

benefits program

Brookhaven Science Associates, LLC (BSA) believes that employee benefits are an important and meaningful part of the compensation received by every employee.

BSA has provided its employees with a broad benefits program, which includes the following:

MEDICAL PLAN
DENTAL PLAN
LIFE INSURANCE PLAN
LONG TERM DISABILITY PLAN
TRAVEL ACCIDENT INSURANCE PLAN
RETIREMENT PLAN
401(K) PLAN
FLEXIBLE SPENDING ACCOUNTS PLAN
TUITION REFUND PROGRAM
SEVERANCE PAY PLAN
LONG TERM CARE PLAN
VACATION BUY PLAN
ADOPTION ASSISTANCE PROGRAM
TRANSIT COMMUTER BENEFIT PLAN

The information in this booklet is intended to provide only a summary of BSA's benefits program. Nothing contained in any section of this booklet should be construed as a promise of employment or continued employment, or to constitute contractual obligations. If questions arise, official plan documents and insurance agreements are controlling and govern final determination of benefits consistent with applicable laws and regulations.

BSA maintains the right to modify, suspend, or terminate benefit plans in whole or in part at any time.

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MEDICAL PLAN

The Medical Plan provides benefits for medical coverage. Enrollment in the Medical Plan is optional.

WHO IS ELIGIBLE FOR THE MEDICAL PLAN?

Active Employees

All regular employees who work at least 20 hours per week are eligible to participate in the group Medical Plan on the first day of active employment.

Eligible Dependents

The following members of your family are also eligible for Medical Plan coverage:

- Your spouse, defined as the person of the opposite sex to whom you are legally married.
- Your eligible same-sex domestic partner and that partner's eligible child(ren). To be eligible, you must provide a copy of your marriage certificate, domestic partner registry or proof of financial interdependence. Additional information is available at <http://www.bnl.gov/hr/Benefits/DomesticPartners.asp>

Children of your eligible domestic partner must meet the criteria for children indicated below.

- Your child(ren) up to his or her 26th birthday, including adopted children and stepchildren.
- Coverage may be continued for your eligible dependents who are or over age 26 and who are or 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.

If a dependent is no longer eligible for coverage and you do not remove that dependent from your coverage within the applicable period indicated in the Qualifying Event section, your dependent will be removed from your coverage as of the date the Benefits Office is notified.

Dependents of Deceased Participants

If you are participating in the Medical Plan and die while receiving Long Term Disability (LTD) Plan benefits, and are not eligible for retiree medical coverage or are in active service and die, your covered dependents may continue in the plan, for one year following the date of your death, by paying the required employee premiums.

After the first year:

- If you had less than 3 years of Continuous Service, your covered dependents may continue in the plan under the COBRA provisions by paying the COBRA cost of the plan.
- If you were not in the calendar year of your 58th birthday or later and do not meet the eligibility requirements for retiree medical coverage (see below) and you had at least 3 but less than 15 years of Continuous Service, your covered dependents may continue in the plan by paying the COBRA cost of the plan.
- If you were not in the calendar year of your 58th birthday or later and you had at least 15 or more years of Continuous Service, your covered dependents may continue in the plan

by paying the required retiree premiums.

- If you were in the calendar year of your 58th birthday or later and had at least 3 years of Continuous Service, your covered dependents may continue in the plan by paying the required retiree premiums.
- If you meet the eligibility requirements for the retiree medical coverage (see below), your covered dependents may continue in the plan by paying the required retiree premiums.

If you are participating in the Medical Plan and die while receiving Long Term Disability (LTD) Plan benefits, and are eligible for retiree medical coverage or die while on retiree medical coverage, your covered dependents may continue in the plan by paying the required retiree premiums.

These provisions will not apply to covered dependents if eligible for coverage under another group medical insurance plan. Coverage will terminate when they no longer qualify as eligible dependents. Coverage will also terminate for covered dependents on the date the surviving spouse remarries.

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.

ENROLLMENT

Eligible employees may enroll in one of the medical programs within 30 days of their date of hire. Once you enroll, you must continue participation in the program until the end of the calendar year or your termination date of employment, if earlier. If you do not enroll for coverage within 30 days of your date of hire, you will be required to wait until the next Open Enrollment Period or when you have a Qualifying Event to elect coverage.

To enroll, you must complete an enrollment form and list all dependents you want covered. Enrollment forms are available through the Benefits Office. By completing the form, you will authorize the necessary payroll premiums for the coverage you select. The coverages available are:

- Employee only.
- Employee and one dependent.
- Employee and two or more dependents.

You cannot enroll your eligible dependents without also enrolling yourself for medical coverage. Employees cannot enroll their dependents in a different medical program than the one they select for themselves.

Coverage begins on your date of hire if you complete all enrollment forms and submit them to the Benefits Office within 30 days of your date of hire.

MEDICAL PROGRAMS AVAILABLE

Eligible employees and their dependents may enroll in one of the non-Medicare medical programs.

Non-Medicare-eligible retirees, non-Medicare-eligible participants receiving LTD Plan benefits, and non-Medicare eligible dependents of retirees and participants receiving LTD Plan benefits may enroll in one of the non-Medicare medical programs.

Medicare-eligible retirees, Medicare-eligible participants receiving LTD Plan benefits, and Medicare-eligible dependents of retirees and participants receiving LTD Plan benefits may enroll in one of the Medicare medical programs.

A brief summary of the benefits provided under each program is at the end of the Medical Plan section.

Medical Programs Available

Non-Medicare-Eligible Participants	Medicare-Eligible Participants
Aetna HMO	CIGNA Open Access Plus
CIGNA Open Access Plus	HIP VIP HMO
HIP HMO	
Vytra PPO	

- If you and your spouse are **not** eligible for Medicare, you may both participate in a non-Medicare plan but must both elect the same plan.
- If you and your spouse are eligible for Medicare, you may both participate in a Medicare plan but must both elect the same plan.

- If you are **not** eligible for Medicare but your spouse is eligible for Medicare (or vice versa), the Medicare-eligible participant may participate in any of the Medicare plans. The non-Medicare-eligible participant may participate in any of the non-Medicare plans.

THE OPEN ACCESS PLUS (OAP) ADMINISTERED BY CIGNA

Under the CIGNA OAP program, services are provided through a network of physicians and facilities, but benefits are also provided for use of providers who are not in the network.

If services are received from an in-network provider, there is no claim filing. Most in-network services are covered in full after a small co-payment.

If services are received from a provider who is not in the CIGNA OAP network (thus is out-of-network), you have a deductible, must file claim forms, and most services are covered at a percentage of the Reasonable and Customary (R&C) amount.

The CIGNA OAP program provides benefits to cover in-hospital and out-of-hospital expenses. Under this program, you use the physician of your choice for medical care for you and your covered dependents. For expenses to be covered by the program, they must be for necessary and essential care and treatment of an injury, illness, or pregnancy. Certain facilities and care providers may not be covered by this program.

Additional information on benefits, exclusions, and limitations is provided in your CIGNA Insurance Certificate which is available at no charge in the Benefits Office.

THE PREFERRED PROVIDER ORGANIZATION (PPO) ADMINISTERED BY VYTRA

Under the Vytra PPO program, services are provided through a network of physicians and facilities, but benefits are also provided for use of providers who are not in the network.

If services are received from an in-network provider, there is no claim filing. Most in-network services are covered in full after a small co-payment.

If services are received from a provider who is not in the Vytra PPO network (thus is out-of-network), you have a deductible, must file claim forms, and most services are covered at a percentage of the Reasonable and Customary (R&C) amount.

The Vytra PPO program provides benefits to cover in-hospital and out-of-hospital expenses. Under this program, you use the physician of your choice for medical care for you and your covered dependents. For expenses to be covered by the program, they must be for necessary and essential care and treatment of an injury, illness, or pregnancy. Certain facilities and care providers may not be covered by this program.

Prescription drug coverage for Vytra participants is provided through CIGNA.

Additional information on benefits, exclusions, and limitations is provided in your Vytra Insurance Certificate which is available at no charge in the Benefits Office.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

HMO programs are available for medical coverage. Currently, non-Medicare HMOs are provided through Aetna and HIP and a Medicare HMO is provided through HIP. Information on the benefits provided through the HMOs is contained in literature available at no charge in the Benefits Office. Under the HMOs, services are provided through a network of participating physicians and facilities. Coverage is not provided for providers who are not in the HMO's network. To change providers in your HMO, you must contact the HMO. If you require the care of a medical specialist, your participating physician must give you a referral to a specialist in that HMO's network. Many of the services are provided for a small co-payment. There are no deductibles or claim forms to file. Please note that coverage under the HMOs is subject to change by the HMO and is based on provisions at the time the service is provided. Many preventive services, such as an annual physical, are provided by the HMOs.

If you have any questions about your HMO, contact the HMO.

Authorization

- If your primary care physician believes you need to see a specialist, he or she will provide you with a referral.
- In case of an emergency, you do not require prior approval or authorization by your primary care physician or insurance company. However, you must notify your primary care physician and your insurance company of your visit to the emergency room as soon as reasonably possible.

Preventive Services

Services such as well child care, routine physicals, and routine gynecological examinations are provided. For a list of such services, refer to your member handbook.

	PHONE NUMBERS	PROVIDER DIRECTORY*
AETNA	(800) 323-9930	www.aetna.com
CIGNA	(800) 244-6224	www.cigna.com
HIP	(800) 447-8255	www.hipusa.com
VYTRA	(631) 694-6565	www.hipusa.com

*Provider directories are available online at the websites indicated above.

COORDINATION OF BENEFITS**Coverage Under Other Employers' Plans**

If you and your covered dependents are eligible to receive benefits under another group medical plan, coordination of benefits is based on the terms of those plans. In many cases the HMOs do not provide additional reimbursement when coordinated with another group medical plan.

In the case of dependent children who are covered by more than one group plan, the insurance plan of the parent whose birthday occurs earlier in the calendar year will be the primary insurance plan for the children.

To obtain all the benefits available, you and your family members must file claims under each plan.

Dual Coverage

Prior to January 1, 2006, dual coverage allowed both spouses to participate in the CIGNA programs where they could elect to cover each other and their eligible dependents in such programs provided they paid the required premiums. Dual coverage was eliminated as of January 1, 2006. Dual coverage was also eliminated for members of the IBEW union as of January 1, 2011.

Medicare

For retired employees, participants who are receiving LTD Plan benefits and their dependents who are eligible for Medicare, the medical programs will not pay for any medical expenses that are eligible for reimbursement under Medicare. Retired employees, participants who are receiving LTD Plan benefits and their dependents who are eligible for Medicare must enroll for both Parts A and B of Medicare. If the participant does not enroll for Medicare Parts A and B, (a) the participant is not eligible to enroll in a Medicare HMO and (b) the OAP program, administered by CIGNA, will reduce benefits as if Medicare coverage is in place.

CLAIMS**How to File a Claim**

To file a claim under the out-of-network portion of the OAP or PPO programs you must complete a claim form that is available in the Benefits Office or through the Benefits Office website at:

www.bnl.gov/hr/Benefits/.

If you are retired, on long term disability or a dependent and covered by Medicare, you should submit your bills to Medicare first. For items not covered in full by Medicare, submit the explanation of benefits from Medicare, copies of the bills, and a completed claim form to CIGNA (for the OAP program).

Completed CIGNA program claim forms and copies of your bills should be submitted to the address on the back of your identification card.

Vytra claims should be submitted to the address on the claim form.

There are no claim forms to file under the HMOs. The providers will bill the HMO for you.

Questions About Claims

If you have a question about your CIGNA OAP program claim, you should contact CIGNA. If you have a question about your Vytra PPO claim, you should contact Vytra. If you participate in the Vytra PPO and have a question about your prescription drugs, you should contact CIGNA (not Vytra) at (800) 244-6224. When discussing your claim, please refer to the explanation of benefits, the claim form, and any other correspondence that you may have received. You can contact the CIGNA claims administrator at (800) 244-6224 or the Vytra claims administrator at (631) 694-6565.

How to Appeal a Claim

Under the CIGNA OAP program, you may request a review of the denied claim in writing to the insurance company within 365 days of the receipt of the notice of denial. You should state the reasons why your claim should not have been denied, including any additional documents which you believe support your claim. In normal cases, the insurance company will render a decision within 30 days of the date your request for review is received.

Under the Vytra PPO, your explanation of benefits will identify if a claim is denied and the reason for the denial. You may request a review of the denied claim in writing to the insurance company within 180 days of the receipt of the notice of denial. You should state the reasons why your claim should not have been denied, including any additional documents which you believe support your claim. You will then receive a written acknowledgment within 15 business days of receipt of your request. In normal cases, the insurance company will provide resolution of your appeal within 30 calendar days of receiving all necessary information.

Under the Aetna program, you may request a review of the denied claim by contacting the insurance company at (800) 323-9930. You will then receive a written acknowledgement that you must sign and return to the insurance company. Within 15 days of receipt, the insurance company will request additional information. You should provide any additional information to assist them in reviewing the claim. In normal cases, the insurance company will render a decision within 30 days of the date your request for review is received.

Under the HIP program, you may request a review of the denied claim within 180 days of the receipt of an adverse determination notice by contacting the insurance company at (800) 447-8255, or submit your request in writing to HIP Grievance and Appeal Department, JAF Station, P.O. Box 2844, New York, N.Y. 10116-2844 or submit your request in person to the Customer Service Walk-In Unit, 55 Water Street Lobby, New York, N.Y. 10041-8190. If the insurance company requests additional information you should provide such information to assist them in reviewing the claim. In normal cases the insurance company will render a decision within 30 business days of the date your request for review is received.

EXCLUSIONS

The OAP program, administered by CIGNA, will not provide payment for:

- Expenses that are covered by Workers' Compensation, no-fault automobile insurance, or uninsured motorist insurance law.
- Charges for unnecessary services or charges which you would not be legally required to pay or which would not have been made if there was no insurance.
- Charges for supplies, care, treatment or surgery which are not considered essential for the care and treatment of an injury or sickness.
- Charges in excess of reasonable and customary limits or program maximums.
- Charges for private duty nursing while confined as an inpatient.
- Charges for or in connection with custodial services, education or training.
- Expenses for or in connection with experimental procedures, treatment methods, drugs or substances not approved by the American Medical Association, the Food and Drug Administration, or the appropriate medical society.
- Charges for or in connection with routine refractions, eye exercises, surgical treatment of a refractive error, or purchase or replacement of contact lenses or eyeglasses.
- Charges for or in connection with speech therapy if (a) used to improve speech skills that have not fully developed, (b) considered custodial or educational, or (c) intended to maintain speech communication.
- Charges made by a provider who is a member of your or your dependent's family.
- Charges covered by Medicare.
- Dental x-rays and examinations, and dental work unless made necessary by accidental injury to sound natural teeth.

Additional exclusions may apply. Refer to your CIGNA Insurance Certificate for additional information.

The Vytra PPO program will not provide coverage for:

- Cosmetic, plastic or reconstructive surgery, except as specified in your Certificate of Coverage.
- Disabilities connected to military service.
- Examinations required for employment, school, licensing, insurance, etc..
- Transportation, except in the case of an emergency.
- Dental care, except as specified in your Certificate of Coverage.
- Custodial care, except as may be covered through Hospice Care or by a Skilled Nursing Facility.
- Personal or comfort items, subject to your rights to an appeal, and external review.

Additional exclusions may apply. Contact Vytra for information on such exclusions.

The Aetna and HIP HMO programs will not provide coverage for:

- Expenses that are covered by Workers' Compensation, no-fault automobile insurance, or uninsured motorist insurance law.
- Charges for or in connection with custodial services, education or training.
- Expenses for or in connection with experimental procedures, treatment methods, drugs or substances not approved by the American Medical Association, the Food and Drug Administration, or the appropriate medical society.

- Charges for cosmetic surgery except when such service is incidental to or follows surgery for trauma, infection or other diseases of the part of the body involved. For a covered child, coverage is provided for reconstructive surgery to treat congenital disease or anomaly which results in a functional defect.
- Hearing aids.
- Certain expenses for infertility services.
- Charges made by a provider who is a member of your or your dependent's family.
- Charges covered by Medicare.
- Dental x-rays and examinations, and dental work unless made necessary by accidental injury to sound natural teeth (Aetna).

Additional exclusions may apply. For a list of such exclusions refer to your HMO's member handbook.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers 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. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurance issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

WOMEN'S BREAST CANCER

Federal law requires group health plans to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services are subject to deductibles, co-insurance and co-payment amounts that are consistent with those that apply to other benefits under the plan.

EMPLOYEE PREMIUMS

Employees who elect to participate in the Medical Plan must pay the required premiums. Your premiums are based on your Base Salary, the cost of the plan you elect, and whether you elect to cover (a) yourself only, (b) yourself and one dependent or (c) yourself and two or more dependents. You may pay your premiums with before-tax or after-tax dollars. Before-tax premiums are deducted from your pay before state and federal income taxes and Social Security taxes are withheld, resulting in a lower actual cost to you. After-tax premiums are deducted from your pay after taxes are withheld and result in no tax savings to you. Employee premiums are indicated at the end of the Medical Plan section.

If your annual salary is below the Social Security wage base and you pay your premiums with before-tax dollars, your future Social Security benefits may be reduced.

RETIREE PREMIUMS

Retiree premiums are affected by both your eligibility for Medicare and the Medicare eligibility of your covered dependents. If a participant lives outside of the United States and is ineligible for Medicare, the premium for that participant for Medical Plan coverage will be the Medicare Part B premium in addition to any other required Medical Plan premium.

Retiree premiums are indicated at the end of the Medical Plan section, and are subject to change.

DISPLACED WORKERS HEALTH BENEFITS PROTECTION ACT (DWHBP) PREMIUMS

Employees who are terminated from employment as part of a reduction-in-force may continue their medical coverage by paying the required premiums. Premiums during the first year after termination of employment will be the active employee premium based on your Base Salary on the day immediately preceding termination of employment. During the second year, premiums will be one-half of the applicable COBRA premium. After the second year, such participants may continue coverage under COBRA for up to 18 months. Premiums are indicated at the end of the Medical Plan section. Such DWHBP benefits as described in this section are not available to participants, their spouse or their dependent child if eligible for Medicare, retiree medical coverage, or for coverage under another employer's group health plan. If a participant is ineligible for DWHBP benefits, they may be eligible to continue coverage for up to 18 months under COBRA.

OPEN ENROLLMENT PERIOD

Open enrollment is held once a year. During an Open Enrollment Period, you may change medical programs, drop coverage and/or add or drop dependents from your coverage. Employees who did not previously elect medical coverage may elect it during the Open Enrollment Period. Participants receiving LTD Plan benefits, retirees, and their dependents who did not previously elect medical coverage, may not elect it during the Open Enrollment Period. Changes you elect during the Open Enrollment Period will be effective January 1 of the following calendar year. Your elections will be in effect for the remainder of the calendar year unless you notify the Benefits Office of a Qualifying Event within 31 days of the event.

QUALIFYING EVENT

A Qualifying Event is a change in your family status and includes:

- (a) Change in legal marital status
 1. marriage
 2. death of spouse
 3. divorce
 4. legal separation
 5. annulment
- (b) Change in the number of dependents
 1. birth
 2. adoption
 3. placement for adoption
 4. death of a dependent
- (c) Change in employment status
 1. termination or commencement of employment of the employee, spouse or dependent (other than for misconduct)

- (d) Changes in work schedule
 1. an increase or decrease in the number of hours of employment by the employee, spouse or dependent
 2. a switch between full-time and part-time status
 3. a strike or lockout
 4. commencement or return from an unpaid leave of absence
- (e) The dependent satisfies or ceases to satisfy the requirements for dependents
 1. attainment of age
- (f) A change in the place of residence or work site of the employee, spouse or dependent

In addition, based on the provisions of the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA), employees and dependents that are eligible but not enrolled for BSA health insurance plan coverage may enroll for coverage if one 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*.

*CHIP (Children's Health Insurance Program) is a state program designed to provide health care coverage for uninsured children and some adults.

You have 31 days from the date of a Qualifying Event to make changes to your medical coverage for all items indicated above except (a)(3), (a)(4), and (e)(1). You have 60 days from the date of a Qualifying Event to make changes to your medical coverage for items (a)(3), (a)(4), (e)(1), and changes related to CHIPRA. The change requested must relate to the change that affects eligibility for medical coverage. Changes are made by completing an enrollment form, available in the Benefits Office. The completed form must be submitted, with proof of the Qualifying Event, to the Benefits Office. Your premiums will then be changed for the remainder of the calendar year. Coverage will become effective as of the date of the event.

If you do not make a change to your medical coverage within the applicable period indicated above, you must wait until the next Open Enrollment Period. If a dependent is no longer eligible for coverage and you do not remove that dependent from your coverage within the applicable period indicated above, your dependent will be removed from your coverage as of the date the Benefits Office is notified.

MISCELLANEOUS

Base Salary

Base Salary for the purpose of the medical programs means your basic rate of pay, before any salary reductions. It does not include overtime, bonuses, or any other compensation. For part-time employees, Base Salary is based on the full-time equivalent basic rate of pay. For union employees, Base Salary is based on the terms of the union contract.

Continuous Service

Continuous Service means service from your most recent hire date. Service performed prior to a break in employment is not included in Continuous Service. Continuous Service will be reduced by periods on approved Leave of Absence and will not include periods when the employee is not eligible for medical benefits. Continuous Service shall include Continuous Service, if any, with Associated Universities, Inc., Battelle Memorial Institute, Research Foundation of the State University of New York or the State University of New York at Stony Brook immediately prior to a transfer of employment to Brookhaven Science Associates, LLC.

Deductible

Under the out-of-network portion of the OAP and the PPO programs, the Deductible is the amount you pay out of your pocket before you receive reimbursement for covered medical expenses. The Deductible does not include expenses that exceed the Reasonable and Customary charges.

For all participants:

- The annual Deductible for the OAP program, administered by CIGNA, is \$500 per individual (\$1500 per family) per calendar year.
- The annual Deductible for the Vytra PPO program is \$2,000 per individual (\$4,000 per family) per calendar year.

In general:

- In-network OAP and PPO medical expenses do not have a Deductible nor do they count toward the Deductible.
- If three or more members of a family incur total out-of-pocket expenses, during the calendar year, in excess of the Family Deductible, no further Deductible amounts are required for the entire family during the remainder of that year.
- The deductibles indicated above do not apply to the HMOs.
- In addition to the above, there is a separate \$100 per individual (\$300 per family) annual prescription deductible for the OAP and PPO programs. This applies, in total, to both the retail pharmacy and mail order portions of the program.

