) means the contractual partner of Brookhaven Science Associates, LLC and provider of group health benefits for Participants as described in this document.