General Information

Information regarding the plan identification number, plan year, plan funding, type of plan, plan sponsor, plan administrator, agent for legal process, your rights under ERISA, prudent actions by plan fiduciaries, modification, suspension, or termination of the plan, and privacy of information can be found in the General Information section of this booklet.

Hospital Preadmission Certification

Under the OAP and PPO programs, all covered participants must obtain Hospital Preadmission Certification. This certification is mandatory for a hospital stay of one or more nights. If you are retired or disabled and covered by Medicare, you are not required to pre-certify your hospital admission.

If Hospital Preadmission Certification is not obtained, a \$250 penalty will be applied to the OAP and PPO programs. In addition, under the OAP and PPO programs, benefits for any days not approved by the insurance company will be reduced by 50% of the amount otherwise payable. The expenses that you incur because of these benefit limitations will not apply to your Out-Of-Pocket Maximum.

For Hospital Preadmission Certification, call the toll free phone number provided on your medical identification card before admission to the hospital or within 48 hours of an emergency admission.

Under the HMOs, you must call the telephone number shown on your medical identification card to obtain approval for hospital care or the applicable claims will be denied.

Leave of Absence

If you are on an approved Leave of Absence, including for military duty, you may continue your medical coverage during the term of the approved leave from the starting date of your leave by paying the required employee premiums. This coverage will cease when the employee is no longer on the approved Leave of Absence. Participants on approved military leave may drop medical coverage for themselves while continuing to cover their dependents.

Continuation of insurance is not allowed while on leave for other employment when (1) the other employer offers coverage or (2) the other employer is an agency or prime contractor of the federal government that will cover you under its insurance program.

If you drop medical coverage while on an approved Leave of Absence, you may enroll again upon your return to work in an eligible status.

Lifetime Maximum Medical Benefits

There is no lifetime maximum amount of medical benefits under the medical programs.

Out-Of-Pocket Maximum

Under the out-of-network portion of the OAP and PPO programs, when a participant incurs the amount of covered out-of-pocket medical expenses indicated below, in addition to the Individual Deductible, medical expenses for that person will be reimbursed at 100% of the R&C amount for the remainder of the calendar year. In-network OAP and PPO expenses do not count toward the out-of-pocket maximum.

	Annual Calendar Year Out-Of-Pocket Maximum	
	Individual	Family
— CIGNA OAP	\$2500	\$7500
— Vytra PPO	\$5000	\$10000
— Aetna HMO	\$1500	\$3000
— HIP HMO	Not Applicable	Not Applicable

Participants Receiving Long Term Disability Plan Benefits

Participants who are receiving BSA LTD Plan benefits may continue medical coverage for themselves and their eligible dependent(s) by paying the required premiums. Currently, for participants whose eligibility date to receive LTD Plan benefits was prior to January 1, 2009, no premium is required to continue this coverage. For participants who were not members of the IBEW union whose eligibility date to receive LTD Plan benefits was after December 31, 2008, coverage may be continued by paying the active employee premium. This coverage will cease when the employee is no longer eligible to receive LTD Plan benefits. If the participant is then eligible for retiree medical benefits, the participant may continue medical coverage by paying the required retiree premiums.

For participants who were members of the IBEW union whose eligibility date to receive LTD plan benefits was after December 31, 2008, no premium is required to continue this coverage.

Qualified Medical Child Support Order

Information on the administration of a qualified medical child support order can be obtained at no charge from the Benefits Office.

Reasonable and Customary (R&C)

Under the OAP and PPO programs, a charge is considered Reasonable and Customary if it is the normal charge made by the provider for a similar service or supply and it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by the insurance company.

Second Surgical Opinion

Second surgical opinions are based on the terms of each program. You must call the telephone number shown on your medical identification card to obtain the procedures for a second surgical opinion.

Termination of Coverage

Medical coverage for active employees, and their dependents under the Medical Plan will cease on the earlier of the date your employment terminates, the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay the required premiums.

Coverage for terminated employees, who continue benefits under COBRA, will cease on the earlier of the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay the required premiums.

Medical coverage for retirees and their dependents and participants receiving LTD Plan benefits will cease on the earlier of the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay the required premiums.

Dependent coverage will also cease when the dependent becomes ineligible. Coverage for your spouse also ceases due to divorce or legal separation from you. Coverage for your dependent children also ceases when the child no longer meets the eligibility requirements of this plan.

COBRA

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 members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

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 previously in this notice. 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 your coverage under the Plan because either one of the following qualifying 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 happens:

- 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 Benefits Office 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, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Benefits Office of the qualifying event.

Notification Requirements

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Benefits Office in writing within 60 days after the qualifying event occurs and provide documentation of the event.

When the Benefits Office has been notified that one of these events has occurred, they will in turn notify you and your dependents of the right to elect continuation coverage.

If you do not elect continuation coverage within 60 days from the date of the notice from the Benefits Office or the date of the qualifying event, whichever is later. Your group medical insurance coverage will end retroactively to the date of the event that caused the loss of coverage.

If you elect continuation coverage, you will have the same medical coverage you had before the event, although it may be modified if coverage changes for similarly situated participants.

How is COBRA Coverage Provided?

Once the Benefits Office 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 Benefits Office in a timely manner, 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 notify the Benefits Office within 60 days after the qualifying event occurs and provide documentation of the event.

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.

COBRA Premium Requirements

You, or your dependents, will be required to pay 102% of the full cost of the continuation coverage under the provisions of COBRA. You will be billed for the required premium on a regular basis. COBRA premiums are indicated at the end of the Medical Plan section.

Termination of Coverage Under COBRA

Continuation coverage will end when any of the following events occur:

- The Benefits Office is notified by you or your dependent to discontinue coverage.
- 18 months after continuation coverage begins (if coverage was continued due to termination or resignation of the employee).
- 29 months after continuation coverage begins (if coverage was continued due to disability).
- 36 months after continuation coverage begins (if coverage was continued because of death of the employee, divorce, legal separation or loss of dependent status).
- The individual becomes eligible for Medicare after the date of the COBRA election.
- An individual becomes covered under another group plan, unless a pre-existing condition prevents you or your dependent from being covered by the other plan.
- For a spouse or dependent child: If the Benefits Office is not notified within 31 days of the date of divorce or legal separation.
- For a dependent child: If the Benefits Office is not notified within 31 days of the date the dependent status ends.
- Payment for continuation coverage is not paid on time.
- The group health care plan is terminated for active employees.

CONVERSION

You or your dependents may be entitled to convert your medical coverage to an individual policy if (a) you were insured under the OAP program, for the three months immediately prior to when coverage ceased, (b) coverage ceased because you were no longer in active employment or no longer eligible for Medicare, or (c) coverage ceased due to ineligibility. You are not eligible for a converted policy if insurance under this plan is replaced by similar coverage within 45 days. If you qualify for conversion, no medical examination will be required, but you must apply in writing and pay the premium for the coverage to the insurance company within 45 days from the date your group medical insurance coverage ceased. The necessary application forms are available directly from the insurance company.

ERISA

Refer to the General Information section of this booklet for information regarding your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

**EMPLOYEE PREMIUMS
(JANUARY 1, 2011)
Monthly Contribution**

For monthly paid employees:

Annual Base Salary*	Medical Plan	Coverage		
		Employee Only	Employee + 1 Dependent	Employee + 2 or More Dependents
\$0 - \$39,999.99	Aetna	\$73.33	\$174.68	\$241.44
	CIGNA	\$74.72	\$157.63	\$216.43
	HIP	\$54.80	\$100.28	\$159.29
	Vytra	\$51.17	\$104.02	\$147.91
\$40,000 - \$69,999.99	Aetna	\$110.00	\$262.02	\$362.16
	CIGNA	\$112.08	\$236.44	\$324.64
	HIP	\$82.20	\$150.42	\$238.94
	Vytra	\$76.75	\$156.03	\$221.86
\$70,000 - \$99,999.99	Aetna	\$139.33	\$331.89	\$458.74
	CIGNA	\$141.96	\$299.49	\$411.21
	HIP	\$104.12	\$190.53	\$302.65
	Vytra	\$97.22	\$197.64	\$281.02
\$100,000 and over	Aetna	\$175.99	\$419.22	\$579.46
	CIGNA	\$179.32	\$378.30	\$519.43
	HIP	\$131.52	\$240.67	\$382.30
	Vytra	\$122.80	\$249.65	\$354.97

Weekly Contribution

For weekly paid employees:

Annual Base Salary*	Medical Plan	Coverage		
		Employee Only	Employee + 1 Dependent	Employee + 2 or More Dependents
\$0 - \$39,999.99	Aetna	\$16.92	\$40.31	\$55.72
	CIGNA	\$17.24	\$36.38	\$49.94
	HIP	\$12.65	\$23.14	\$36.76
	Vytra	\$11.81	\$24.01	\$34.13
\$40,000 - \$69,999.99	Aetna	\$25.38	\$60.47	\$83.58
	CIGNA	\$25.86	\$54.56	\$74.92
	HIP	\$18.97	\$34.71	\$55.14
	Vytra	\$17.71	\$36.01	\$51.20
\$70,000 - \$99,999.99	Aetna	\$32.15	\$76.59	\$105.86
	CIGNA	\$32.76	\$69.11	\$94.90
	HIP	\$24.03	\$43.97	\$69.84
	Vytra	\$22.44	\$45.61	\$64.85
\$100,000 and over	Aetna	\$40.61	\$96.74	\$133.72
	CIGNA	\$41.38	\$87.30	\$119.87
	HIP	\$30.35	\$55.54	\$88.22
	Vytra	\$28.34	\$57.61	\$81.92

For medical plan participants who are not members of the IBEW union and whose eligibility date to receive BSA Long Term Disability Plan benefits was after December 31, 2008: Premium: Employee Premium indicated above

For medical plan participants whose eligibility date to receive BSA Long Term Disability Plan benefits was prior to January 1, 2009 or for participants who were members of the IBEW union: Premium: \$0.00

*The Base Salary category for eligible part-time employees is based on their full-time equivalent salary.

These premiums are subject to change.

RETIREE PREMIUMS
FOR PARTICIPANTS WHO WERE NOT IN THE IBEW UNION
(January 1, 2011)
Monthly Premium

Retirement Date	Medicare-Eligible	Medical Plan(s)	Annual Base Salary*	Coverage		
				One Person	2 People	3 or More People
Prior to 10/1/95	N/A	Aetna CIGNA HIP HIP VIP Vytra	N/A	\$0.00	\$0.00	\$0.00
10/1/95 - 9/30/96	No	Aetna	Less than \$30,000	\$10.29	\$15.71	\$21.13
		CIGNA	\$30,000 - \$39,999.99	\$14.63	\$21.67	\$29.25
		HIP	\$40,000 - \$59,999.99	\$18.96	\$28.17	\$37.92
		Vytra	\$60,000 and over	\$24.97	\$37.48	\$49.97
10/1/95 - 12/31/01	Yes	CIGNA HIP VIP	N/A	\$0.00	\$0.00	\$0.00
10/1/96 - 12/31/01	No	Aetna	Less than \$30,000	\$20.58	\$31.42	\$42.25
		CIGNA	\$30,000 - \$39,999.99	\$29.25	\$43.33	\$58.50
		HIP	\$40,000 - \$59,999.99	\$37.92	\$56.33	\$75.83
		Vytra	\$60,000 and over	\$49.93	\$74.95	\$99.94
1/1/02 or later	Yes	CIGNA	N/A	\$83.12	\$166.36	\$282.51
		HIP VIP (Suffolk)	N/A	\$85.01	\$170.02	
1/1/02 or later	No	Aetna	N/A	\$146.66	\$349.35	\$482.88
		CIGNA	N/A	\$149.43	\$315.25	\$432.86
		HIP	N/A	\$109.60	\$200.56	\$318.58
		Vytra	N/A	\$102.34	\$208.04	\$295.81

*The Base Salary category is based on your full-time equivalent salary on the day immediately preceding your retirement. If you retired from long term disability status, the Base Salary category is based on your full-time equivalent salary on the day immediately preceding your termination of employment. Your retirement date is determined to be the date LTD Plan benefits cease.

These premiums are subject to change.

RETIREE PREMIUMS
FOR PARTICIPANTS WHO WERE IN THE IBEW UNION
(January 1, 2011)
Monthly Premium

Retirement Date	Medicare-Eligible	Medical Plan(s)	Annual Base Salary*	Coverage		
				One Person	2 People	3 or More People
Prior to 10/1/95	N/A	Aetna CIGNA HIP HIP VIP Vytra	N/A	\$0.00	\$0.00	\$0.00
10/1/95 - 9/30/96	No	Aetna	Less than \$30,000	\$10.29	\$15.71	\$21.13
		CIGNA	\$30,000 - \$39,999.99	\$14.63	\$21.67	\$29.25
		HIP	\$40,000 - \$59,999.99	\$18.96	\$28.17	\$37.92
		Vytra	\$60,000 and over	\$24.97	\$37.48	\$49.97
10/1/95 - 7/31/06	Yes	CIGNA HIP VIP	N/A	\$0.00	\$0.00	\$0.00
10/1/96 - 7/31/00	No	Aetna	Less than \$30,000	\$20.58	\$31.42	\$42.25
		CIGNA	\$30,000 - \$39,999.99	\$29.25	\$43.33	\$58.50
		HIP	\$40,000 - \$59,999.99	\$37.92	\$56.33	\$75.83
		Vytra	\$60,000 and over	\$49.93	\$74.95	\$99.94
8/1/00 - 12/31/03	No	Aetna	Less than \$30,000	\$22.64	\$34.56	\$46.48
		CIGNA	\$30,000 - \$39,999.99	\$32.18	\$47.66	\$64.35
		HIP	\$40,000 - \$59,999.99	\$41.71	\$61.96	\$83.41
		Vytra	\$60,000 and over	\$54.92	\$82.45	\$109.93
1/1/04 - 7/31/06	No	Aetna CIGNA HIP Vytra	Actual Monthly Base Salary*	3% of Monthly Base Salary*	3.5% of Monthly Base Salary*	4% of Monthly Base Salary*
8/1/06 or later	Yes	CIGNA	N/A	\$83.12	\$166.36	\$282.51
		HIP VIP (Suffolk)		\$85.01	\$170.02	
8/1/06 or later	No	Aetna	N/A	\$146.66	\$349.35	\$482.88
		CIGNA		\$149.43	\$315.25	\$432.86
		HIP		\$109.60	\$200.56	\$318.58
		Vytra		\$102.34	\$208.04	\$295.81

*The Base Salary category is based on your full-time equivalent salary on the day immediately preceding your retirement. If you retired from long term disability status, the Base Salary category is based on your full-time equivalent salary on the day immediately preceding your termination of employment. Your retirement date is determined to be the date LTD Plan benefits cease.

These premiums are subject to change.

DWHBP PREMIUMS

During 1st year following termination of employment	see Employee Premiums
During 2nd year following termination of employment	one-half of COBRA Premiums

These premiums are subject to change.

COBRA PREMIUMS**(January 1, 2011)****Monthly Premium**

Medical Plan	Coverage		
	One Person	2 People	3 or More People
Aetna	\$747.97	\$1,781.71	\$2,462.69
CIGNA	\$762.11	\$1,607.78	\$2,207.57
CIGNA for Medicare-Eligible Participants	\$423.90	\$848.44	
HIP	\$558.95	\$1022.84	\$1,624.77
HIP VIP (Suffolk) for Medicare-Eligible Participants	\$433.54	\$867.08	
Vytra	\$521.91	\$1061.02	\$1,508.63

These premiums are subject to change.

MEDICAL PROGRAMS

- All Employees
- Non-Medicare-Eligible Retirees
- Non-Medicare-Eligible Participants on LTD

	CIGNA		Aetna		Vytra		HIP	
	In-Network	Out-of-Network	In-Network Only	In-Network	Out-of-Network	In-Network	In-Network Only	
Medical Care Provider	Participating physician/facility	Any physician/facility	Participating physician/facility	Participating physician/facility	Any physician/facility	Participating physician/facility	Participating physician/facility	
Payment of Benefits	No claim forms	Submit claim forms	No claim forms	No claim forms	Submit claim forms	No claim forms	No claim forms	
Age Limit for Dependent Children	Up to 26th birthday	Up to 26th birthday	Up to 26th birthday	Up to 26th birthday	Up to 26th birthday	Up to 26th birthday	Up to 26th birthday	
Annual Deductible (Individual/Family)	N/A	\$500/\$1500	N/A	N/A	\$2000/\$4000	N/A	N/A	
Annual Out-of-Pocket Maximum (Indiv/Family) (Excl. Deductible)	N/A	\$2500/\$7500	\$1500/\$3000	N/A	\$5000/\$10000	N/A	N/A	
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	
Pre-Existing Condition Limitation	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Office Visits	Covered in full after \$20 co-pay PCP \$30 co-pay Specialist	80% of R&C after deductible	Covered in full after \$20 co-pay PCP \$25 co-pay Specialist	Covered in full after \$20 co-pay PCP \$25 co-pay Specialist	70% of R&C after deductible	Covered in full after \$20 co-pay PCP \$30 co-pay Specialist	Covered in full after \$20 co-pay PCP \$30 co-pay Specialist	
Emergency Room (Accident/Illness)	Covered in full	Emergency: Covered in full Non-emergency: 80% of R&C after deductible	Covered in full after \$50 co-pay (waived if admitted)	Covered in full after \$50 co-pay (waived if admitted)	Emergency: Covered in full after \$50 co-pay (waived if admitted) Non-emergency: only covered out of network: 70% of R&C after deductible	Covered in full after \$50 co-pay (waived if admitted)	Covered in full after \$50 co-pay (waived if admitted)	
Inpatient Hospital (Semi-Private Room, Board, Services, Supplies)	Covered in full	Covered in full	Covered in full	Covered in full	70% of R&C after deductible	Covered in full	Covered in full	
(Physician/Surgeon)	Pre-admission certification required or \$250 penalty plus 50% reduction in benefits on any days not approved.	Pre-admission certification required or \$250 penalty plus 50% reduction in benefits on any days not approved.	Pre-admission certification required or \$250 penalty plus 50% reduction in benefits on any days not approved.	Pre-admission certification required or \$250 penalty plus 50% reduction in benefits on any days not approved.	Pre-admission certification required or \$250 penalty plus 50% reduction in benefits on any days not approved.	Pre-admission certification required or \$250 penalty plus 50% reduction in benefits on any days not approved.	Pre-admission certification required or \$250 penalty plus 50% reduction in benefits on any days not approved.	
Second Surgical Opinion (Office Visit)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	70% of R&C after deductible	Covered in full	Covered in full	
Laboratory/X-Ray	Covered in full	100% of R&C	Covered in full after \$25 co-pay	Covered in full after \$25 co-pay	100% of R&C	Covered in full	Covered in full	
Maternity (Initial Visit To Determine Pregnancy) (Subsequent Visits/Delivery)	Covered in full after \$20 co-pay	80% of R&C after deductible	Lab: Covered in full X-ray: Covered in full after \$25 co-pay	Lab: Covered in full X-ray: Covered in full after \$25 co-pay	70% of R&C after deductible	Covered in full after \$20 co-pay	Covered in full after \$20 co-pay	
Prescription Medication (Retail)	\$10 generic \$25 brand name formulary \$40 brand name non-formulary (up to 30-day supply) after deductible*	Use in-network benefit	\$10 generic \$20 brand name formulary \$40 brand name non-formulary (up to 30-day supply)	\$10 generic \$20 brand name formulary \$40 brand name non-formulary (up to 30-day supply)	Administered by Cigna (see CIGNA column for prescription drug benefits coverage)	\$15 generic \$30 brand name formulary \$50 brand name non-formulary (up to 30-day supply)	\$15 generic \$30 brand name formulary \$50 brand name non-formulary (up to 30-day supply)	
(Mail Order)	\$20 generic \$50 brand name formulary \$80 brand name non-formulary (up to 90-day supply) after deductible*	Use in-network benefit	\$20 generic \$40 brand name formulary \$80 brand name non-formulary (31 to 90-day supply)	\$20 generic \$40 brand name formulary \$80 brand name non-formulary (31 to 90-day supply)	Administered by Cigna (see CIGNA column for prescription drug benefits coverage)	\$22.50 generic \$45 brand name formulary \$150 brand name non-formulary (up to 90-day supply)	\$22.50 generic \$45 brand name formulary \$150 brand name non-formulary (up to 90-day supply)	

* after meeting a \$100 per person/\$300 per family annual drug deductible
 PCP = Primary Care Physician
 R&C = Reasonable & Customary

MEDICAL PROGRAMS

- Medicare-Eligible Retirees
- Medicare-Eligible Participants on LTD

Preventive Care		The Patient Protection and Affordable Care Act requires that certain, but not all, preventive care services be covered at 100% with no deductible, coinsurance or co-pay. Such preventive services will be defined by agencies and committees identified by the government and may be subject to change. Not all preventive care services are included in this mandate.	
Mental Health Care (Inpatient) (Outpatient)	Same as inpatient hospital	Covered in full	Covered in full
	Covered in full after \$20 co-pay	Covered in full after \$20 co-pay	Covered in full after \$25 co-pay
Substance Abuse Treatment (Inpatient Detox) (Outpatient Rehab)	Same as inpatient hospital	Covered in full	Covered in full
	Covered in full after \$20 co-pay	Covered in full after \$20 co-pay	Covered in full after \$25 co-pay
Alternate Care (Home Health Care)	80% of R&C after deductible	Covered in full after \$20 co-pay	Covered in full
	Covered in full (Max: 40 visits/year combined in and out of network)	Covered in full after \$20 co-pay (Max: 3 intermittent visits/day)	Covered in full (Max: 200 visits/year)
(Skilled Nursing Facility Non-Custodial)	Same as inpatient hospital	Covered in full	Covered in full
	Covered in full (Max: 60 days/year combined in and out of network)	Covered in full	Covered in full
(Outpatient Short-Term Rehab: Physical Therapy)	80% of R&C after deductible	Covered in full after \$25 co-pay	Covered in full after \$30 co-pay
	Covered in full after \$30 co-pay	Covered in full after \$25 co-pay (Max: 60 consecutive days/injury/lifetime)	Covered in full after \$30 co-pay (Max: 90 visits/year)
Durable Medical Equipment	80% of R&C after deductible	Covered in full	Covered in full
External Prosthetic Devices	80% of R&C after deductible	Covered in full for initial device only	Covered in full
	Not covered	Covered in full	Covered in full
Vision Care** (Routine Eye Exam)	Not covered	Covered in full	Covered in full for optometrist in discount program (1 exam every 24 months)
	1 pair of glasses following cataract surgery	Coverage available. Based on fee schedule.	Coverage available. Based on fee schedule.
Hearing Aids	Covered in full (Max: \$2000/ 1095 days)	Not covered	Not covered

** Also available to all employees is a vision discount program through National Vision, Inc located at the Walmart in Middle Island, NY.

PCP = Primary Care Physician R&C = Reasonable & Customary

MEDICAL PROGRAMS

For Medicare-eligible retirees
For Medicare-eligible participants on long term disability

	CIGNA		HIP VIP
	In-Network	Out-of-Network	
Medical Care Provider	Participating physician/facility	Any physician/facility	In-Network Only
Payment of Benefits	No claim forms	Submit claim forms	No claim forms
Age Limit for Dependent Children	Up to 26th birthday	Up to 26th birthday	Up to 26th birthday
Annual Deductible (Individual/Family)	N/A	\$500/\$1500	N/A
Annual Out-of-Pocket Maximum (Indiv/Family) (Excl. Deductible)	N/A	\$2500/\$7500	N/A
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Pre-Existing Condition Limitation	N/A	N/A	N/A
Office Visits	Covered in full after \$20 co-pay PCP \$30 co-pay Specialist	80% of R&C after deductible	Covered in full for PCP \$10 co-pay Specialist
Emergency Room (Accident/illness)	Covered in full	Emergency: Covered in full Non-emergency: 80% of R&C after deductible	Covered in full after \$50 co-pay (waived if admitted) (Doctors/Specialists: \$10 co-pay)
Inpatient Hospital (Semi-Private Room, Board, Services, Supplies)	Covered in full	Covered in full	Covered in full
(Physician/Surgeon)	Pre-admission certification required or \$250 penalty plus 50% reduction in benefits on any days not approved.		
Second Surgical Opinion (Office Visit)	Covered in full	80% of R&C after deductible	Covered in full
Laboratory/X-Ray	Covered in full	100% of R&C 80% of R&C after deductible	Covered in full Covered in full after \$20 co-pay
Prescription Medication (Retail)	\$10 generic \$25 brand name formulary \$40 brand name non-formulary (up to 30-day supply) after deductible*	Use in-network benefit	\$5 formulary \$45 non-formulary (up to 30-day supply)
(Mail Order)	\$20 generic \$50 brand name formulary \$80 brand name non-formulary (up to 90-day supply) after deductible*	Use in-network benefit	\$7.50 formulary \$135 non-formulary (up to 90-day supply)

* after meeting a \$100 per person/\$300 per family annual drug deductible

DENTAL PLAN

The Dental Plan provides benefits for preventive, diagnostic, restorative, and orthodontic dental services. Enrollment in the Dental Plan is optional.

WHO IS ELIGIBLE FOR THE DENTAL PLAN?

Active Employees

All regular employees who work at least 20 hours per week are eligible to participate in the group Dental Plan on the first day of active employment.

Eligible Dependents

The following members of your family are also eligible for Medical Plan coverage:

- Your spouse, defined as the person of the opposite sex to whom you are legally married.
- Your eligible same-sex domestic partner and that partner's eligible child(ren). To be eligible, you must provide a copy of your marriage certificate, domestic partner registry or proof of financial interdependence. Additional information is available at <http://www.bnl.gov/hr/Benefits/DomesticPartners.asp>

Children of your eligible domestic partner must meet the criteria for 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. An unmarried child is considered to be eligible for dependent coverage up to his or her 19th birthday.
- 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're 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. You must provide proof of full-time student status within 31 days of the beginning of each school semester.

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 follows:

- Dependent coverage ends as of the end of the month in which he or she is no longer a full-time student.
- Based on the provisions of Michelle’s Law, 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 a BSA health care 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.

If a dependent is no longer eligible for coverage and you do not remove that dependent from your coverage within the applicable period indicated in the Qualifying Event section, your dependent will be removed from your coverage as of the date the Benefits Office is notified.

ENROLLMENT

Eligible employees may enroll in one of the dental programs within 30 days of their date of hire. Once you enroll, you must continue participation in the program until the end of the calendar year or your termination date of employment, if earlier. If you do not enroll for coverage within 30 days of your date of hire, you will be required to wait until the next Open Enrollment Period or when you have a Qualifying Event to elect coverage.

To enroll, you must complete an enrollment form and list all dependents you want covered. Enrollment forms are available through the Benefits Office. By completing the form, you will authorize the necessary payroll premiums for the coverage you select. The coverages available are:

- Employee only.
- Employee and one dependent.
- Employee and two or more dependents.

You cannot enroll your eligible dependents without also enrolling yourself for dental coverage nor can you enroll them in a different dental program than the one you select for yourself.

Coverage begins on your date of hire if you complete all enrollment forms and submit them to the Benefits Office within 30 days of your date of hire.

DENTAL PROGRAMS AVAILABLE

Eligible employees and their dependents may enroll in the Delta Dental Indemnity Plan, the Delta Dental DMO Plan (DeltaCare USA), or the Delta Dental PPO Plan.

DELTA DENTAL INDEMNITY PLAN

The Delta Dental Indemnity Plan allows you to use any dentist to care for you and your family. It is a fee-for-service plan and provides reimbursement for a portion of the cost of covered dental services based on a schedule.

Benefits Provided

The Delta Dental Indemnity Plan pays a combined maximum of \$1,000 in benefits per calendar year for each covered individual for preventive and diagnostic services plus basic and major dental services. The maximum lifetime benefit for covered orthodontic services is \$1,000 per eligible child.

Schedule of Maximum Allowable Covered Dental Expenses

The maximum allowable amounts specified in the following schedule are not intended to represent what your dentist's charges will be or should be. These are the maximum reimbursement amounts for specified dental services. The claims administrator will pay benefits for dental services that are covered by the plan but not listed below. The claims administrator will determine benefits on the basis of the complexity and severity of the type of service in an amount consistent with the maximum allowance specified for other dental services. Limitations may apply.

The schedule of benefits is at the end of the Dental section. Coverage information indicated is not all inclusive.

Coordination of Benefits

Coverage Under Other Employers' Plans

If you or your covered dependents are eligible to receive benefits under another group dental plan, the benefits from that plan will be coordinated with the benefits from the Delta Dental Indemnity Plan so that up to 100% of the "allowable expenses" incurred during a calendar year will be paid jointly by the plans.

An allowable expense is any necessary, reasonable, and customary expense covered in full or in part under any one of the group plans involved.

In the case of dependent children who are covered by more than one group plan, the insurance plan of the parent whose birthday occurs earlier in the calendar year will be the primary insurance plan for the children.

To obtain all the benefits available, you and your family members must file claims under each plan.

Claims

How to File a Claim

You have the following options to file a claim under the Delta Dental Indemnity Plan.

- Your dentist can submit the claim electronically or
- Send a claim form to:

Delta Dental of New York, Inc.
P.O. Box 2105
Mechanicsburg, PA 17055-2105

Claim forms are available in the Benefits Office or on the Web at: www.bnl.gov/hr/Benefits/dental/linkablefiles/DeltaCImFrm.pdf.

Questions About Claims

If you have a question about your Delta Dental Indemnity Plan claim, you should contact the claims administrator at Delta Dental at (800) 932-0783. When discussing your claim, please refer to the explanation of benefits, the claim form, and any other correspondence that you may have received.

How to Appeal a Claim

Your explanation of benefits will identify if a claim is denied and the reason for the denial. You may request a review of the denied claim in writing to Delta Dental at One Delta Drive, Mechanicsburg, PA 17055 within 180 days of the date of the notice of denial. You should state the reasons why you feel your claim should not have been denied, including any additional documents which you believe support your claim. In normal cases, a decision will be rendered within 30 days of the date your request for review is received.

Phone Number

Delta Dental: (800) 932-0783

DELTA DENTAL DMO PLAN (DELTACARE USA)

The Delta Dental DMO Plan (DeltaCare USA) provides services through a network of participating dentists. It is a dental maintenance organization, DMO, and services are based on a fee schedule. If you choose to participate in this plan, you must select a participating dentist. You may select different participating dentists for you and your dependents. By contacting Delta Dental, you may change participating dentists as of the first day of the month after you request the change provided the request is made by the 21st of the month. Coverage is not provided for providers who are not in the Delta Dental DMO (DeltaCare USA) network. If you require the care of a dental specialist, your participating dentist must give you a referral to a specialist in Delta Dental's DMO (DeltaCare USA) network.

Benefits Provided

The Delta Dental DMO Plan (DeltaCare USA) provides coverage for preventive, basic and restorative dental services, and orthodontia for both adults and children. The schedule of benefits is at the end of the Dental Section.

Please note that the cost of dental services is subject to change and is based on provisions of the Delta Dental DMO Plan (DeltaCare USA) at the time the service is provided. The cost of other dental services covered by the Delta Dental DMO Plan (DeltaCare USA) are included in the Delta Dental Care patient charge schedule which can be obtained at no cost through the Benefits Office or directly from Delta .

Emergency Services

Delta Dental will pay for up to \$100 in dental expenses for each emergency if (1) the need for treatment occurs at least 35 miles from the participant's contracted dentist's facility or (2) the participant is unable to contact the designated participating dentist. You are responsible for the copayment(s) as well as any charges over the \$100.

Emergency is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned contract dentist.

Specialty Referrals

When specialized dental care services are required, your designated participating dentist must initiate the referral process and refer you to a specialist in Delta Dental's DMO (DeltaCare) network.

Coordination of Benefits

If you or any of your covered dependents are eligible to receive benefits under another group dental plan, benefits from that plan will be coordinated with the benefits from the Delta Dental DMO Plan (DeltaCare USA).

How to File a Claim

There are no claim forms to file under the Delta Dental DMO Plan (DeltaCare USA). You just pay the dentist the scheduled fee.

Questions About Claims

If you have any questions about costs or procedures under the Delta Dental DMO Plan (DeltaCare USA), you should contact Delta Dental at (800) 422-4234.

How to Appeal a Claim

You may request a review of the denied claim in writing to DeltaCare, Quality Management Dept., P. O. Box 6050, Artesia, CA 90702 or by telephone to the Delta Dental DMO Plan (DeltaCare USA). You should state the reasons why you feel your claim should not have been denied. In normal cases, the insurance company will render a decision within 30 days of the date your request for review is received.

Phone Number

Delta Dental DMO Plan (DeltaCare USA): (800) 422-4234

Provider Directory

Provider directories are available on the Web at: www.deltadentalins.com

DELTA DENTAL PPO PLAN

Under the Delta Dental PPO Plan, services are provided through a network of participating dentists, but benefits are also provided for use of providers who are not in the network. You do not need to enroll with a specific dentist to receive coverage under this plan. In-network benefits are provided if you use a provider in Delta's dental PPO or Premier network. Out-of-network benefits are provided if you use a provider who is not in Delta's dental PPO or Premier network. The plan is a preferred provider organization, PPO, and provides reimbursement for a portion of the cost of covered dental services based on a schedule. To receive reimbursement of covered expenses you or your provider must submit a claim.

Benefits Provided

The Delta Dental PPO Plan pays a combined maximum of \$1,000 in benefits per calendar year for each covered individual for preventive and diagnostic services plus basic and major dental services. The maximum lifetime benefit for covered orthodontic services is \$1,000 per eligible child.

Coordination of Benefits

Coverage Under Other Employers' Plans

If you or your covered dependents are eligible to receive benefits under another group dental plan, the benefits from that plan will be coordinated with the benefits from the Delta Dental PPO Plan so that up to 100% of the "allowable expenses" incurred during a calendar year will be paid jointly by the plans.

An allowable expense is any necessary, reasonable, and customary expense covered in full or in part under any one of the group plans involved.

In the case of dependent children who are covered by more than one group plan, the insurance plan

of the parent whose birthday occurs earlier in the calendar year will be the primary insurance plan for the children.

To obtain all the benefits available, you and your family members must file claims under each plan.

Claims

How to File a Claim

You have the following options to file a claim under the Delta Dental PPO Plan.

Claim forms are available in the Benefits Office or on the Web at: www.bnl.gov/dental/linkablefiles/DeltaCImFrm.pdf.

- Your dentist can submit the claim electronically or
- Send a claim form to:

Delta Dental of New York, Inc.
P.O. Box 2105
Mechanicsburg, PA 17055-2105

Questions About Claims

If you have a question about your Delta Dental PPO Plan claim, you should contact Delta Dental at (800) 932-0783. When discussing your claim, please refer to the explanation of benefits, the claim form, and any other correspondence that you may have received.

How to Appeal a Claim

Your explanation of benefits will identify if a claim is denied. You may request a review of the denied claim in writing to the insurance company within 365 days of the receipt of the notice of denial. You should state the reasons why your claim should not have been denied, including any additional documents which you believe support your claim. In normal cases, the insurance company will render a decision within 30 days of the date your request for review is received.

Phone Number

Delta Dental PPO Plan: (800) 932-0783

Provider Directory

Provider directories are available on the Web at: www.deltadentalins.com

DUAL COVERAGE

Prior to January 1, 2006, dual coverage allowed both spouses to participate in the dental program where they could elect to cover each other and their eligible dependents provided they paid the required premiums. Dual coverage was eliminated as of January 1, 2006. Dual coverage was also eliminated for all members of the IBEW union as of January 1, 2011.

EXCLUSIONS

The following dental expenses are not covered by the Delta Dental Indemnity Plan, the Delta Dental Care Plan (DeltaCare USA), or the Delta Dental PPO Plan:

- Cosmetic treatment, experimental treatment, dietary planning, plaque control, oral hygiene instructions, treatment for the correction of any congenital or developmental malformation.
- Replacement of a lost or stolen appliance, extra appliances, or a dentally acceptable bridge, cap, crown, or denture.

- Replacement of a bridge, denture, cap, crown, etc. within five years of its original installation unless this is necessary owing to installation of an original opposing full denture, the extraction of natural teeth, or irreparable damage as a result of an accident while the denture is in place.
- Replacement of a fixed or removable prosthodontic or orthodontic appliance that has been made useless due to patient abuse, misuse, or neglect, or has been lost, stolen, or damaged.
- Appliances or restorations to alter vertical dimensions, stabilize teeth, restore occlusion, or diagnose or treat conditions or dysfunction of the temporomandibular joint.
- Installation of an initial appliance replacing teeth that were already missing when you or a dependent became insured.
- Any procedure or service associated with the placement or prosthodontic restoration of a dental implant. (Delta Dental DMO only)
- Services related to an injury or illness paid under Workers' Compensation, no-fault automobile or uninsured motorist insurance law, government laws, regulations, public programs, or similar laws.
- Charges in excess of Reasonable and Customary limits.
- Charges for unnecessary services or charges which would not have been made had no benefit existed or which you would not be legally required to pay.
- Services covered by a group medical plan.
- Prescription drugs.
- Charges for broken appointments or for completion of claim forms.

Additional exclusions may apply. Contact the Benefits Office at (631) 344-2877 or (631) 344-5126 for additional information, including a copy of the dental schedules.

EMPLOYEE PREMIUMS

Employees who elect to participate in the Dental Plan must pay the required premiums. Your premiums are based on the Plan you elect and whether you elect to cover (a) yourself only, (b) yourself and one dependent or (c) yourself and two or more dependents. You may pay your premiums with before-tax or after-tax dollars. Before-tax premiums are deducted from your pay before state and federal income taxes and Social Security taxes are withheld, resulting in a lower actual cost to you. After-tax premiums are deducted from your pay after taxes are withheld and result in no tax savings to you.

If your annual salary is below the Social Security wage base and you pay your premiums with before-tax dollars, your future Social Security benefits may be reduced.

Employee premiums are indicated at the end of the Dental Plan section.

OPEN ENROLLMENT PERIOD

Open enrollment is held once a year. During an Open Enrollment Period, you may change dental programs, drop coverage and/or add or drop dependents from your coverage. Employees who did not previously elect dental coverage may elect it during the Open Enrollment Period. Changes you elect during the Open Enrollment Period will be effective January 1 of the following calendar year. Your elections will be in effect for the remainder of the calendar year unless you notify the Benefits Office of a Qualifying Event within a limited period of time from the date of the event.

QUALIFYING EVENT

A Qualifying Event is a change in your family status and includes:

- (a) Change in legal marital status
 1. marriage
 2. death of spouse
 3. divorce

4. legal separation
5. annulment
- (b) Change in the number of dependents
 1. birth
 2. adoption
 3. placement for adoption
 4. death of a dependent
- (c) Change in employment status
 1. termination or commencement of employment of the employee, spouse or dependent (other than for misconduct)
- (d) Changes in work schedule
 1. an increase or decrease in the number of hours of employment by the employee, spouse or dependent
 2. a switch between full-time and part-time status
 3. a strike or lockout
 4. commencement or return from an unpaid leave of absence
- (e) The dependent satisfies or ceases to satisfy the requirements for unmarried dependents
 1. attainment of age
 2. student status
- (f) A change in the place of residence or work site of the employee, spouse or dependent

In addition, based on the provisions of the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA), employees and dependents that are eligible but not enrolled for BSA health insurance plan coverage may enroll for coverage if one 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*.

*CHIP (Children's Health Insurance Program) is a state program designed to provide health care coverage for uninsured children and some adults.

You have 31 days from the date of a Qualifying Event to make changes to your dental coverage for all items indicated above except (a)(3), (a)(4) and (e)(1). You have 60 days from the date of a Qualifying Event to make changes to your dental coverage for items (a)(3), (a)(4), (e)(1) and changes related to CHIPRA. The change requested must relate to the change in your family status that affects eligibility for dental coverage. Changes are made by completing an enrollment form, available in the Benefits Office. The completed form must be submitted, with proof of the Qualifying Event, to the Benefits Office. Your premiums will then be changed for the remainder of the calendar year. Coverage will become effective as of the date of the event.

If you do not make a change to your dental coverage within the applicable period indicated above, you must wait until the next Open Enrollment Period. If a dependent is no longer eligible for coverage and you do not remove that dependent from your coverage within the applicable period indicated above, your dependent will be removed from your coverage as of the date the Benefits Office is notified.

MISCELLANEOUS

General Information

Information regarding the plan identification number, plan year, plan funding, type of plan, plan sponsor, plan administrator, agent for legal process, your rights under ERISA, prudent actions by plan fiduciaries, modification, suspension, or termination of the plan, and privacy of information can be found

in the General Information section of this booklet.

Leave of Absence

If you are on an approved Leave of Absence, including for military duty, you may continue your dental coverage during the term of the approved leave from the starting date of your leave by paying the required active employee premiums. This coverage will cease when the employee is no longer on the approved Leave of Absence. Participants on approved military leave may drop dental coverage for themselves while continuing to cover their dependents.

Continuation of insurance is not allowed while on leave for other employment when (1) the other employer offers coverage or (2) the other employer is an agency or prime contractor of the federal government that will cover you under its insurance program.

If you drop dental coverage while on an approved Leave of Absence, you may enroll again upon your return to work in an eligible status.

Participants Receiving Long Term Disability Benefits

Employees who qualify for Long Term Disability (LTD) Plan benefits may continue dental coverage for themselves and their eligible dependent(s) by payment of the required active employee premiums. This coverage will cease when the employee is no longer eligible to receive LTD Plan benefits.

Reasonable and Customary (R&C)

Under the Delta Dental PPO Plan, a charge is considered Reasonable and Customary if it is the normal charge made by the provider for a similar service or supply and it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by Delta Dental.

Termination of Coverage

Dental coverage for active employees, participants receiving LTD Plan benefits, and their dependents under the Dental Plan will cease on the earlier of the date your employment terminates, the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay the required premiums. Coverage for terminated employees, who continue benefits under COBRA, will cease on the earlier of the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay the required premiums.

Individual dependent coverage will also cease when the dependent becomes ineligible. Coverage for your spouse also ceases due to divorce or legal separation from you. Coverage for your dependent children also ceases when the child no longer meets the eligibility requirements of this plan.

COBRA

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 members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

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 previously in this notice. 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 your coverage under the Plan because either one of the following qualifying 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 happens:

- 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 Benefits Office 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, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Benefits Office of the qualifying event.

Notification Requirements

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Benefits Office in writing within 60 days after the qualifying event occurs and provide documentation of the event.

When the Benefits Office has been notified that one of these events has occurred, they will in turn notify you and your dependents of the right to elect continuation coverage.

If you do not elect continuation coverage within 60 days from the date of loss of coverage due to one of the events described above, your group dental insurance coverage will end retroactively to the date of the event that caused the loss of coverage.

If you elect continuation coverage, you will have the same dental coverage you had before the event, although it may be modified if coverage changes for similarly situated participants.

How is COBRA Coverage Provided?

Once the Benefits Office 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 Benefits Office 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 notify the Benefits Office within 60 days after the qualifying event occurs and provide documentation of the event.

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.

COBRA Premium Requirements

You, or your dependents, will be required to pay 102% of the full cost of the continuation coverage under the provisions of COBRA. You will be billed for the required premium on a regular basis. COBRA premiums are indicated at the end of the Dental Plan section.

Termination of Coverage Under COBRA

Continuation coverage will end when any of the following events occur:

- The Benefits Office is notified by you or your dependent to discontinue coverage.
- 18 months after continuation coverage begins (if coverage was continued due to termination or resignation of the employee).
- 29 months after continuation coverage begins (if coverage was continued due to disability).
- 36 months after continuation coverage begins (if coverage was continued because of death of the employee, divorce, legal separation or loss of dependent status).
- The individual becomes eligible for Medicare after the date of the COBRA election.
- An individual becomes covered under another group plan, unless a pre-existing condition prevents you or your dependent from being covered by the other plan.
- For a spouse or dependent child: If the Benefits Office is not notified within 31 days of the date of divorce or legal separation.
- For a dependent child: If the Benefits Office is not notified within 31 days of the date the dependent status ends.

- Payment for continuation coverage is not paid on time.
- The group health care plan is terminated for active employees.

ERISA

Refer to the General Information section of this booklet for information regarding your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

**EMPLOYEE PREMIUMS
(January 1, 2011)**

Coverage	Delta Dental Indemnity Plan (Delta Dental) or Delta DMO		Delta PPO	
	Weekly	Monthly	Weekly	Monthly
Employee only	\$1.15	\$ 5.00	\$2.33	\$10.11
Employee + 1 dependent	\$2.31	\$10.00	\$4.81	\$20.86
Employee + 2 or more dependents	\$4.38	\$19.00	\$7.90	\$34.23

**COBRA PREMIUMS
(January 1, 2011)**

Coverage	Monthly Premium		
	Delta Dental Indemnity Plan	Delta Dental DMO (DeltaCare)	Delta Dental PPO
Employee only	\$14.35	\$17.90	\$31.58
Employee + 1 dependent	\$30.49	\$36.36	\$67.07
Employee + 2 or more dependents	\$42.75	\$54.11	\$94.06

These premiums are subject to change.

DENTAL PROGRAMS			
DELTA DENTAL			
	PPO	Indemnity	DMO
Network	PPO and Premier Networks	PPO and Premier Networks	DeltaCare
Provider	In-Network Participating Provider	In- and Out-of-Network Any Provider	In-Network Only Participating Provider
Claim Process	Dentist will charge you applicable coinsurance	Must submit claim to Delta Dental	Pay dentist scheduled fee
Dependent Children Age Limit	To age 19. End of year age 23 if full-time student.	To age 19. End of year age 23 if full-time student.	To age 19. End of year age 23 if full-time student.
Annual Deductible Per Individual/Family (for basic & major restorative dental services. Does not apply to preventive services.) For the family Deductible to apply, at least three family members must reach their individual Deductible.	\$25/\$75 (in- and out-of-network combined)	\$25/\$75	N/A
Calendar Year Maximum Benefit Per Person (for all services other than orthodontia.)	\$1,000 (in- and out-of-network combined)	\$1,000	N/A
Eligibility for Orthodontia Coverage	Children: To age 19. Employee/Spouse: not eligible.	Children: To age 19. Employee/Spouse: not eligible.	Children: To age 19. End of year age 23 if full-time student. Employee/Spouse: eligible.
Predetermination of Benefits	Predetermination of Benefits allows you to determine what services will be covered and what payments will be made before your dental treatment is performed. The procedure is as follows: The dentist informs the claims administrator of the proposed course of treatment by itemizing services and charges. The claims administrator then determines the amount the plan will pay and informs you and your dentist. You and your dentist should discuss the result before the work is done. If a Predetermination of Benefits is not requested, the claims administrator will pay the claims based on the information provided. If your dentist submits a treatment plan for Predetermination of Benefits and then changes the treatment plan, the claims administrator will adjust the payments accordingly. If any major changes in the treatment plan are made, your dentist should send in a revised course of treatment to the claims administrator.		
Services Provided After Eligibility Ceases	Normally, the plans will not pay for services or supplies beyond termination of your coverage or when dependent is no longer eligible for coverage, even if a Predetermination of Benefits has been made before coverage ceases. However, there are three exceptions for which benefits are payable: - A prosthetic device (such as full or partial denture) if the dentist took the impressions and prepared the abutment teeth while the patient was covered; - A crown if the dentist prepared the tooth for the crown while the patient was covered by the plan; - Root canal therapy if the dentist opened the tooth while the patient was covered.		

Network	PPO		Indemnity		DMO
	PPO and Premier Networks	N/A	PPO and Premier Networks	DeltaCare	
Medical	In-Network	Out-of-Network	In- and Out-of-Network	In-Network Only	
	The Medical Plan, specifically the OAP medical program, administered by Cigna Healthcare, covers a limited number of specific dental procedures. When dental benefits are available under both the OAP medical program and the Delta Dental Indemnity or PPO plans, the benefits payable under the Delta Dental Indemnity or PPO plans will be coordinated with the benefits payable under the OAP medical program so that up to 100% of allowable expenses will be paid jointly by the plans. In all such cases, the Delta Dental Indemnity or PPO program is considered the primary policy to which you must submit claims first.				
Coverage Based On	Reduced Contracted Fees	Reasonable & Customary Fees	Reimbursement Schedule	Fee Schedule	
	Amount insurance company pays		Amount insurance company pays		Amount participant pays
Diagnostic & Preventive Services					
Periodic exams (limits apply) (D0120)	80%	70%	\$22.00	\$0.00	\$0.00
Bitewing x-rays/radiographs four films (limits apply) (D0274)	80%	70%	\$23.00	\$0.00	\$0.00
Panoramic film (D0330)	80%	70%	\$50.00	\$0.00	\$0.00
Prophylaxis (cleaning) (limits apply) (D1110)	80%	70%	\$38.00	\$0.00	\$0.00
Restorative					
Fillings: Amalgam - one surface (D2140)	60%	45%	\$26.00	\$0.00	\$0.00
Resin-based composite - one surface, anterior (D2330)	60%	45%	\$30.00	\$5.00	\$5.00
Resin-based composite - one surface, posterior (D2391)	60%	45%	Not Covered	\$55.00	\$55.00
Inlay - metallic - one surface (D2510)	50%	35%	\$125.00	\$170.00	\$170.00
Onlay - metallic - two surfaces (D2542)	50%	35%	Not Covered	\$185.00	\$185.00
Inlay - porcelain/ceramic - one surface (D2610)	50%	35%	Not Covered	\$295.00	\$295.00
Onlay - porcelain/ceramic - two surfaces (D2642)	50%	35%	Not Covered	\$325.00	\$325.00
Inlay - resin based composite - one surface (D2650)	50%	35%	Not Covered	\$195.00	\$195.00
Onlay - resin based composite - two surfaces (D2662)	50%	35%	Not Covered	\$250.00	\$250.00
Crowns: Resin with high noble metal (D2720)	50%	35%	\$200.00	\$320.00	\$320.00

Network	PPO		Indemnity	DMO
	PPO and Premier Networks	Out-of-Network		
	In-Network	Out-of-Network	In- and Out-of-Network	In-Network Only
Implants				
Surgical placement of implant body, endosteal implant (D6010)	50%	35%	\$1,000.00	Not Covered
Surgical placement of interim implant body for transitional prosthesis: endosteal implant (D6012)	50%	35%	\$1,000.00	Not Covered
Surgical replacement: endosteal implant (D6040)	50%	35%	\$1,000.00	Not Covered
Surgical replacement: transosteal implant (D6050)	50%	35%	\$1,000.00	Not Covered
Abutments (D6057)	50%	35%	\$370.00	Not Covered
Endodontics				
Pulp Cap:				
direct (excluding final restoration) (D3110)	60%	45%	\$20.00	\$0.00
indirect (excluding final restoration) (D3120)	60%	45%	\$20.00	\$0.00
Root Canal/endodontic therapy:				
anterior tooth (excluding final restoration) (D3310)	60%	45%	\$187.00	\$110.00
bicuspid tooth (excluding final restoration) (D3320)	60%	45%	\$225.00	\$200.00
molar (excluding final restoration) (D3330)	60%	45%	\$282.00	\$350.00
Apicoectomy/periradicular surgery:				
anterior (D3410)	60%	45%	\$187.00	\$130.00
bicuspid (first root) (D3421)	60%	45%	Not Covered	\$140.00
molar (first root) (D3425)	60%	45%	\$75.00	\$150.00
Periodontics				
Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant (D4210)	60%	45%	\$150.00	\$145.00
Gingival flap procedure, including root planning - four or more contiguous teeth or tooth bounded spaces per quadrant (D4240)	60%	45%	\$56.00	\$150.00

Network	PPO		Indemnity	DMO
	PPO and Premier Networks	N/A		
	In-Network	Out-of-Network	In- and Out-of-Network	In-Network Only
Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant (D4260)	60%	45%	\$350.00	\$345.00
Periodontal scaling and root planing - four or more teeth per quadrant - limits apply (D4341)	60%	45%	\$45.00	\$55.00
Full mouth debridement to enable comprehensive evaluation and diagnosis - limits apply (D4355)	60%	45%	Not Covered	\$55.00
Periodontal maintenance - limits apply (D4910)	60%	45%	\$38.00	\$40.00
Additional periodontal maintenance - limits apply (D4910)	60%	45%	\$38.00	\$55.00
Prosthodontics (Removable) limits apply				
Complete denture - maxillary (D5110)	50%	35%	\$275.00	\$335.00
Complete denture - mandibular (D5120)	50%	35%	\$250.00	\$335.00
Immediate denture - maxillary (D5130)	50%	35%	\$300.00	\$355.00
Immediate denture - mandibular (D5140)	50%	35%	\$275.00	\$355.00
Replace missing or broken teeth - complete denture (each tooth) (D5520)	50%	35%	Not Covered	\$25.00
Prosthodontics (Fixed)				
Pontic - cast high noble metal (D6210)	50%	35%	\$175.00	\$380.00
Pontic - porcelain fused to high noble metal (D6240)	50%	35%	\$250.00	\$380.00
Pontic - resin with high noble metal (D6250)	50%	35%	\$198.00	\$320.00
Inlay - porcelain/ceramic, two surfaces (D6600)	50%	35%	Not Covered	\$330.00
Inlay - cast high noble metal, two surfaces (D6602)	50%	35%	Not Covered	\$280.00
Onlay - porcelain/ceramic, two surfaces (D6608)	50%	35%	Not Covered	\$325.00
Onlay - cast high noble metal, two surfaces (D6610)	50%	35%	Not Covered	\$285.00
Crown - resin with high noble metal (D6720)	50%	35%	Not Covered	\$320.00
Crown - porcelain/ceramic (D6740)	50%	35%	\$228.00	\$380.00
Crown - porcelain fused to high noble metal (D6750)	50%	35%	\$250.00	\$380.00

Network	PPO		Out-of-Network	Indemnity		DMO
	PPO and Premier Networks	N/A		PPO and Premier Networks	DeltaCare	
	In-Network	Out-of-Network		In- and Out-of-Network	In-Network Only	
Oral and Maxillofacial Surgery						
Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (D7140)	60%	45%	\$37.00	\$8.00		
Removal of impacted tooth - soft tissue (D7220)	60%	45%	\$100.00	\$60.00		
Removal of impacted tooth - partial bony (D7230)	60%	45%	\$130.00	\$80.00		
Removal of impacted tooth - completely bony (D7240)	60%	45%	\$150.00	\$110.00		
Biopsy of oral tissue - does not include pathology laboratory procedures (D7286)	60%	45%	\$95.00	\$30.00		
Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant (D7311)	60%	45%	Not Covered	\$85.00		
Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant (D7321)	60%	45%	Not Covered	\$100.00		
Orthodontic Benefits						
Limited orthodontic treatment of the adolescent dentition - adolescent to age 19 (D8030)	50%	50%	\$1,000.00	\$1,150.00		
Limited orthodontic treatment of the adult dentition - adults, including covered dependent adult children (D8040)	Not Covered	Not Covered	Not Covered	\$1,350.00		
Interceptive orthodontic treatment of the primary dentition (D8050)	50%	50%	\$1,000.00	\$1,150.00		
Interceptive orthodontic treatment of the transitional dentition (D8060)	50%	50%	\$1,000.00	\$1,150.00		
Comprehensive orthodontic treatment of the transitional dentition - child or adolescent to age 19 (D8070)	50%	50%	\$1,000.00	\$1,900.00		
Comprehensive orthodontic treatment of the adult dentition - adults, including covered dependent adult children (D8090)	Not Covered	Not Covered	Not Covered	\$2,100.00		
Pre-orthodontic treatment visit (D8660)	50%	50%	50%	\$25.00		

Network	PPO		Indemnity		DMO
	PPO and Premier Networks	N/A	PPO and Premier Networks	DeltaCare	
	In-Network	Out-of-Network	In- and Out-of-Network	In-Network Only	
Orthodontic retention (removal of appliances, construction and placement of removable retainers) (D8680)	50%	50%	50%	\$275.00	
Orthodontic Lifetime Maximum Benefit Per Person	\$1,000 (in- and out-of-network combined)		\$1,000.00	N/A	
Adjunctive General Services					
Deep sedation/general anesthesia - first 30 minutes (D9220)	60%	40%	Covered with Allowable Oral Surgery Procedures	\$165.00	
Deep sedation/general anesthesia - each additional 15 minutes (D9221)	60%	40%	Not Covered	\$80.00	
Intravenous conscious sedation/analgesia - first 30 minutes (D9241)	60%	40%	\$37.00	\$165.00	
Intravenous conscious sedation/analgesia - each additional 15 minutes (D9242)	60%	40%	Not Covered	\$80.00	

This represents only a portion of the dental schedule. For additional information, refer to the schedule of benefits for each plan.

LIFE INSURANCE PLAN

The Life Insurance Plan offers Basic and Supplemental Life Insurance coverage and Accidental Death and Dismemberment benefits.

WHO IS ELIGIBLE FOR THE LIFE INSURANCE PLAN?

Active Employees

All regular employees who work at least 20 hours per week are eligible for Basic Life Insurance, Supplemental Life Insurance, and Accidental Death and Dismemberment (AD&D) coverages on the first day of active employment.

ENROLLMENT

Eligible employees must enroll for Basic Life Insurance coverage on their date of hire, and coverage will be effective on their date of hire. Supplemental Life Insurance coverage is optional. You will automatically be enrolled for Basic AD&D coverage when you enroll for Basic Life Insurance Coverage. You will automatically be enrolled for Supplemental AD&D coverage when you enroll for Supplemental Life Insurance coverage. All such coverages will be delayed if the employee is not actively at work. It will begin on the first day that eligibility requirements are met and the employee is actively at work.

To enroll, you must complete an enrollment form and indicate one or more Beneficiaries. Enrollment forms are available through the Benefits Office. By completing the form, you will authorize the necessary payroll premiums for the coverage you select. Eligible employees have 90 days from their date of hire to enroll for Supplemental Life Insurance coverage, and coverage will be effective on the date the enrollment form is signed.

After 90 days, employees may request enrollment, but must submit evidence of insurability and be approved by the Insurance Company before insurance can become effective. If approved, Supplemental Life Insurance coverage will become effective on the date of such approval.

LIFE INSURANCE PLAN COVERAGE EMPLOYEES UNDER AGE 65

Basic Life Insurance Benefits Provided

Basic Life Insurance coverage is provided in an amount equal to the nearest multiple of \$2,500 that exceeds your Annual Base Salary. For part-time employees, coverage is based on the actual part-time Annual Base Salary. Basic Life Insurance coverage is provided at no cost to eligible employees.

Supplemental Life Insurance Benefits Provided

In addition to Basic Life Insurance coverage, two levels of Supplemental Life Insurance coverage are also available. Supplemental I Life Insurance coverage can be purchased in an amount equal to your Basic Life Insurance coverage. Supplemental II Life Insurance coverage is available in an amount sufficient to make total Life Insurance coverage equal to approximately three times your Annual Base Salary. The total Life Insurance coverage is rounded to the nearest \$500.

Examples:

An employee whose Annual Base Salary is \$30,000 per year will have Life Insurance coverage available as follows:

Annual Base Salary	Basic Insurance	Supplemental I Insurance	Supplemental II Insurance	Total Insurance
\$30,000	\$32,500	\$32,500	\$25,000	\$90,000

If an employee works 20 hours per week, which, in this example, is assumed to be fifty percent of the regular work schedule and has an Annualized Base Salary of \$30,000, Life Insurance coverage is available as follows:

Annualized Base Salary	Actual Base Salary	Basic Insurance	Supplemental I Insurance	Supplemental II Insurance	Total Insurance
\$30,000	\$15,000	\$17,500	\$17,500	\$10,000	\$45,000

The following schedule outlines the Basic and Supplemental coverage available at various Annual Base Salary levels:

Annual Base Salary	Basic Insurance	Supplemental I Insurance	Supplemental II Insurance
\$20,000 to \$22,499.99	\$22,500	\$22,500	Additional insurance to make total coverage from Basic, Supplemental I, and Supplemental II equal to three times Annual Base Salary rounded to the nearest \$500.
\$22,500 to \$24,999.99	\$25,000	\$25,000	
\$25,000 to \$27,499.99	\$27,500	\$27,500	
\$27,500 to \$29,999.99	\$30,000	\$30,000	
\$30,000 to \$32,499.99	\$32,500	\$32,500	
\$32,500 to \$34,999.99	\$35,000	\$35,000	

(continues in multiples of \$2,500)

LIFE INSURANCE PLAN COVERAGE EMPLOYEES AGE 65 OR OVER

Basic Life Insurance Benefits Provided

Basic Life Insurance coverage is provided at no cost to eligible employees and is in accordance with the following schedule:

Age	Basic Life Insurance as Percentage of Annual Base Salary
65 to 69	66 ² /3%
70 to 74	45%
75 to 79	30%
80 or over	20%

Supplemental Life Insurance Benefits Provided

Supplemental I and Supplemental II coverages are available in amounts equal to the Basic Life Insurance coverage amount indicated above. The amount of Basic Life Insurance coverage available is determined as a fraction of Annual Base Salary rounded to the nearest \$500. Examples:

A 65 year-old employee earning \$35,200 per year enrolled in Supplemental I and II would have the following Life Insurance coverage:

Basic	\$23,500
Supplemental I	\$23,500
Supplemental II	\$23,500
Total Life Insurance	\$70,500

A 70 year-old employee earning \$35,200 per year enrolled in Supplemental I and II would have the following Life Insurance coverage:

Basic	\$16,000
Supplemental I	\$16,000
Supplemental II	\$16,000
Total Life Insurance	\$48,000

MAXIMUM LIFE INSURANCE PLAN COVERAGE

The maximum total life insurance coverage, including supplemental life insurance, is \$1 million. The minimum is \$5,000.

OPTION TO ACCELERATE PAYMENT OF DEATH BENEFITS

If you become terminally ill while insured under this Plan, you may elect Terminal Illness Proceeds. Terminal Illness Proceeds are equal to a minimum of 25% or \$50,000 if less and a max of \$500,000 not to exceed 80% of your total life insurance coverage on the date the Insurance Company receives proof of your terminal illness (but not to exceed \$50,000). Such proceeds may be reduced on account of age. Such benefits are payable to you. Additional conditions apply. One such condition is that your life expectancy is 6 months or less. If you elect this option, your total life insurance coverage at death will be reduced by the Terminal Illness Proceeds.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Benefits Provided

Accidental Death and Dismemberment (AD&D) Insurance coverage is in addition to Life Insurance coverage and is provided in amounts as follows:

Annual Base Salary	Basic AD&D Insurance	Supplemental AD&D Insurance*	Total AD&D Insurance
Less than \$5,000	\$ 5,000	\$ 5,000	\$10,000
\$5,000 to \$7,499.99	\$ 7,500	\$ 7,500	\$15,000
\$7,500 to \$9,999.99	\$10,000	\$10,000	\$30,000
\$10,000 or over	\$12,500	\$12,500	\$25,000

*Only provided if you elect Supplemental Life Insurance coverage.

The maximum total AD&D coverage is \$25,000.

This insurance will be paid, regardless of other insurance, for any of the following losses resulting from an accident occurring on or off the job while you are insured:

Loss	AD&D Coverage Amount
Life	100%
One hand by severance at or above the wrist	50%
One foot by severance at or above the ankle	50%
Sight in one eye (entire and irrecoverable)	50%
Speech	50%
Hearing	50%
More than one of the above	100%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	25%
Thumb and index finger of same hand	25%

No more than 100% of the total coverage amount can be paid.

Exclusions

AD&D insurance does not cover a loss occurring more than 90 days after the accident, or a loss if it results from any of these:

- 1) Suicide or attempted suicide.
- 2) Intentionally self-inflicted injuries, or any attempt to inflict such injuries.
- 3) War, or any act of war. “War” means declared or undeclared war and includes resistance to armed aggression.
- 4) Injury sustained during service in the armed forces (land, water, air) of any country or international authority.
- 5) Travel or flight in any vehicle used for aerial navigation. This includes getting in, out, on or off any such vehicle. This (8) applies only if:
 - a) the person is riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
 - b) the person is performing as a pilot or a crew member of any aircraft; or
 - c) you are riding as a passenger in an aircraft owned, leased or operated by your employer.
- 6) Commission of or attempt to commit a felony.
- 7) Being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a doctor.
- 8) Participation in these hazardous sports: bungee jumping; skydiving; parachuting; hang gliding; or ballooning.

Additional Benefits

The additional amount payable for loss of life as a result of an accident in a four wheel vehicle while using a seat belt is the lesser of (a) 10% of the AD&D Coverage amount, and (b) \$10,000. Additional conditions apply.

CLAIMS

How to File a Claim

To file a claim under the Life Insurance Plan, you or a family member must notify the Benefits Office. The Hartford will mail the claim form directly to the Beneficiary on file which will need to be completed and submitted to The Hartford directly with written proof of the loss within 90 days after the date of the loss. The amount of your Life and/or AD&D Insurance will be paid when the Insurance Company receives proof that you died, or were injured while insured for these benefits, and approves the claim.

Questions About Claims

If you have a question about a Life Insurance Plan claim, you should contact the Benefits Office at (631) 344-5126.

How to Appeal a Claim

If your claim is denied, you will receive a written notice of the denial from the Insurance Company. The notice will explain the reason for the denial and indicate the review procedures. You may request a review of the denied claim. The request must be submitted in writing to the Insurance Company within 180 days after you receive the denial notice. Submit your request, including your reasons for requesting the review and any additional documents which you believe support your claim. The Insurance Company will review the claim and ordinarily notify you within 45 days of the date your request for review is received. In special cases requiring a delay, the Insurance Company will render a decision

no later than 90 days after your request for review is received. If your initial appeal is denied, you may submit a second appeal within 180 days of the date such claim was denied. The Insurance Company has up to 90 days to render a decision.

EMPLOYEE PREMIUMS

Employees who elect Supplemental I or II Life Insurance coverage must pay the required employee premiums.

For under age 30: \$.08 per \$1,000 of supplemental life insurance coverage.

For ages 30 to 44: \$.20 per \$1,000 of supplemental life insurance coverage.

For ages 45 and over: \$.30 per \$1,000 of supplemental life insurance coverage.

Any change in the amount of your Life Insurance due to a change in your Annual Base Salary will result in an adjustment to your employee premiums.

Participants who are receiving BSA Long Term Disability (LTD) Plan benefits and are not members of the IBEW union may also continue Life Insurance coverage by paying the required premium.

Currently, for participants whose eligibility date to receive LTD Plan benefits was prior to January 1, 2009, no premium is required to continue this coverage. Currently, for participants whose eligibility date to receive LTD Plan benefits, was after December 31, 2008, and were not members of the IBEW union coverage may be continued by paying the active employee premium.

MISCELLANEOUS

Annual Base Salary

Annual Base Salary is the insured person's annual base salary, before exercise of any salary reduction option, as of the time of the accident or death. Overtime pay and premium pay are not included in Annual Base Salary.

Assignment of Your Life Insurance and AD&D Benefits

Instead of naming a Beneficiary, you may elect to make an assignment of your Life and AD&D Insurance benefits to your spouse or another designated person. When you assign your benefits to another person, you divest yourself of all ownership rights or interests including the right to change Beneficiaries.

You may obtain additional information and the necessary assignment forms from the Benefits Office or online through PeopleSoft self-service.

Beneficiary

In the event of your death, from any cause, your Life Insurance benefits will be paid to the Beneficiary(ies) you have designated. You may designate anyone you wish as a Beneficiary, and you may change your Beneficiary at any time. You may obtain change of beneficiary forms from the Benefits Office or online through PeopleSoft self-service.

If there is no Beneficiary at your death, your benefits will be payable to the first of the following: your (a) surviving spouse; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate. Any assignment you have designated will apply and supercedes the above.

Changes in the Amount of Life and AD&D Insurance

Any change in the amount of your Life and AD&D Insurance coverages due to a change in your Annual Base Salary will become effective on the date your Annual Base Salary changes. If you are not in active employment on that date, the increase will become effective after you return to active employment for one full day.

You may reduce your Supplemental Life Insurance coverage at any time by completing the required form available in the Benefits Office.

To increase Supplemental Life Insurance coverage, you must complete an enrollment form, submit evidence of insurability and be approved by the Insurance Company before the insurance can become effective. Forms are available in the Benefits Office. If approved, the insurance will become effective on the date of such approval, and you will be required to pay the appropriate employee premiums.

Evidence of Insurability

Evidence of insurability is required if:

- You enroll more than 90 days after you are first eligible for coverage.
- You were eligible for any coverage under the prior policy, but did not enroll and later choose to enroll for that coverage under The Hartford.

General Information

Information regarding the plan identification number, plan year, plan funding, type of plan, plan sponsor, plan administrator, agent for legal process, your rights under ERISA, prudent actions by plan fiduciaries, modification, suspension, or termination, and privacy of information of the plan can be found in the General Information section of this booklet.

Insurance Company

The Insurance Company is The Hartford.

Leave of Absence

If you are on an approved Leave of Absence, you may continue your Life Insurance coverage during the term of the approved leave from the starting date of your leave by paying the required active employee premiums.

Continuation of insurance is not allowed while on leave for other employment when (1) the other employer offers coverage or (2) the other employer is an agency or prime contractor of the federal government that will cover the employee under its insurance program.

Participants Receiving Long Term Disability Benefits

Life Insurance coverage will be continued at no cost for employees who were members of the IBEW union or employees who qualify for Long Term Disability (LTD) Plan benefits with an effective date prior to 1-1-09. Non-IBEW members who qualify for LTD plan benefits with an effective date after 12-31-08 continue by paying the active employee premiums. This coverage will cease when the employee is no longer eligible for LTD Plan benefits.

Termination of Coverage

Life Insurance coverage will cease on the earlier of the date your employment terminates, the date you are no longer eligible for coverage, when you fail to pay the required premiums, or the date the contract with the Insurance Company ends. If coverage has ceased and you die within 31 days after coverage ceased, the benefit amount will still be paid if the claim is approved.

CONVERSION

You are entitled to convert to an individual policy only if (a) your insurance ceases because you are no longer in active employment or no longer eligible for life insurance, (b) your insurance ceases or is reduced because of retirement or age, (c) your insurance is reduced due to a change in your class or amendments of the policy, or (d) the policy is canceled for your class of employees. No medical examination will be required, but you must submit a completed application form and pay the premium for this coverage to the Insurance Company within 31 days from the date your employment terminates. Hartford will mail you the necessary conversion application form directly.

LONG TERM DISABILITY PLAN

The Long Term Disability (LTD) Plan provides you with protection against complete loss of income during a long period of absence because of a disabling illness or injury.

WHO IS ELIGIBLE FOR THE LONG TERM DISABILITY PLAN?

Active Employees

All regular employees who work at least 20 hours per week are required to participate in the LTD Plan upon completion of one year of active service.

Service shall include Continuous Service, if any, with Associated Universities, Inc., Battelle Memorial Institute, Research Foundation of the State University of New York, or the State University of New York at Stony Brook immediately prior to a transfer of employment to Brookhaven Science Associates, LLC.

ENROLLMENT

Employees must enroll for LTD Plan coverage on their date of hire. Your coverage will be effective upon completion of one year of Continuous Service. You must be in active employment status for coverage to become effective.

LONG TERM DISABILITY PLAN COVERAGE

Income Benefits Provided

LTD benefits are provided if you are continuously Totally Disabled during the elimination period. The elimination period is 180 days. If your disability stops less than one-half (1/2) the number of days of your elimination period during the elimination period, your disability will be treated as continuous. The days you are not disabled will not count toward your elimination period. The Insurance Company will determine if you are eligible for these benefits.

If eligible, and you first became disabled and entitled to a benefit under the LTD Plan before January 1, 2005, LTD benefits were based on the plan in existence at that time.

If eligible, and you first become disabled and entitled to a benefit under the LTD Plan on or after January 1, 2005, commencing with the seventh consecutive month of disability, you will receive monthly income payments equal to sixty percent (60%) of your monthly full-time or part-time Base Salary.

Your gross monthly income payments will be reduced by the following sources of income:

- The amount that you receive as loss of time benefits under:
 - a workers' compensation law;
 - an occupational disease law; or
 - any other act or law with similar intent.
- The amount that you receive or are entitled to receive as loss of time disability income payments under any:
 - state compulsory benefits act or law.
 - group insurance or self-insured plans where the employer, directly or indirectly, has paid all or part of the cost or made payroll deductions.
 - governmental retirement system as the result of your job with your employer.

- The gross amount that you receive or are entitled to receive as loss of time disability payments because of your disability under:
 - the United States Social Security Act;
 - the Railroad Retirement Act;
 - the Canada Pension Plan;
 - the Quebec Pension Plan;
 - any similar plan or act.
- The gross amount that you receive as retirement payments under:
 - the United States Social Security Act;
 - the Railroad Retirement Act;
 - the Canada Pension Plan;
 - the Quebec Pension Plan; or
 - any similar plan or act
- The amount that you:
 - (a) receive as disability payments under your employer's retirement plan;
 - (b) voluntarily elect to receive as retirement or early retirement payments under your employer's retirement plan.
- The amount you receive under the maritime doctrine of maintenance, wages and cure. This includes only the “wages” part of such benefits.
- The amount identified as earnings replacement or disability income benefits that you receive, due to your disability, from a third party by judgment, settlement or otherwise.
- The amount of loss of time benefits that you receive or are entitled to receive under any salary continuation.
- The amount of loss of time benefits that you receive or are entitled to receive under any accumulated sick leave, to the extent that your total monthly benefits exceed or would exceed 100% of your monthly earnings.
- The amount that you receive from a partnership, proprietorship or any similar draws.
- The amount that you receive or are entitled to receive under any unemployment income act or law due to the end of employment with your employer.

With the exception of retirement payments, or amounts that you receive from a partnership, proprietorship or any similar draws, the Insurance Company will only subtract deductible sources of income which are payable as a result of the same disability.

However, if you continue to be disabled after receiving LTD benefits for 24 months or after obtaining age 65, and you elect to receive Retirement Plan benefits, this will not cause a reduction in your LTD benefits.

If you become Totally Disabled, you may be eligible to receive monthly benefit payments for up to 2 years. However, if you continue to be Totally Disabled and if your disability prevents you from engaging in any occupation for which you are qualified by training, education, or experience, benefit payments will continue beyond the 2-year period until you are no longer Totally Disabled, or as indicated in the following schedule:

Maximum Period of Benefits

Your Age on Date Disablement Begins	Your Maximum Benefits Duration
Under age 61	To your NRA*, but not less than 60 months
Age 61	To your NRA*, but not less than 48 months
Age 62	To your NRA*, but not less than 42 months
Age 63	To your NRA*, but not less than 36 months
Age 64	To your NRA*, but not less than 30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

* Your normal retirement age (NRA) is your retirement age under the Social Security Act where retirement age depends on your year of birth.

LTD benefits cease on the date you cease to be Totally Disabled.
The maximum monthly benefit is \$20,000.

Contributions to the Retirement Plan

If you were a participant in the Retirement Plan before becoming Totally Disabled, monthly contributions will be made by the Insurance Company to the Retirement Plan as long as you qualify for LTD benefit payments.

The monthly contribution to the Retirement Plan will equal one-twelfth of the total of the following:

12.5% of your annual Base Salary that is taxable under the Social Security Act on the day prior to the day you become eligible to receive LTD benefits and 17.5% of the remaining amount of your annual Base Salary.

Portable Adaptive Equipment

The Insurance Company may be able to assist you to identify portable adaptive equipment that is likely to help you remain at work or return to work. Additional details are available from the Insurance Company.

Rehabilitation

The Insurance Company has a rehabilitation program available. They will contact you if, upon review of your information, you qualify to participate.

CLAIMS

How to File a Claim

If you want to file a claim for LTD Plan benefits, you must contact the Benefits Office who will provide the applicable forms to you. The completed forms must be submitted to the Insurance Company within 90 days after the elimination period.

Questions About Claims

If you have a question about your LTD claim, you should contact the Benefits Office at (631) 344-7516 or The Hartford Group Disability Office at (800) 538-0134.

How to Appeal a Claim

If your claim is denied, you will receive a written notice of the denial from the Insurance Company. The notice will explain the reason for the denial and indicate the review procedures. You may request a review of the denied claim. The request must be submitted in writing within 180 days after you receive the denial notice. Submit your request, including your reasons for requesting the review, to The Hartford, 200 Hopmeadow St., Simsbury CT 06089. They can also be reached at (800) 538-0134. The Insurance Company will review the claim and ordinarily notify you within 45 days of the date your request for review is received. In special cases requiring a delay, the Insurance Company will render a decision no later than 90 days after your request for review is received.

EMPLOYEE PREMIUMS

When participating in the LTD Plan, employees must pay the required employee premiums (\$0.431 per \$100 of coverage).

OTHER INSURANCE COVERAGES WHILE ON LTD

Medical Coverage

Currently, as long as you continue to qualify for LTD Plan benefits and were enrolled in the Medical Plan immediately prior to your disability, you and your eligible dependents will be provided with Medical Plan coverage by paying the required premiums. Currently, for participants whose eligibility date to receive LTD Plan benefits was prior to January 1, 2009, no premium is required to continue this coverage. Currently, for participants whose eligibility date to receive LTD Plan benefits was after December 31, 2008, and were not members of the IBEW union, coverage may be continued by paying the active employee premium.

If you qualify for Medicare Health Insurance coverage because of your disability, or if you have reached age 65, you must elect both Parts A and B of Medicare and pay the applicable premium. Medicare then becomes your primary medical insurance coverage.

Life Insurance Coverage

Currently, as long as you continue to qualify for LTD benefits, you may continue your Life Insurance Plan coverage by paying the required premiums. Currently, for participants whose eligibility date to receive LTD Plan benefits was prior to January 1, 2009, no premium is required to continue this coverage. Currently, for participants whose eligibility date to receive LTD Plan benefits was after December 31, 2008, and were not members of the IBEW union, coverage may be continued by paying the active employee premium. Life Insurance coverage will be the amount in force on the day immediately preceding your first day of disability. Life Insurance coverage amounts will reduce at age 65 or over in accordance with the provisions of the Life Insurance Plan.

Dental Coverage

Currently, if you were enrolled in the Dental Plan, you and your eligible dependents may continue dental coverage by paying the required employee premiums. This coverage will cease when LTD benefits cease.

MISCELLANEOUS

Base Salary

Base Salary means your actual Base Salary on the day immediately preceding the day you become eligible to receive LTD benefits. It does not include overtime, shift or holiday premium, bonus or any other forms of compensation. For part-time employees, Base Salary is based on the part-time basic rate of pay.

An increase in Base Salary will not be recognized under this LTD Plan if it occurs between separate periods of Total Disability which are considered one period of disability for LTD benefits.

Changes in the Amount of LTD Coverage

Any change in the amount of your LTD coverage due to a change in your Base Salary will become effective on the date your Base Salary changes.

Continuous Service

Continuous Service means service from your most recent hire date. Service performed prior to a break in employment is not included in Continuous Service. Continuous Service will be reduced by periods on approved Leave of Absence. Continuous Service shall include continuous service, if any, with Associated Universities, Inc., Battelle Memorial Institute, Research Foundation of the State University of New York or the State University of New York at Stony Brook immediately prior to a transfer of employment to Brookhaven Science Associates, LLC.

Disabilities Not Covered

The LTD Plan does not cover any disabilities caused by, contributed to, or resulting from your:

- intentionally self-inflicted injuries;
- commission of or attempt to commit a felony for which you have been convicted under state or federal law.
- disability due to war, declared or undeclared, or any act of war.

Employment Status While Receiving LTD Benefits

If you are an active employee, effective on the date you qualify for LTD benefits (commencing with your seventh consecutive month of disability), you will be placed on a leave of absence of up to 12 months. If, at the end of this period, you continue to qualify for LTD benefits, your employment will be terminated, but your insurance coverages will continue as indicated above.

Evidence of Insurability

If you return to work immediately after an approved Leave of Absence, but did not continue your LTD coverage during the leave and are age 30 or over with one year of Continuous Service, then Evidence of Insurability is not required.

General Information

Information regarding the plan identification number, plan year, plan funding, type of plan, plan sponsor, plan administrator, agent for legal process, your rights under ERISA, prudent actions by plan fiduciaries, modification, suspension, or termination of the plan, and privacy of information can be found in the General Information section of this booklet.

Insurance Company

The Hartford as of August 1, 2010.

Leave of Absence

If you are on an approved Leave of Absence, you may continue your LTD coverage during the term of the approved leave from the starting date of your leave by paying the required active employee premiums.

Continuation of insurance is not allowed while on leave for other employment when (1) the other employer offers coverage or (2) the other employer is an agency or prime contractor of the federal government that will cover the employee under its insurance program.

Overpayment

If you are overpaid LTD benefits, you will be required to repay such amounts. The Insurance Company will determine the method of repayment.

Reduction in Benefits Due to Earnings

The monthly LTD benefits for any month during which you are Totally Disabled will be reduced and will take into account the amount you earn through work during that month.

Social Security Benefits

You are required to file for Social Security benefits if you are disabled. If you are covered under the Federal Social Security Act for disability or Old Age Benefits, you will be assumed to be receiving such benefits. The level of such benefits will be estimated by the Insurance Company. Your monthly LTD benefits will be reduced by the amount of such estimated benefits unless you have applied and, if denied for benefits, reapplied and been denied. Upon proof of the actual benefit amount, the Insurance Company will adjust your LTD benefits accordingly.

Successive Periods of Disability

If, after receiving LTD benefits, you return to work on a part-time or full-time basis and again become Totally Disabled, you will be eligible for the continuation of your previous LTD benefits and will not be required to establish a new 180 day disability elimination period, provided that your disability recurs within three months after you return to work and is due to the same or related cause. This means that your return to work must be for less than six months to qualify for this provision. If, however, your disability has an entirely new and unrelated cause or if you have returned to work on a full-time basis for more than six months, you will be required to establish a new 180 day disability elimination period before becoming eligible for LTD benefits.

Termination of Coverage

LTD Plan coverage will cease on the earlier of the date you are no longer receiving LTD benefits and are no longer employed, the date you are no longer eligible for coverage, when you fail to pay the required premiums, or the date the group contract is cancelled.

Totally Disabled

You will be considered Totally Disabled if, because of injury or illness, you are unable to perform one or more of the Essential Duties of your regular occupation during the elimination period and are under the regular care of a doctor. After monthly LTD benefits have been paid for twenty four months, you will be considered Totally Disabled if, because of injury or illness, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience and are under the regular care of a doctor.

Essential Duty is defined as:

- Substantial, not incidental
- Fundamental or inherent to the occupation and
- Cannot be reasonably omitted or changed.

Your ability to work the number of hours in your regularly scheduled work week is an Essential Duty.

TRAVEL ACCIDENT INSURANCE PLAN

The Travel Accident Insurance Plan provides 24-hour accident coverage while on Authorized Business Travel. Coverage begins at the actual starting point of an anticipated trip, whether this is your place of employment, your home, or some other location, whichever occurs last. Coverage terminates upon your return to home or place of employment, whichever occurs first.

WHO IS ELIGIBLE FOR THE TRAVEL ACCIDENT INSURANCE PLAN?

All regular, temporary and part-time employees, visiting scientists, Guests, and members of the Board of Directors are eligible for Travel Accident Insurance coverage.

ENROLLMENT

If you are eligible for the Travel Accident Insurance Plan, you do not need to enroll.

TRAVEL ACCIDENT INSURANCE PLAN COVERAGE

Benefits Provided

Category	
(1)	All regular, temporary and part-time employees, visiting scientists and Guests.
(2)	All members of the Board of Directors.
(3)	All management and patrol officers of the police group
(4)	Spouses of Category (1), Category (2) and Category (3) insured persons
(5)	Dependent Children of Category (1), Category (2) and Category (3) insured persons
Coverage	
For Category (1) and Category (2):	Coverage is for periods while on Authorized Business Travel (away from premises of residence or place of regular employment) including sojourn and personal deviation, and including while riding as a passenger in any regular, special or chartered flight or military aircraft being used for the transportation of passengers, or as a passenger in any tried, tested and approved civilian aircraft.
For Category (3)	Coverage under this Category applies to business only War Risk Coverage (on and off premises) including acts of war or terrorism. It excludes sojourn and personal deviation. Persons covered under Category (3) are also included under Category (1). In the event of a loss, coverage under either Category (1) or Category (3) will apply, but not both. Only that coverage which provides the greatest benefit amount shall be payable in the event of a loss.
For Category (4) and Category (5):	Coverage is for periods while traveling with or in conjunction with the Authorized Business Travel of the insured person and/or in connection with the relocation of the insured person, provided the expenses for such trips are authorized and paid by BSA.

Coverage Amount

Travel Accident Insurance benefits are based on the Principal Sum indicated below.

Category	Principal Sum (applicable to Accidental Death & Dismemberment benefits and Permanent & Total Disability benefits)
(1)	Five times Annual Salary. Minimum benefit of \$100,000. Maximum benefit of \$2,000,000.
(2)	\$500,000
(3)	\$100,000
(4)	\$100,000
(5)	\$ 50,000

Travel Accident Insurance benefits will be paid as follows for bodily injuries sustained within one year from the date of an Accident:

For Accidental Death	100% of Principal Sum.
For Permanent Total Disability	100% of Principal Sum. (not applicable to Categories, (4) and (5))
For Loss of Both Eyes, Two Limbs, One Limb and One Eye, or Speech and Hearing in Both Ears	100% of Principal Sum.
For Loss of One Eye, One Limb, Speech, or Hearing in Both Ears	50% of Principal Sum
For Loss of Thumb and Index Finger of Same Hand	25% of Principal Sum.
For Quadriplegia	100% of Principal Sum.
For Paraplegia	75% of Principal Sum.
For Hemiplegia	50% of Principal Sum.

In addition, Accident Medical Expenses, up to a maximum of \$10,000, will be paid for medical expenses incurred within 365 days of the date of the accident (only for Category (2) insured persons).

An Emergency Medical Benefit of up to \$10,000 is also available to satisfy a medical providers' medical expense guarantee or hospital admission guarantee should an insured person suffer from an emergency illness or injury during a covered trip.

Exclusions

The plan does not provide coverage for commutation and vacation travel, suicide or attempt thereof, sickness or disease, other than bacterial infections which result from an accidental cut or wound, declared or undeclared war or any act thereof occurring in the U.S., or the insured's country of permanent residence, service in the armed forces, or riding as a pilot or crew member in any aircraft or as a passenger in any aircraft used for acrobatic or stunt flying, racing or endurance tests, crop dusting, seeding or banner towing, or any aircraft owned or leased by BSA or any employee of the BSA, losses resulting from the commission of a common law felony, defined as, but not limited to, robbery, murder, rape, arson and kidnapping. An aggregate limit of benefits of \$23,000,000 is imposed on any single aircraft and war Accident causing loss involving more than one injured person. If the total benefits payable exceed that amount, claimants will share the benefits in proportional amounts.

Accidental Burn and Disfigurement Benefit

Coverage is extended for covered injuries if an insured person suffers burns that leave him or her Disfigured. The burns must result directly and independently of all other causes from a covered Accident. The Disfigurement must satisfy all of the conditions below.

1. reconstructive or cosmetic surgery is required to restore the insured person's physical abilities or correct Disfigurement, and must be commenced/performed within twelve months of the covered Accident.;

2. the covered Accident must occur while the insured:
 - a. is on BSA/BNL premises; and
 - b. engaged in the course of his or her job.
3. a doctor must determine that the burn satisfies all of the following:
 1. involves the minimum percentage of body disfigurement shown below;
 2. be classified as second degree burns or worse as shown below; and
 3. results in Disfigurement or loss of physical abilities.

Accidental Burn and Disfigurement Benefit Schedule

75-100% Body Disfigurement	Lesser of 25% of the Principal Sum or \$25,000
50-74% Body Disfigurement	Lesser of 15% of the Principal Sum or \$25,000
25-49% Body Disfigurement	Lesser of 5% of the Principal Sum or \$25,000

Airbag Benefit

An additional benefit of 10% of the insured person's principal sum up to a maximum of \$15,000 will be payable if an insured person's death results from a covered Accident while positioned in a seat protected by a properly functioning and properly deployed supplemental restraint system (airbag) while operating or riding as a passenger in an Automobile.

Bomb Scare and/or Explosion Coverage: On Premises

Coverage is extended to insured persons for covered injuries resulting from a bomb scare or explosion while on BNL/BSA premises, subject to an aggregate limit of benefits of \$23,000,000 on any single loss involving more than one insured person.

Carjacking Benefit

An additional benefit shall be payable if the insured person suffers a covered Loss resulting directly and independently of all other causes from a covered Accident that occurs during a carjacking of an Automobile that the insured person was operating, getting into or out of, or riding as a passenger. Verification of the Carjacking must be made part of an official police report within 24 hours of the carjacking, or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within 24 hours of the Carjacking, or as soon as reasonably possible.

The additional benefit payable is 10% of the insured person's principal sum subject to a maximum benefit of \$10,000.

Coma Benefit Coverage

Coverage is extended for covered injuries resulting in an insured person lapsing into a Coma within 21 days of the Accident and continues for 3 successive months. The monthly benefit is equal to 1% of the insured's Principal Sum. The monthly benefits will start on the beginning of the 4th continuous month of the Coma and will continue until the earlier of:

1. the date the Coma ends;
2. the date the insured dies; or
3. the end of a period of 100 consecutive months.

A prorated benefit will be payable for partial months.

Continuation of Insurance Expense Benefit

An additional benefit will be paid if a surviving insured spouse or a surviving insured Dependent Child elects to continue group medical and/or dental insurance provided by BSA/BNL of an insured who died, subject to all of the following conditions:

1. the insured's death results directly and independently of all other causes from a covered Accident;
2. the insured is survived by an insured spouse, insured Dependent Child who are insured under the policy on the date the insured dies;
3. the insured spouse, insured Dependent Child is also insured under a medical or dental plan sponsored by BSA/BNL at the time of the insured's death;
4. the insured spouse, insured Dependent Child notifies the insurance carrier of his or her election, within 60 days of the insured's death, to continue his or her existing coverage under group insurance plans sponsored by BSA/BNL as permitted by state or federal continuation law.

This benefit, payable annually, equals the premiums required to continue the medical and or dental insurance described above, as long as the total amount of this benefit does not exceed the lesser of 5% of the Insured person's principal sum or \$7,500.00. The benefit will be paid at the end of each year during which medical and/or dental insurance is continued, if the insurance carrier receives a request for reimbursement and proof of the premiums paid during that year. Benefit payments will continue until the earliest of the following dates:

1. the date a surviving spouse or surviving Dependent Child is no longer eligible to continue medical and/or dental insurance coverage;
2. the date benefits equal the maximum benefit shown above and
3. the end of the maximum benefit period.

Benefits are payable to the surviving spouse, or the person who actually paid the premium on the surviving spouse's behalf, if other than the surviving spouse. lth counseling.

Emergency Medical Evacuation

Coverage is extended to insured persons while traveling outside 100 miles from his/her home or place of permanent assignment. Benefits will be payable for covered expenses if any injury or illness commencing during a covered trip results in the emergency evacuation of an insured person. The emergency evacuation must be coordinated through the Travel Assistance Services Company and be ordered by a legally licensed physician who certifies that the severity of the insured person's injury or illness warrants the emergency evacuation of the insured person.

Extended Terrorism Coverage

Coverage is extended to insured persons for covered injuries sustained as indicated herein.

The war exclusion does not apply to acts of terrorism occurring in the U.S. causing a loss covered by the plan. Acts of terrorism means an activity that 1) involves any violent act or any act dangerous to human life, and that threatens or causes accidental injury to persons; and 2) appears to be in any way intended to: a) intimidate or coerce a civilian population; or b) disrupt any segment of a nation's economy; or c) influence the policy of a government by intimidation or coercion; or d) affect the conduct of a government by mass destruction, assassination, kidnapping or hostage-taking; or e) respond to governmental action or policy. It includes the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid liquid or gaseous, chemical or biological agent. It shall also include any incident declared to be an act of terrorism by an official, department or agency that has been specifically authorized by federal statute to make such a determination. This includes, but is not limited to, murder, kidnapping, hijacking, sabotage, or bombings.

Extended terrorism coverage does not include conventional warfare designed to result in wholesale loss of life through use of missiles, aerial bombardment, nuclear, chemical or biological warfare, or outright invasion. With the exception of Category (3), as described previously, this coverage does not apply on premises of BNL/BSA.

Felonious Assault Coverage: On Premises

Coverage is extended to insured persons for covered injuries resulting from any felonious acts committed by a non-employee who is not a family member upon the insured person while on BNL/BSA premises, subject to an aggregate limit of benefits of \$23,000,000 on any single loss involving more than one insured person.

Hijacking/Skyjacking Coverage

Coverage is extended to insured persons for covered losses sustained resulting from hijacking or skyjacking of a conveyance while traveling on Authorized Business Travel regardless of whether the hijacking/skyjacking is or is not the result of an act of war.

Kidnap and Extortion Benefit

An additional benefit of up to \$50,000 shall be payable if the insured person is a victim of kidnap or extortion.

On-Premises Emergency Fire/Disaster Team Coverage

Coverage is extended while acting as a member of a BSA Emergency Fire/Disaster team.

Personal Deviation Provision

Coverage is extended to insured persons for side trips taken, which are incidental to Authorized Business Travel, unless indicated otherwise.

Reasonable Accommodation at Worksite Benefit

The insurance carrier will reimburse costs, up to the maximum benefit shown in the Schedule of Benefits, subject to the following conditions, when BSA/BNL incurs costs for any worksite change required to enable the insured to return to work. The insured must have suffered a covered Loss resulting directly and independently of all other causes from a covered Accident, and be returning to work as soon thereafter as permitted by his or her doctor.

The benefit payable to BSA/BNL is the reimbursement costs of any pre-approved change made to the worksite for the Insured, up to the maximum amount specified in the Schedule of Benefits.

Reimbursement will be subject to all of the following conditions:

1. insurance provided under the policy must be in force for the insured on the date the covered Accident occurs;
2. change to the worksite must be made within 12 months of the date of the covered Accident;
3. there is reasonable expectation that such change to the worksite will enable the insured to return to work;
4. the insurance carrier approves any change to the worksite in writing before it is made.

Benefits will not be payable if:

1. there is no cost involved in making any change to the worksite; or
2. any change to the worksite does not meet the standards found in Title I of the Americans with Disabilities Act (ADA).

The insurance carrier will not reimburse the cost of any change to the worksite for which reimbursement is made under more than one policy insuring the insured and issued by the insurance carrier or any other insurance company.

Changes to the worksite means:

1. making existing facilities used by the insured readily accessible and usable; and
2. job restructuring, reassignment to a vacant position, acquisition or modification of equipment or devices, appropriate adjustment or modification of examinations, training materials or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities resulting from a covered Accident.

Rehabilitation Benefit

Coverage is intended to reimburse an insured person for Rehabilitation Expenses arising from a covered injury if:

1. the insured person is participating in a Rehabilitation program due to an injury that results directly from, and from no other cause, but a covered accident; and
2. a doctor prescribes the Rehabilitation program.

Benefits are payable for:

1. the facility providing the Rehabilitation program in which the insured is participating; and
2. immediate family members who incur expenses for travel to and from the location at which the insured is participating in a Rehabilitation program provided actual receipts are submitted with the claim.

Benefits will end when the first of the following events occur:

1. the date the insured completes the Rehabilitation program; or
2. the date the insured dies.

Reimbursement of covered Rehabilitation expenses is subject to a maximum benefit of \$50,000.

Repatriation of Remains

Coverage is extended to insured persons while outside a 100-mile radius from his/her home or regular place of employment. Benefits will be payable for the reasonable covered expenses incurred to return the insured person's body home to his/her home country if he/she dies. The repatriation of remains must be coordinated through the Travel Assistance Services Company. Coverage includes, but is not limited to expenses for embalming, cremation, coffin, and transportation.

Seat Belt Benefit

An insured person's Principal Sum will be increased by 10% but not less than \$1,000 to a maximum of \$50,000 for covered losses occurring while riding in an automobile during Authorized Business Travel provided the insured was using a seat belt at the time of the loss.

Special Adaptation Benefit

Special adaptation benefits will be paid if an insured person:

1. suffers a "Presumptive Disability" from a covered Accident; and
2. requires a special housing adaptation; or
3. a special Vehicle to accommodate the disability.

Benefits will not be payable unless the Insured Person's doctor certifies them as necessary.

Special Counseling Benefit

Coverage includes a special counseling benefit for mental health counseling to assist an insured person in dealing with a covered loss if he/she:

1. suffers an injury that results in a Loss for which the Accidental Death and Dismemberment Benefit is payable; and
2. obtains mental health to a maximum of \$25,000.

Covered expenses are reimbursable at 10% of the insured person's Principal Sum subject

Travel Assistance Services

Coverage is extended to insured persons when traveling on BNL/BSA business outside 100 miles from his/her home or place of permanent assignment. These services include:

- Pre-Departure Services
- Lost Baggage/Passport
- Insurance Coordination
- Emergency Cash
- Travel Medical Emergency Services
- Legal Assistance
- Evacuation and Repatriation Assistance Services

Travel Assistance Services Company

Emergency Medical Evacuation and Repatriation of Remains are provided while traveling 100 miles or more from your primary home through Worldwide Assistance Services, Inc. They can be reached at:

Toll-free from the U.S.	800-243-6124
Collect from other locations	202-659-7803

Please provide the name **Brookhaven Science Associates** and this **Travel Assistance Plan Identification Number: 01AH585**

War Risk Coverage

Coverage is extended to insured persons for covered injuries sustained as the result of declared or undeclared war, worldwide with the exception of the U.S., and the insured's country of permanent residence.

CLAIMS

How to File a Claim

To file a claim under the Travel Accident Insurance Plan, you must complete a Travel Accident claim form that is available in the Benefits Office. The completed claim form must be submitted to the Benefits Office.

Questions About Claims

If you have a question about your Travel Accident Insurance claim, you should contact the Benefits Office at (631) 344-7516. When discussing your claim, please refer to the claim form and any correspondence that you may have received.

How to Appeal a Claim

If your claim is denied in whole or in part, you will receive a written notice of the denial from the insurance company. The notice will explain the reason for the denial and the review procedures. You may request a review of the denied claim. The request must be submitted in writing within 60 days after you receive the denial notice. Submit your request, including your reasons for requesting the review, to Ace American Insurance Company, Accident: Health Claims, P. O. Box 15417, Wilmington, DE 19850. They will have the claim reviewed and ordinarily notify you of the final decision within 60 days of receipt of your request. If special circumstances require an extension of time, you will be notified during the 60 days following receipt of your request.

PREMIUMS

Travel Accident Insurance is provided to you at no cost.

MISCELLANEOUS

Accident

An Accident is an occurrence which occurs while eligible or under this plan, causes bodily injury which results in a loss covered by this plan, and causes a loss directly and independently of any other causes not related to the Accident.

Accident Medical Expense

Reasonable medical expenses caused by a covered Accident incurred within 365 days after the date of the Accident, up to the stated maximum amount payable.

Annual Salary

Annual Salary from BSA or from the regular employer of the insured person is the insured person's annual base salary, before exercise of any salary reduction option, as of the time of the Accident. Overtime pay and premium pay are not included in Annual Salary.

Assignment of Your Travel Accident Insurance Policy

If you want to make an outright assignment of your Travel Accident Insurance to another person instead of naming a Beneficiary, a separate assignment form is necessary and may be obtained from the Benefits Office.

Authorized Business Travel

Means a trip taken at the direction and authorization of BNL/BSA.

Automobile

A self-propelled private passenger motor vehicle with four or more wheels, that is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, sport utility vehicle, and a motor vehicle of the pickup, panel, van, camper or motor home type. Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.

Beneficiary

In the event of accidental death covered by this plan, your Beneficiary will be the person or persons designated under your Basic Life Insurance Plan coverage. In the absence of a designated Beneficiary, benefits for loss of life will be paid to the following successor Beneficiaries:

- Your spouse, if living; otherwise
- Your surviving child(ren) in equal shares, if any; otherwise
- Your parent(s) in equal shares, if living; otherwise
- Your brother(s) or sister(s) equally, if any; otherwise
- Your estate.

All other benefits payable under this plan are paid to you.

Carjacking

A person other than the insured person taking unlawful possession of an Automobile by means of force or threats against the person(s) then rightfully occupying such Automobile.

Coma

A state of profound unconsciousness from which an insured person cannot be aroused. The insured must be confined in a hospital or other medical facility and diagnosed as being in a coma by a licensed physician.

Dependent Child(ren)

Dependent Child(ren) are any unmarried children of insured persons in Categories (1) or (2), per the insurance contract, who are under age 19 or age 25 if in an accredited school or college on a full-time basis, and who are wholly dependent on the insured person for support. A child, for eligibility purposes, includes an insured's natural child; adopted child, beginning with any waiting period pending finalization of the child's adoption; or a stepchild who depends on the insured for financial support.

Disfigurement/Disfigured

Spoiled or deformed appearance caused by burns that can be corrected by means of reconstructive or cosmetic surgery.

Emergency Medical Benefit

Pays medically necessary expenses specifically for medical expense guarantee and hospital admission guarantee up to the amount stated should an insured person suffer a medical emergency while traveling 100 miles or more away from his or her place of permanent residence.

General Information

Information regarding the plan identification number, plan year, plan funding, type of plan, plan sponsor, plan administrator, agent for legal process, your rights under ERISA, prudent actions by plan fiduciaries, and modification, suspension, or termination of the plan can be found in the General Information section of this booklet.

Guest

A Guest is a person who travels at the direction or invitation of BSA whose travel expenses are paid for or reimbursed by BSA, or those persons who agree to pay one-half of the airfare while traveling to and from the BNL/BSA premises at the invitation of BSA.

Leave of Absence

You are not covered by the Travel Accident Insurance Plan if you are on an approved Leave of Absence.

Loss

A Loss of member with respect to a hand or foot means complete severance through or above the wrist or ankle joint; with respect to eyes means the total, permanent loss of sight; with respect to speech, means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means; with respect to hearing means entire loss of hearing in both ears that is irrecoverable and cannot be corrected by any means; with respect to thumb and index finger means complete severance through or above the knuckle joints nearest the hand.

A Loss for disability means permanent and total disability resulting from a covered Accident which causes the insured to be unable to engage in any occupation or employment for which he or she is qualified by reason of education, training, or experience. Benefits are payable after such condition has lasted 12 months and is deemed total, continuous, and permanent at that time.

A Loss with regard to quadriplegia means complete and irreversible paralysis of both upper and lower limbs; with regard to paraplegia means the complete and irreversible paralysis of both lower limbs; and with regard to hemiplegia means the complete and irreversible paralysis of upper and lower limbs of one side of the body.

Presumptive Disability

Presumes an insured person is Totally Disabled if he/she suffers the complete and irrecoverable sight of both eyes, speech, hearing in both ears, or of any two limbs, hands or feet, provided the loss occurs within one year of the Covered Accident

Rehabilitation

Medical services, supplies, or treatment, or hospital confinement (or part of a hospital confinement) that satisfies all of the following conditions:

1. are essential for physical rehabilitation required due to the insured's covered loss;
2. meet generally accepted standards of medical practice;
3. are performed under the care, supervision or order of a doctor;
4. prepare the Insured to return to his or any other occupation.

Termination of Coverage

Travel Accident Insurance Plan benefits will cease on the day an insured person is no longer employed or affiliated with BSA in an eligible capacity.

Vehicle

A private passenger land motor vehicle. It includes automobiles, vans, and four wheel drive vehicles. It does not include a vehicle used for farming, commercial business, racing or any type of competitive speed event.

RETIREMENT PLAN

The Retirement Plan provides participants with income at retirement. The Retirement Plan is provided at no cost to participants.

WHO IS ELIGIBLE FOR THE RETIREMENT PLAN?

Active Employees

Effective January 1, 2007, any employee who was not already a participant in the Plan on December 31, 2006 will become eligible to participate after he or she has either: (a) attained age 21 and completed one Year of Service, or (b) attained age 30 and completed six months of Continuous Service, and is not a Part-Time or Temporary Employee.

A Year of Service is a 12-month period of continuous employment with the Employer, except that a Part-Time or Temporary Employee must be credited with at least 1,000 Hours of Service during the twelve month period beginning on the date you first perform an Hour of Service (or each successive anniversary thereof), to earn a Year of Service. Participation begins the first day of the pay period following completion of the age and service requirements.

Service includes Continuous Service, if any, with Associated Universities, Inc., Battelle Memorial Institute, Research Foundation of the State University of New York, or the State University of New York at Stony Brook immediately prior to a transfer of employment to Brookhaven Science Associates, LLC.

If you terminate employment after you have become a participant in the Plan and are re-employed before incurring a Five Year Break in Service or if you had a vested interest in your Plan Account when you left, you will be eligible to re-enter the Retirement Plan on the first pay period beginning after your re-employment. Otherwise, you must satisfy the eligibility requirements described above.

The following individuals are not eligible to participate in the Plan: (1) any leased employee, as defined by Internal Revenue Code Section 414(n); (2) any person holding solely a Guest or Visitor Appointment to Brookhaven; (3) any person whose terms of employment are governed by a collective bargaining agreement whose retirement benefits are the subject of good faith bargaining, unless the collective bargaining agreement specifies that such individual is eligible to participate in the Plan; (4) any individuals hired on or after January 1, 1999 who are designated by the Employer as a research associate, research fellow or student assistant; or (5) any person designated by the Employer as an independent contractor or who performs services pursuant to a written agreement with a third party.

ENROLLMENT

Eligible employees must enroll for the Retirement Plan when first eligible. To enroll, you must complete enrollment forms that are available through the Benefits Office. By completing the forms, you will authorize the funds in which Retirement Plan contributions will be invested.

RETIREMENT PLAN COVERAGE

Benefits Provided

If you work at least 1,000 Hours of Service during a Plan Year and were hired prior to January 1, 2011, Brookhaven will contribute an amount equal to 10% of your Base Salary to your account in this Plan. If you work at least 1,000 hours of service during a plan year and were hired on or after January 1, 2011, Brookhaven will contribute an amount equal to 9% of your Base Salary to your account in

this Plan. (For employees who are members of the IBEW union, the terms of the collective bargaining agreement apply). Federal laws and regulations may limit contributions to this Plan.

Contributions will be made only with respect to the portion of your Base Salary paid while you are a participant in the Plan.

In addition, for each former employee of Brookhaven National Laboratory who was a participant in the AUI Retirement Plan on February 28, 1998, the participant's 401(a) accumulation in that Plan was transferred to this Plan on or about March 1, 1998.

Participants are not required or allowed to contribute to this Plan.

Plan Investments

There are numerous approved TIAA-CREF, Fidelity and Vanguard funds in which a participant can allocate the investment of contributions. The funds available for investment are indicated at the end of the Retirement Plan section.

The Plan is intended to constitute a plan described in Section 404(c) of the Employee Retirement Income Security Act of 1974 (ERISA), and Title 29 of the Code of Federal Regulations Section 2550.404c-1. This means that the fiduciaries of the Plan may be relieved of liability for any losses that are the direct and necessary results of your investment choices. Under these regulations, you have the right to receive additional information regarding the investment options provided under the Plan. The Plan Administrator is the Plan fiduciary responsible for providing this information, and the information may be obtained from the Benefits Office. The additional information includes:

- A description of the annual operating expenses of each investment fund which may reduce the rate of return on the fund, and the amount of expenses expressed as a percentage of the fund's average net assets.
- Copies of prospectuses, financial statements and reports, and other materials relating to the investment funds, to the extent such information is provided to the Plan.
- A list of funds, including the issuer, term and rate of return of all guaranteed investment contracts.
- Information concerning the value of shares or units in each available investment fund, as well as the past and current investment performance of such funds, net of expenses.
- Information concerning the value of shares or units of each fund held in your account.

In addition to this information, each mutual fund whose shares are registered with the U.S. Securities and Exchange Commission must periodically publish a document called a "prospectus", which is a description of the fund, its management and investment philosophy, and certain risk factors involved in investing in the fund. The prospectus will also contain information about the prior investment performance and management expenses of the fund. Each of the investment funds currently available under the Plan is required to issue a prospectus, and you should receive and review the current prospectus before investing any part of your account in the fund. If you do not automatically receive a current prospectus, you can request one from the investment company.

Allocating Contributions

When a participant first enrolls in the Plan, he or she will complete a form indicating how to allocate Plan contributions among investment fund options. The allocation can be changed at any time. If a participant wants to change the allocation within an investment company, he or she must contact the investment company directly. If the participant wants to change investment companies or the allocation between companies, he or she must complete an allocation form available in the Benefits Office.

Transferring Between Funds

Participants are permitted to transfer accumulations between funds and investment companies. To transfer accumulations within an investment company, the participant must contact the investment

company directly. To transfer accumulations from one investment company to another, forms are available in the Benefits Office.

Limitations apply when transferring accumulations out of TIAA. Transfers out of the TIAA Traditional Annuity can only be made over a ten-year period, where the amount to be transferred must first be moved to a TIAA transfer payout annuity.

Designating a Beneficiary

When a participant enrolls in the Plan, he or she will indicate one or more beneficiaries on the enrollment forms. For married participants, the spouse must be the beneficiary for at least 50% of the accumulation unless the spouse consents to the designation of someone else. The spouse's consent must be in writing and witnessed by a Plan representative or a notary public. In the event of a participant's death, retirement benefits will be paid to the designated beneficiary(ies). A beneficiary designation may be changed at any time, prior to beginning retirement benefits, by contacting the Benefits Office or the investment companies directly.

If you do not designate a beneficiary and are not married at the time of your death, any remaining benefits will be paid in a lump sum to your estate. If you are married at the time of your death and have not designated a beneficiary, any remaining benefits will be paid to your spouse in the form of an annuity (although your spouse may elect a different form of benefit that is available under the Plan). Remember to review your designation if you get married or divorced or have another major life event. If you have designated a beneficiary and then get married, remember that your designation will not be effective unless your surviving spouse consents to the designation.

Rollover Contributions

This Plan does not accept rollover contributions.

Vesting

Vesting is the process by which a participant earns the right to the value of the contributions in his or her account. Employees who were participants in the Plan before January 1, 2007 are 100% vested in their accounts under the Plan. For employees who become participants on or after January 1, 2007, accounts will vest according to your Years of Service under the following schedule:

<u>Years of Service</u>	<u>Percentage Vested</u>
Less than 2	0%
2 but less than 3	25%
3 but less than 4	50%
4 but less than 5	75%
5 or more	100%

For vesting purposes, a Year of Service is a 12 consecutive month period beginning on the date you begin working for the Employer (and each successive anniversary) in which you are credited with at least 1,000 Hours of Service.

Effect of Termination and Re-employment

If you were a participant before January 1, 2007, terminate employment, and are re-hired you will continue to be 100% vested in contributions made to your account after your return.

If you became a Participant on or after January 1, 2007, and leave employment before you are 100% vested, any non-vested portion of your benefit will be forfeited once you (a) take a distribution of the vested portion of your benefit from the Plan, or (b) incur a Five Year Break in Service. If you are

re-employed before incurring a Five Year Break in Service you can again earn Years of Service toward vesting your account. If you had taken a distribution of the vested portion of your benefit, the amount you forfeited will be restored only if you repay that distribution within five years of your re-employment. “Lost” earnings will not be restored. If you are re-employed after incurring a Five Year Break in Service, your forfeited benefit will not be restored. Your prior service will count in determining your vested interest in any new contributions to your account only if (a) you had a vested interest in your account before you left, or (b) your pre-break Years of Service exceed your years of Break in Service.

Loans

Loans are not permitted nor provided for under this Plan.

Withdrawals

Withdrawals are not permitted from this Plan while a participant is eligible for contributions to be made to his or her account. See the RETIREMENT OPTIONS and REPURCHASE OF BENEFITS sections for information on withdrawals and the receipt of retirement income after termination of employment.

Statements

Participants will receive quarterly account statements from each of the investment companies in which they have invested Plan contributions. The statements will indicate the amount of accumulations in each of the funds in which the participant has invested.

RETIREMENT OPTIONS

If a participant has terminated employment, he or she may begin receiving retirement benefits. Participants have the benefit options indicated below for the payment of benefits. Payment of retirement benefits, other than the Cash Withdrawal or Rollover options, must be made through TIAA-CREF. This means that in order to establish the payment of benefits other than through the Cash Withdrawal or Rollover options, the participant must transfer accumulations, if any, in Fidelity Investment Services to TIAA-CREF before benefit payments can begin. Other than for the purpose of the Cash Withdrawal Rollover and Retirement Transition Benefit options indicated below, retirement benefits will be provided in the form of an annuity. An annuity, for the purpose of this Plan, is a series of regular payments.

In any case where spousal consent is required to elect a form of benefit, the consent form must be signed before a Plan representative or a notary public.

To apply for benefits, call (800) 842-2776 for TIAA-CREF and/or Vanguard funds or (800) 343-0860 for Fidelity funds.

Cash Withdrawal

If a participant has terminated employment and is age 55 or older, he or she may request to receive up to 100% of his or her total accumulation in the Retirement Plan through cash withdrawals. Cash withdrawals are permitted from TIAA; however, limitations apply. Based on federal law, married participants who request a cash withdrawal must provide their spouse’s written consent for such withdrawal, unless the distribution is \$5000 or less.

Retirement Transition Benefit

When a participant begins the process to establish a retirement annuity, he or she may request that 10% of his or her total accumulation be provided as a single sum payment. This is called a retirement transition benefit. Based on federal law, married participants who request a retirement transition benefit must provide their spouse’s written consent for such benefit.

One-Life Annuity Option

The most basic annuity form is the one-life annuity. This is the normal form of benefits for participants who are not married when distributions begin. It pays income to the participant for his or her lifetime, and the income ceases at death. A participant may elect a guaranteed period of either 10, 15, or 20 years to be added to this option, but restrictions may apply. If the participant dies during the period, the designated beneficiary will continue to receive the full payments until the guaranteed period ends. Based on Federal law, married participants who request a one-life annuity option must provide their spouse's written consent for such benefit.

Two-Life Annuity Option

A two-life annuity provides an income for life for two people. This is the normal form of benefits for participants who are married when distributions begin. Neither the participant nor his or her designated second annuitant can outlive the income. The amount continuing to the survivor after the participant's death depends on the option selected. A participant may elect a guaranteed period of either 10, 15, or 20 years to be added to any of the two-life annuity options indicated below, but restrictions may apply. When a guaranteed period is added to a two-life annuity, the guarantee provides that the benefit will continue to a designated beneficiary until the end of such period if both the participant and the second annuitant die within the guaranteed period. Based on federal law, married participants who request a two-life annuity option must provide their spouse's written consent for such benefit, if the designated second annuitant is not the spouse.

A **two-life annuity with full benefit to survivor** means that there is no benefit reduction after the death of either the participant or the second annuitant. If a guaranteed period is added to this option and both the participant and the second annuitant die during the period, the designated beneficiary will continue to receive the full benefit until the guaranteed period ends.

A **two-life annuity with half benefit to second annuitant** means that if the participant dies first, the benefit to the second annuitant will continue at half of the amount it would otherwise be. If the second annuitant dies first, the income to the participant does not change. If a guaranteed period is added to this option and both the participant and the second annuitant die during the period, the designated beneficiary will receive half of the benefit until the guaranteed period ends.

A **two-life annuity with three-quarters benefit to second annuitant** means that if the participant dies first, the benefit to the second annuitant will continue at three-quarters of the amount it would otherwise be. If the second annuitant dies first, the income to the participant does not change. If a guaranteed period is added to this option and both the participant and the second annuitant die during the period, the designated beneficiary will receive three-quarters of the benefit until the guaranteed period ends.

A **two-life annuity with two-thirds benefit to survivor** means that when either the participant or the second annuitant dies, the benefit is reduced to two-thirds of the amount it would otherwise be for the survivor. This is the only option where the benefit of the participant reduces if the second annuitant dies first. If a guaranteed period is added to this option and both the participant and the second annuitant die during the period, the designated beneficiary will receive the two-thirds benefit until the guaranteed period ends.

Fixed Period Annuity Option

For any vested accumulation that a participant has in CREF, he or she may elect the fixed period annuity option that provides retirement benefits over a number of years based on the participant's election. The number of years available for benefits is between 15 and 30 and depends on the participant's age. During that period, all of the participant's accumulation will be returned to him or her. When the fixed period is over, benefits cease. If a participant dies during the period, the designated beneficiary may elect to continue receiving the remainder of the benefit payments or a lump sum payment. Based on Federal law, married participants who request a fixed period annuity option must provide their spouse's written consent for such benefit.

Interest Payment Retirement Option (IPRO)

For any vested accumulation that a participant has in TIAA, he or she may elect the IPRO that provides for payments consisting only of current interest on the TIAA accumulation. The minimum amount that may be designated for an IPRO is \$10,000. The accumulation remains unchanged during the period that the IPRO income is provided. This option is available to participants between ages 55 and approximately 69½. If a participant elects this option, it must eventually be converted to an annuity or MDO. Based on federal law, married participants who request an IPRO option must provide their spouse's written consent for such benefit.

Minimum Distribution Option

For participants who have terminated employment, have not yet begun receiving retirement benefits, and who are age 70½, Federal laws require that a minimum retirement distribution must begin by April 1 of the year after reaching age 70½. Under this option, payments are set at the minimum level required by law and can continue until (a) the total accumulation has been fully paid out to the participant or if he or she dies before payments are completed, to a designated beneficiary or (b) such time that the participant decides to begin an annuity payment option.

Rollover Distributions

You may also elect to have your account balances directly rolled over to an individual retirement account or another qualified retirement plan, including a Section 403(b) annuity or governmental Section 457 Plan. To receive a rollover distribution, you must be eligible to receive a cash withdrawal from the Plan. Therefore, to receive a rollover of a cash withdrawal, you must have terminated employment and reached age 55. However, some types of distributions, such as annuity payments, cannot be rolled over. To initiate a rollover distribution, contact the Trustee where your accounts are invested.

REPURCHASE OF BENEFITS

Participants who have terminated employment before the fifth anniversary of becoming a participant will receive the vested balance of their total accumulation (if the total value of your Retirement Plan, TIAA-CREF, Fidelity and Vanguard funds is less than \$5,000) in a lump sum payment. Spousal consent is not required for lump sum payments of \$5,000 or less. A lump sum payment from TIAA-CREF will be based on the terms of such annuity contract.

You must request a repurchase of your benefits through the Trustee. If you repurchase benefits before age 55, Federal early distribution penalties may apply.

PRE-RETIREMENT DEATH BENEFITS

If a participant dies before establishing an annuity option, the value of his or her total vested accumulation will be paid to the designated beneficiary. The beneficiary may elect to receive either a lump sum payment or one of the annuity options indicated above. The participant's spouse is automatically the beneficiary for 50% of the total accumulation unless the spouse has consented to a waiver of such benefit. The pre-retirement death benefit may be waived by the participant and his or her spouse beginning on the first day of the Plan year during which the participant attains age 35 and ending on the earlier of (a) the date of the participant's death or (b) the date annuity benefits begin. A waiver may be revoked during that period only if the participant also revokes his or election. A waiver is not available for participants under age 35, unless the participant terminates employment.

INVESTMENT COMPANY CONTACT INFORMATION

Investment Funds	Telephone Numbers	Website
TIAA-CREF and Vanguard	(800) 842-2776	http://www.tiaa-cref.org/bnl
Fidelity	(800) 343-0860	http://netbenefits.non-profits.com

QUESTIONS ABOUT THE PLAN

Questions or concerns about the Retirement Plan may be directed to the Benefits Office at (631) 344-7516 or the investment companies directly.

MISCELLANEOUS

Base Salary

Base Salary is the participant's base salary that is reflected on the participant's W-2 statement, before exercise of any salary reduction option. Overtime payments, shift premiums, termination payments, severance pay, and any other forms of compensation are not included in Base Salary. For union employees, Base Salary is based on the terms of the union contract.

Break in Service

A Break in Service is a 12 consecutive month period (measured from your date of hire and anniversaries of such date) in which you are credited with less than 501 Hours of Service. A Five Year Break in Service means five consecutive Breaks in Service.

Continuous Service

Continuous Service means service from a participant's most recent hire date. Service performed prior to a break in employment is not included in Continuous Service. Continuous Service will be reduced by periods on an approved Leave of Absence.

Discontinuation of Contributions

Contributions to a participant's accumulation will cease on the earlier of the date he or she terminates employment or is no longer eligible for coverage.

Employer

Brookhaven Science Associates, LLC.

General Information

Information regarding the Plan identification number, Plan year, Plan funding, type of Plan, Plan sponsor, Plan administrator, agent for legal process, your rights under ERISA, prudent actions by Plan fiduciaries, and modification, suspension, or termination of the Plan can be found in the General Information section of this booklet.

Hour of Service

An Hour of Service is each hour for which you are entitled to be paid for the performance of duties, or for which you are entitled to be paid for vacation, holiday, illness, incapacity, layoff, jury duty, military duty or leave of absence. No more than 501 Hours of Service will be credited for any single continuous period during which you perform no duties, except in the case of certain absences due to military service.

Leave of Absence

Contributions will not be made to the Retirement Plan during an approved Leave of Absence. If, however, you return to work within the time required by law, from an approved Leave of Absence for military duty, an amount equal to 10%, 9%, if hired 1/1/11 or later and were not a member of the IBEW union, of your Base Salary will be made for any period for which you would have been otherwise eligible for contributions had you not been on a Leave of Absence.

Non-Alienation of Benefits

Benefits under this Plan may not be subject to alienation, encumbrance, the claims of creditors, or legal process. Benefits may not be transferred, assigned, or alienated. The Plan will, however, comply with any judgment, decree, or order which established the rights of another person to all or a portion of a participant's benefits under this Plan to the extent that it is a Qualified Domestic Relations Order under Internal Revenue Code section 414(p).

Participants Receiving Long Term Disability Benefits

For the purpose of this Plan, Base salary for participants who qualify for benefits under the Long Term Disability Plan (LTD) will be based on Base Salary at the rate in effect prior to the day you become eligible to receive LTD benefits. Plan contributions will continue until the earliest of (1) the end of the participant's maximum LTD period of benefits, (2) the date the participant elects to retire, (3) the participant's death, or (4) the end of the participant's disability.

During the period while the participant is receiving LTD benefits, Retirement Plan contributions will be made to the participant's account at a rate of 12½% of Base Salary not in excess of the social security wage base and 17½% of Base Salary in excess of the social security wage base.

Plan Administrator

The Plan administrator is the Retirement Committee and can be reached at (631) 344-2881 and at the address of the Plan Sponsor listed in the General Information section.

Qualified Domestic Relations Order

Information on the administration of a Qualified Domestic Relations Order can be obtained at no charge from the Benefits Office.

Type of Plan

This Plan is a money purchase defined contribution Plan. The amount of benefits that you receive is based on the vested balance of your accounts in the Plan. Because the Plan is an individual account Plan, the benefits provided by the Plan are not insured by the Pension Benefit Guaranty Corporation.

Amendment or Termination of the Plan

BSA reserves the right to amend or terminate this Plan at any time and for any reason. If the Plan is terminated for any reason, the assets in the Plan will be used for the exclusive benefit of Plan participants and their beneficiaries. If you are affected by a termination of the Plan, you will become 100% vested in your account balances.

Brookhaven Science Associates Funds, LLC. Available for Investment

TIAA-CREF

TIAA Traditional Annuity
 TIAA Real Estate Account
 CREF Money Market Account
 CREF Bond Market Account
 CREF Inflation-Linked Bond Account
 CREF Social Choice Account
 CREF Equity Index Account
 CREF Global Equities Account
 CREF Growth Account
 CREF Stock Account
 TIAA-CREF Real Estate Securities
 TIAA-CREF Growth & Income
 TIAA-CREF S&P 500 Index
 TIAA-CREF Social Choice Equity
 TIAA-CREF Large-Cap Value
 TIAA-CREF Mid-Cap Value
 TIAA-CREF Mid-Cap Growth
 TIAA-CREF Small-Cap Equity
 TIAA-CREF International Equity
 TIAA-CREF Lifecycle Fund 2010*
 TIAA-CREF Lifecycle Fund 2015*
 TIAA-CREF Lifecycle Fund 2020*
 TIAA-CREF Lifecycle Fund 2025*
 TIAA-CREF Lifecycle Fund 2030*
 TIAA-CREF Lifecycle Fund 2035*
 TIAA-CREF Lifecycle Fund 2040*
 TIAA-CREF Lifecycle Fund 2045*
 TIAA-CREF Lifecycle Fund 2050*

Fidelity

Retirement Gov't Money Market
 Retirement Money Market
 Intermediate Bond Fund
 Puritan Fund
 Equity-Income Fund
 Magellan Fund
 Diversified International Fund
 Overseas Fund
 Freedom Income Fund
 Freedom 2000 Fund*
 Freedom 2005 Fund*
 Freedom 2010 Fund*
 Freedom 2015 Fund*
 Freedom 2020 Fund*
 Freedom 2025 Fund*
 Freedom 2030 Fund*
 Freedom 2035 Fund*
 Freedom 2040 Fund*
 Freedom 2045 Fund*
 Freedom 2050 Fund*

Vanguard

Prime Money Market Fund
 Federal Money Market Fund**
 Wellington Fund
 Wellesley Income Fund
 500 Index Fund
 Windsor Fund
 Explorer Fund
 Total International Stock Index Fund
 International Growth Fund

*Qualified Default Investment Alternative (QDIA). (TIAA-CREF and Vanguard funds are administered by TIAA-CREF, so the QDIA for TIAA-CREF and Vanguard funds is the same.)

**Closed to new investors

401(k) PLAN

The 401(k) Plan provides participants with the opportunity to supplement income at retirement. Enrollment in the 401(k) Plan is optional.

WHO IS ELIGIBLE FOR THE 401(k) PLAN?

Active Employees

Each employee of Brookhaven Science Associates, LLC who was a participant in the Plan on December 31, 2001 remained eligible to participate in this Plan on January 1, 2002.

In addition, all full-time employees are eligible to participate in the 401(k) Plan on the first day of active employment. Employees who work on a part-time, temporary or irregular basis may participate on the earlier of January 1 or July 1 following completion of 1,000 Hours of Service during the 12 consecutive calendar month period beginning with the first day of active employment (or each successive anniversary thereof).

An Hour of Service is each hour for which you are entitled to be paid for the performance of duties, or for which you are entitled to be paid for vacation, holiday, illness, incapacity, layoff, jury duty, military duty or leave of absence. No more than 501 Hours of Service will be credited for any single continuous period during which you perform no duties, except in the case of certain absences due to military service.

Service shall include Continuous Service, if any, with Associated Universities, Inc., Battelle Memorial Institute, Research Foundation of the State University of New York or the State University of New York at Stony Brook immediately prior to a transfer of employment to Brookhaven Science Associates, LLC.

The following individuals are not eligible to participate in the Plan: (1) any leased employee, as defined by Internal Revenue Code Section 414(n); (2) any person holding solely a guest or visitor appointment to Brookhaven; (3) any person whose terms of employment are governed by a collective bargaining agreement whose retirement benefits are the subject of good faith bargaining, unless the collective bargaining agreement specifies that such individual is eligible to participate in the Plan; or (4) any person designated by the Employer as an independent contractor or who performs services pursuant to a written agreement with a third party.

ENROLLMENT

To enroll, you must complete enrollment forms which are available through the Benefits Office. By completing the forms, you will authorize contributions, as a percent of Base Salary, from your paycheck and the funds in which 401(k) Plan contributions will be invested.

401(k) PLAN COVERAGE

Benefits Provided

Participants may make contributions to the Plan through regular payroll reductions. Contributions are drawn from a participant's salary before taxes are calculated. This reduces taxable income, so a participant pays less in taxes now. This arrangement is called "salary reduction." Income on contributions is tax-deferred until withdrawn in the future.

The maximum contribution a participant can make to the Plan is 25% of Base Salary. Federal laws and regulations may further limit a participant's ability to contribute to this Plan.

The limits are subject to change based on changes in the laws.

Catch Up Contributions

The Plan allows catch up contributions (as provided under the Internal Revenue Code) for participants who are or will become age 50 or over during the calendar year. Federal laws and regulations limit such contributions and are subject to change. Participants must complete an enrollment form to elect this catch up provision or in PeopleSoft self-service. The dollar amount elected will remain in effect unless a participant completes another enrollment form indicating otherwise.

Plan Investments

There are numerous approved TIAA- Cref, Fidelity and Vanguard funds in which a participant can allocate the investment of his or her contributions. The funds available for investment are indicated at the end of the 401(k) Plan section.

The Plan is intended to constitute a plan described in Section 404(c) of the Employee Retirement Income Security Act of 1974 (ERISA), and Title 29 of the Code of Federal Regulations Section 2550.404c-1. This means that the fiduciaries of the Plan may be relieved of liability for any losses that are the direct and necessary results of your investment choices. Under these regulations, you have the right to receive additional information regarding the investment options provided under the Plan. The Plan Administrator is the Plan fiduciary responsible for providing this information, and the information may be obtained from the Benefits Office. The additional information includes:

- A description of the annual operating expenses of each investment fund which may reduce the rate of return on the fund, and the amount of expenses expressed as a percentage of the fund's average net assets.
- Copies of prospectuses, financial statements and reports, and other materials relating to the investment funds, to the extent such information is provided to the Plan.
- A list of funds, including the issuer, term and rate of return of all guaranteed investment contracts.
- Information concerning the value of shares or units in each available investment fund, as well as the past and current investment performance of such funds, net of expenses.
- Information concerning the value of shares or units of each fund held in your account.

In addition to this information, each mutual fund whose shares are registered with the US Securities and Exchange Commission must periodically publish a document called a “prospectus”, which is a description of the fund, its management and investment philosophy, and certain risk factors involved in investing in the fund. The prospectus will also contain information about the prior investment performance and management expenses of the fund. Each of the investment funds currently available under the Plan is required to issue a prospectus, and you should receive and review the current prospectus before investing any part of your account in the fund. If you do not automatically receive a current prospectus, you can request one from the Benefits Office.

Allocating Contributions

When a participant first enrolls in the Plan, he or she will complete a form indicating how to allocate Plan contributions. The allocation can be changed at any time. If a participant wants to change the allocation within an investment company, he or she must contact the investment company directly. If the participant wants to change investment companies or the allocation between companies, he or she must complete forms available in the Benefits Office or in PeopleSoft self-service.

Designating a Beneficiary

When a participant enrolls in the Plan, he or she will indicate one or more beneficiaries on the enrollment forms. For married participants, the spouse must be the beneficiary for at least 50% of the accumulation unless the spouse consents to the designation of someone else. The spouse's consent must

be in writing and witnessed by a Plan representative or a notary public. In the event of a participant's death, retirement benefits will be paid to the designated beneficiary(ies). A beneficiary designation may be changed at any time, prior to beginning retirement benefits, by contacting the investment companies directly or the Benefits Office.

Changing the Amount Being Contributed

A participant may change the percentage he or she is contributing to this Plan once each calendar month. This includes a change from no contributions to starting contributions and vice versa. A participant can, however, cease contributions at any time. To make a change to the amount being contributed, a participant must complete a form available online through the Benefits Office website at www.bnl.gov/hr/Benefits/ and return it to Payroll or in PeopleSoft self-service.

Transferring Between Funds

Participants are permitted to transfer accumulations between funds and investment companies. To transfer accumulations within an investment company, the participant must contact the investment company directly. To transfer accumulations from one investment company to another, forms are available by contacting the investment companies directly or the Benefits Office.

Rollover Contributions

An employee who is eligible to participate in the 401(k) Plan (including employees who have not yet satisfied the Plan's service requirements for eligibility) may contribute to the Plan as a rollover any qualified rollover distribution payable to the employee from any other qualified plan, 403(a) or 403(b) Plan, 457 Plan or individual retirement account. However, the rollover amount cannot contain any after-tax contributions, even if the employee's prior plan allowed for after-tax contributions.

Vesting

Vesting is the process by which a participant earns the right to the value of the contributions in his or her account. Under the 401(k) Plan, participants are immediately vested in the Plan benefits.

Loans

Loans are permitted from a participant's TIAA-CREF accumulation in this Plan. When a participant begins a loan, a portion of his or her accumulation will be set aside as security for the loan but will continue to earn income while the loan is being repaid.

The minimum loan amount available is \$1,000. The maximum amount is the least of the following:

- \$50,000 or
- 45% of the participant's TIAA-CREF accumulation or
- 90% of the participant's TIAA accumulation.

If a participant has Plan accumulations in CREF, Fidelity or Vanguard funds, he or she may transfer all or part of the accumulation to TIAA to increase the available loan amount.

A participant may have more than one outstanding loan. If a participant applies for a second loan, the amount available may be effected by the outstanding loan.

Loan repayments may be made over a period of one to five years with payments due monthly or quarterly. A ten year repayment option is available if the loan is being used to purchase a principal residence.

Participants who want to pursue a loan must contact TIAA-CREF directly for a loan application and additional information on loan provisions including the interest rate, billing, and default.

Based on Federal law, married participants who request a loan must provide their spouse's written consent for such benefit.

Both active employees and terminated employees are eligible to apply for a loan.

Withdrawals

Withdrawals during employment are permitted from this Plan if any of the following events occur:

- The participant wishes to withdraw any rollover contributions that he or she made to the Plan;
- The participant attains age 59½; or
- The participant incurs a financial hardship.

For a participant to incur a financial hardship, the participant must have an immediate and heavy financial need that meets one of the following hardship criteria:

- Purchase of the participant's principal residence.
- Prevention of foreclosure on or eviction from the participant's principal residence.
- Payment of medical expenses which are not reimbursed through insurance for the participant or his or her spouse or dependents.
- Payment of tuition, related educational expenses, and/or room and board for post-secondary education for the participant or his or her spouse or dependents for the next twelve months.
- Payment of funeral expenses for a member of the participant's family.
- Expenses for the repair of damage to the participant's principal residence that would qualify for a casualty deduction under Code Section 165.

A withdrawal for hardship reasons is only available if the financial need cannot be reasonably relieved through other sources.

The hardship withdrawal cannot exceed the amount required to satisfy the immediate hardship and may only include the participant's Plan contributions, not income earned. A participant who receives a withdrawal for hardship reasons will be required to discontinue Plan contributions for six months. To apply for a hardship withdrawal, participants must contact the Fiscal Officer.

In addition, a withdrawal of rollover contributions may be made at any time. If a participant withdraws rollover contributions before age 59½, Federal early distribution penalties may apply.

Based on Federal law, married participants who request a withdrawal must provide their spouse's written consent for such benefit.

For information on withdrawals, other than for financial hardship, and the receipt of retirement income see the RETIREMENT OPTIONS section.

Statements

Participants will receive quarterly account statements from each of the investment companies in which they have invested Plan contributions. The statements will indicate the amount of accumulations in each of the funds in which the participant has invested.

RETIREMENT OPTIONS

If a participant retires, terminates employment, becomes disabled and terminates employment, or attains age 59½, he or she may begin receiving retirement benefits. Participants have the benefit options indicated below for the payment of benefits. Payment of retirement benefits, other than the Cash Withdrawal or Rollover options, must be made through TIAA-CREF. This means that in order to establish the payment of benefits other than through the Cash Withdrawal or Rollover options, the participant must transfer accumulations, if any, in Fidelity Investment Services to TIAA-CREF before benefit payments can begin. Other than for the purpose of the Cash Withdrawal, Rollover, and Retirement Transition Benefit options indicated below, retirement benefits will be provided in the form of an annuity. An annuity, for the purpose of this Plan, is a series of regular payments.

In any case where spousal consent is required to elect a form of benefit, the consent form must be signed before a Plan representative or a notary public.

To apply for benefits, call (800) 842-2776 for TIAA-CREF and/or Vanguard funds or (800) 343-0860 for Fidelity funds.

Cash Withdrawal

A participant may elect, as a retirement benefit, a cash withdrawal of up to 100% of his or her total accumulation in the 401(k) Plan. Based on Federal law, participants who request a cash withdrawal must provide their spouse's written consent for such withdrawal, unless the withdrawal is \$5,000 or less.

One-Life Annuity Option

The most basic annuity form is the one-life annuity. This is the normal form of benefits for participants who are not married when distributions begin. It pays income to the participant for his or her lifetime, and the income ceases at death. A participant may elect a guaranteed period of either 10, 15, or 20 years to be added to this option, but restrictions may apply. If the participant dies during the period, the designated beneficiary will continue to receive the full payments until the guaranteed period ends. Based on Federal law, married participants who request a one-life annuity option must provide their spouse's written consent for such benefit.

Two-Life Annuity Option

A two-life annuity provides an income for life for two people. This is the normal form of benefits for participants who are married when distributions begin. Neither the participant nor his or her designated second annuitant can outlive the income. The amount continuing to the survivor after the participant's death depends on the option selected. A participant may elect a guaranteed period of either 10, 15, or 20 years to be added to any of the two-life annuity options indicated below, but restrictions may apply. When a guaranteed period is added to a two-life annuity, the guarantee provides that the benefit will continue to a designated beneficiary until the end of such period if both the participant and the second annuitant die within the guaranteed period. Based on Federal law, married participants who request a two-life annuity option must provide their spouse's written consent for such benefit, if the designated second annuitant is not the spouse.

A two-life annuity with full benefit to survivor means that there is no benefit reduction after the death of either the participant or the second annuitant. If a guaranteed period is added to this option and both the participant and the second annuitant die during the period, the designated beneficiary will continue to receive the full benefit until the guaranteed period ends.

A two-life annuity with half benefit to second annuitant means that if the participant dies first, the benefit to the second annuitant will continue at half of the amount it would otherwise be. If the second annuitant dies first, the income to the participant does not change. If a guaranteed period is added to this option and both the participant and the second annuitant die during the period, the designated beneficiary will receive half of the benefit until the guaranteed period ends.

A two-life annuity with two-thirds benefit to survivor means that when either the participant or the second annuitant dies, the benefit is reduced to two-thirds of the amount it would otherwise be for the survivor. This is the only option where the benefit of the participant reduces if the second annuitant dies first. If a guaranteed period is added to this option and both the participant and the second annuitant die during the period, the designated beneficiary will receive the two-thirds benefit until the guaranteed period ends.

A two-life annuity with three-quarters benefit to second annuitant means that if the participant dies first, the benefit to the second annuitant will continue at three-quarters of the amount it would otherwise be. If the second annuitant dies first, the income to the participant does not change. If a guaranteed period is added to this option and both the participant and the second annuitant die during the period, the designated beneficiary will receive three-quarters of the benefit until the guaranteed period ends.

Fixed Period Annuity Option

For any accumulation that a participant has in TIAA-CREF, he or she may elect the fixed period annuity option which provides retirement benefits over a number of years based on the participant's election. The number of years available for benefits is between 2 and 30 and depends on the participant's age. During that period, all of the participant's accumulation will be returned to him or her. When the fixed period is over, benefits cease. If a participant dies during the period, the designated beneficiary may elect to continue receiving the remainder of the benefit payments or a lump sum payment. Based on Federal law, married participants who request a fixed period annuity option must provide their spouse's written consent for such benefit.

Minimum Distribution Option

For participants who have terminated employment, have not yet begun receiving retirement benefits, and who are age 70½, Federal laws require that a minimum retirement distribution must begin by April 1 of the year after reaching age 70½. Under this option, payments are set at the minimum level required by law and can continue until (a) the total accumulation has been fully paid out to the participant or if he or she dies before payments are completed, to a designated beneficiary or (b) such time that the participant decides to begin an annuity payment option.

Rollover Distributions

When you terminate your employment, you may also elect to have your account balances directly rolled over to an individual retirement account or another qualified retirement Plan, including a Section 403(b) annuity or governmental Section 457 plan. To initiate a rollover distribution, contact the Trustee where your accounts are invested or contact the Benefits Office.

REPURCHASE OF BENEFITS

Participants who have terminated employment before the fifth anniversary of becoming a participant will receive the balance of their total accumulation (if the total value of your 401(k) Plan TIAA-CREF, Fidelity and Vanguard funds is less than \$5,000) in a lump sum payment. Spousal consent is not required for lump sum payments of \$5,000 or less. A lump sum payment from TIAA-CREF will be based on the terms of such annuity contract.

You must request a repurchase of your benefits through the Trustee or the Benefits Office. If you repurchase benefits before age 55, Federal early distribution penalties may apply.

PRE-RETIREMENT DEATH BENEFITS

If a participant dies before establishing an annuity option, the value of his or her total accumulation will be paid to the designated beneficiary. The beneficiary may elect to receive either a lump sum payment or one of the annuity options indicated above. The participant's spouse is automatically the beneficiary for 50% of the total accumulation unless the spouse has consented to a waiver of such benefit. The pre-retirement death benefit may be waived by the participant and his or her spouse beginning on the first day of the Plan Year during which the participant attains age 35 and ending on the earlier of (a) the date of the participant's death or (b) the date annuity benefits begin. A waiver may be revoked during that period only if the participant also revokes his or her election. A waiver is not available for participants under age 35, unless the participant terminates employment.

INVESTMENT COMPANY CONTACT INFORMATION

Investment Funds	Telephone Numbers	Website
TIAA-CREF and Vanguard	(800) 842-2776	http://www.tiaa-cref.org/bnl
Fidelity	(800) 343-0860	http://netbenefits.non-profits.com

QUESTIONS ABOUT THE PLAN

Questions or concerns about the 401(k) Plan may be directed to the Benefits Office at (631) 344-7516 or the investment companies directly.

MISCELLANEOUS

Base Salary

Base Salary is the participant's Base Salary which is reflected on the participant's W-2 statement including vacation pay, overtime payments and, shift premiums before exercise of any salary reduction option. Reimbursements or other expense allowances, fringe benefits (cash and noncash), moving expenses, other welfare benefits, and any other forms of compensation are not included in Base Salary. For union employees, Base Salary is based on the terms of the union contract.

Discontinuation of Contributions

Contributions to a participant's accumulation will cease on the earlier of the date he or she (a) terminates employment, (b) begins receiving benefits under the Long Term Disability Plan, (c) elects to discontinue contributions, or (d) is no longer eligible for coverage.

Fiscal Officer

The Fiscal Officer can be reached at (631) 344-8000 and at the address of the Plan Sponsor listed in the General Information section.

General Information

Information regarding the Plan identification number, Plan year, Plan funding, type of Plan, Plan sponsor, Plan administrator, agent for legal process, your rights under ERISA and prudent actions by Plan fiduciaries can be found in the General Information section of this booklet.

Leave of Absence

Contributions cannot be made to the 401(k) Plan during an approved Leave of Absence.

If you return to work from an approved Leave of Absence for military duty, you may contribute an amount not greater than that which you were allowed to contribute had you not been on a Leave of Absence.

Non-Alienation of Benefits

Benefits under this Plan may not be subject to alienation, encumbrance, the claims of creditors, or legal process. Benefits may not be transferred, assigned, or alienated. The Plan will, however, comply with any judgment, decree, or order which established the rights of another person to all or a portion of a participant's benefits under this Plan to the extent that it is a Qualified Domestic Relations Order under Internal Revenue Code section 414(p).

Participants Receiving Long Term Disability Benefits

Contributions to this Plan cease when a participant qualifies for Long Term Disability Plan benefits.

Plan Administrator

The Plan administrator is the Retirement Committee and can be reached at (631) 344-2881 and at the address of the Plan Sponsor listed in the General Information section.

Qualified Domestic Relations Order

Information on the administration of a Qualified Domestic Relations Order can be obtained at no charge from the Benefits Office.

Type of Plan

This Plan is a defined contribution Plan with a 401(k) deferral feature. The amount of benefits that you receive is based on the balance of your accounts in the Plan. Because the Plan is an individual account Plan, the benefits provided by the Plan are not insured by the Pension Benefit Guaranty Corporation.

AMENDMENT OR TERMINATION OF THE PLAN

BSA reserves the right to amend or terminate this Plan at any time and for any reason. If the Plan is terminated for any reason, the assets in the Plan will be used for the exclusive benefit of Plan participants and their beneficiaries. If you are affected by a termination of the Plan, you will be 100% vested in your account balances.

Brookhaven Science Associates, LLC. Funds Available for Investment

TIAA-CREF

TIAA Traditional Annuity
 TIAA Real Estate Account
 CREF Money Market Account
 CREF Bond Market Account
 CREF Inflation-Linked Bond Account
 CREF Social Choice Account
 CREF Equity Index Account
 CREF Global Equities Account
 CREF Growth Account
 CREF Stock Account
 TIAA-CREF Real Estate Securities
 TIAA-CREF Growth & Income
 TIAA-CREF S&P 500 Index
 TIAA-CREF Social Choice Equity
 TIAA-CREF Large-Cap Value
 TIAA-CREF Mid-Cap Value
 TIAA-CREF Mid-Cap Growth
 TIAA-CREF Small-Cap Equity
 TIAA-CREF International Equity
 TIAA-CREF Lifecycle Fund 2010*
 TIAA-CREF Lifecycle Fund 2015*
 TIAA-CREF Lifecycle Fund 2020*
 TIAA-CREF Lifecycle Fund 2025*
 TIAA-CREF Lifecycle Fund 2030*
 TIAA-CREF Lifecycle Fund 2035*
 TIAA-CREF Lifecycle Fund 2040*
 TIAA-CREF Lifecycle Fund 2045*
 TIAA-CREF Lifecycle Fund 2050*

Fidelity

Retirement Gov't Money Market
 Retirement Money Market
 Intermediate Bond Fund
 Puritan Fund
 Equity-Income Fund
 Magellan Fund
 Diversified International Fund
 Overseas Fund
 Freedom Income Fund
 Freedom 2000 Fund*
 Freedom 2005 Fund*
 Freedom 2010 Fund*
 Freedom 2015 Fund*
 Freedom 2020 Fund*
 Freedom 2025 Fund*
 Freedom 2030 Fund*
 Freedom 2035 Fund*
 Freedom 2040 Fund*
 Freedom 2045 Fund*
 Freedom 2050 Fund*

Vanguard

Prime Money Market Fund
 Federal Money Market Fund**
 Wellington Fund
 Wellesley Income Fund
 500 Index Fund
 Windsor Fund
 Explorer Fund
 Total International Stock Index Fund
 International Growth Fund

*Qualified Default Investment Alternative (QDIA). (TIAA-CREF and Vanguard funds are administered by TIAA-CREF, so the QDIA for TIAA-CREF and Vanguard funds is the same.)

**Closed to new investors

FLEXIBLE SPENDING ACCOUNTS PLAN

The Flexible Spending Accounts Plan consists of two accounts, the Health Care Reimbursement Account and the Dependent Day Care Reimbursement Account, which allow you to pay for a variety of health care and dependent day care expenses on a before-tax basis. By paying for expenses on a before-tax basis, you reduce your income for the purpose of state, federal and Social Security taxes. Enrollment in the Flexible Spending Accounts Plan is optional.

WHO IS ELIGIBLE FOR THE FLEXIBLE SPENDING ACCOUNTS PLAN?

Active Employees

All regular employees who work at least 20 hours per week are eligible to participate in the Flexible Spending Accounts Plan on the first day of active employment.

Participation in the Dependent Day Care Reimbursement Account also requires that you are:

- a single parent and require dependent day care so you can work, or look for work or,
- married and require day care so you can work and your spouse can work, or look for work (if filing jointly) or be a full-time student.

ENROLLMENT

Eligible employees may enroll in the Health Care and/or Dependent Day Care Reimbursement Accounts within 30 days of their date of hire. Once you enroll, you must continue participation in the plan until the end of the calendar year. If you do not enroll for coverage within 30 days of your date of hire, you will be required to wait until the next Open Enrollment Period or when you have a Qualifying Event to elect coverage.

To enroll, you must complete an enrollment form and indicate the amount you want to contribute to the Health Care and/or Dependent Day Care Reimbursement Accounts. Enrollment forms are available through the Benefits Office. By completing the form, you will authorize an annual salary reduction amount. Your actual contributions will be made from your paycheck in equal monthly or weekly installments depending on your pay status.

Coverage begins on your date of hire if you complete the enrollment form and submit it to the Benefits Office within 30 days of your date of hire.

Enrollments completed during an Open Enrollment Period will be effective on January 1 of the following calendar year.

HEALTH CARE REIMBURSEMENT ACCOUNT

Benefits Provided

You can use the plan to set aside money on a pre-tax basis into a reimbursement account to pay for eligible health care expenses. You determine what types of expenses you expect to have during the plan year and fund your Health Care Reimbursement Account through automatic salary reduction.

Throughout the year, you draw money out of your Account and reimburse yourself for the health care expenses as you and your eligible dependents incur them.

Your eligible dependents include:

- Your spouse.
- Your children up to age 26.
- Your unmarried children who are mentally or physically incapable of earning their own living.

What Health Care Expenses are Reimbursed?

Expenses that are reimbursable under the Health Care Reimbursement Account are mainly those goods and services currently allowed by the Internal Revenue Service (IRS) as an income tax deduction, but not all items that qualify for a tax deduction also qualify for the Reimbursement Account. However, this does not include premiums paid for insurance coverages. Eligible expenses include, but are not limited to:

- Deductibles and co-insurance payments that are not reimbursed under the medical or dental insurance plans.
- Out-of-pocket expenses.
- Charges not reimbursed by the medical or dental insurance plans that are above reasonable and customary charges.
- Hearing and vision care expenses such as exams, eyeglasses, and contact lenses.
- Annual physical examinations.
- Approved weight-loss and stop-smoking programs, if prescribed by a physician to treat a specific condition.
- Over-the-counter medications used to alleviate or treat personal illness or injuries that are deemed medically necessary and for which the participant has received a prescription. Dietary supplements to maintain one's health (such as vitamins) do not qualify for reimbursement.

How Much May You Contribute Each Year to the Health Care Reimbursement Account?

You may contribute any amount from a minimum of \$300 to a maximum of \$4,000 each calendar year.

It is extremely important that you carefully determine the amount you elect to contribute, if any, since under IRS regulations, all amounts that you do not use toward expenses incurred in the calendar year will be forfeited.

DEPENDENT DAY CARE REIMBURSEMENT ACCOUNT

Benefits Provided

You can use the Dependent Day Care Reimbursement Account to reimburse yourself for eligible dependent day care expenses with before-tax dollars. Estimate the amount you will be spending in the coming year on day care. Then, to cover these costs, you contribute to the Account through automatic salary reduction. Throughout the year, you draw money out of your Account and reimburse yourself for payments you have made to your day care provider.

What Dependent Day Care Expenses are Reimbursed?

Expenses that are reimbursable under the Dependent Day Care Reimbursement Account are mainly those currently allowed by the IRS as a tax credit, but not all items that qualify for a tax credit also

qualify for the Reimbursement Account. All day care must be rendered by eligible providers. Eligible expenses include, but are not limited to:

- Care of a dependent in your home by a paid provider.
- Care of a dependent outside of your home by a licensed nursery or day care center.
- Household services, such as a housekeeper, provided some portion of the service is to a dependent.

A relative is considered an eligible provider of dependent day care if he or she is not claimed as your dependent for tax purposes. The provider's name, address and Tax Identification Number or Social Security Number must be supplied to receive reimbursement.

Who are Eligible Dependents?

Expenses may be claimed for:

- A child under age 13 who is claimed as a dependent on your income tax return.
- Any dependent you claim for income tax purposes who requires day care because of physical or mental inability.

How Much May You Contribute Each Year to the Dependent Day Care Reimbursement Account?

You may contribute any amount from a minimum of \$300 to a maximum of \$5,000. However, there are certain guidelines you must follow. If you are single or if you are married and file separate income tax returns, the maximum amount you may contribute is \$2,500 in a calendar year. Your total contribution in any calendar year may not exceed your annual earnings or, if less, your spouse's annual earnings.

It is extremely important that you carefully determine the amount you elect to contribute, if any, since under IRS regulations, all amounts you do not use toward expenses incurred in the calendar year will be forfeited.

Dependent Day Care Reimbursement Account or Tax Credit

Federal law currently permits an individual to take a tax credit against federal income taxes for allowable dependent care expenses. When considering contributions to the Dependent Day Care Reimbursement Account, you may want to consider if it is better to take the tax credit or to pay for your dependent care expenses through the Flexible Spending Account.

With the dependent care tax credit, you pay your dependent day care expenses yourself and claim a credit for them on your federal income tax return.

You may use only one of these methods for any given dollar of dependent care costs. You cannot use the Dependent Day Care Reimbursement Account for a particular expense and also claim a credit for that same expense on your tax return.

You should consult your tax advisor to determine whether it is better for you to reimburse yourself for day care expenses with the Dependent Day Care Reimbursement Account or use the tax credit on your income tax return.

Does the Use of Before-Tax Contributions to the Flexible Spending Accounts Plan Affect Any Other Benefits?

It may. If your annual salary is below the Social Security wage base, your future Social Security benefit may be reduced, but only minimally.

CLAIMS/PAYMENT OF EXPENSES

How to File a Claim or Pay for Expenses

You must either:

- use your PayFlex card (which is similar to a debit card) at the point of purchase for your eligible expenses where the expenses are debited directly from your Account, or
- complete a PayFlex Health/Dependent Care Flexible Spending Accounts Claim Form, available in the Benefits Office or through the Benefits Office website at <http://www.bnl.gov/hr/Benefits/ReimbursementAccounts.asp> , or
- go online to www.bnl.healthhub.com and submit your claim electronically.

In general, when submitting a claim for reimbursement, you must submit a receipt along with your claim form including provider name and address, date of service, type of service provided, and dollar amount charged for the service.

For Health Care expense claims, you must first submit your medical and dental claims to the applicable insurance company. You will receive your Explanation of Benefits (EOB) from the insurance company. If you are not enrolled in the medical or dental plans or are enrolled in an HMO, you must provide itemized bills.

You can pay for your eligible expenses with the PayFlex card or submit for reimbursement for up to the amount of funds in your Account. If you submit for reimbursement of your claims, you may either set up a direct deposit option with PayFlex or receive a check which is mailed to your home.

Payments will be issued daily for eligible expenses. For eligible health care expenses, you can be reimbursed for up to the total amount you have elected for the calendar year even though you have not yet contributed that amount into your Account. For eligible dependent care expenses, you can only be reimbursed for up to the total amount that is in your Account at the time of your claims submission or when you use your PayFlex card. You cannot be reimbursed for expenses incurred prior to your participation in the plan.

How Long Do You Have to Submit Claims for Reimbursement?

You have until March 31 following the calendar year in which you incurred expenses to submit claims for reimbursement. So, for example, if you buy eyeglasses in December, you would still have up to March 31 to claim the expense, provided there is money remaining in your Health Care Reimbursement Account.

If you have any funds in your Account at the time you terminate employment, terminate participation or cease to be eligible to participate, these funds will be forfeited if they are not used for expenses incurred prior to these dates and you do not submit them for reimbursement within the applicable timeframes. Any expenses incurred after these dates are not eligible for reimbursement.

Questions About Claims

If you have a question about your Flexible Spending Account claim, you should contact PayFlex at (800) 284-4885.

How to Appeal a Claim

If your claim is denied, you will receive a written notice of the denial from the Claims Administrator. The notice will explain the reason for the denial and indicate the review procedures. You may request a review of the denied claim. The request must be submitted in writing to the Claims Administrator within 60 days after you receive the denial notice. Submit your request, including your reasons for requesting the review and any additional documents which you believe support your claim. The Claims Administrator will review the claim and ordinarily notify you within 60 days of the date your request for review is received. In special cases requiring a delay, the Claims Administrator will render a decision no later than 120 days after your request for review is received.

CHANGES IN CONTRIBUTION AMOUNTS

The amount of pre-tax dollars you elect to contribute to your Health Care or Dependent Day Care Reimbursement Account is irrevocable and thus, will remain in effect for the entire calendar year. You may be eligible to change your contribution only if you have a Qualifying Event.

OPEN ENROLLMENT PERIOD

Open enrollment is held once a year. During an Open Enrollment Period, you may elect your contribution amount for the following calendar year. Your election during the Open Enrollment Period will be effective January 1 of the following calendar year. Coverage will not automatically carry forward from year to year. You must elect coverage during the Open Enrollment Period for the following calendar year. Your elections will be in effect for the remainder of the calendar year unless you notify the Benefits Office of a Qualifying Event within 31 days of the event.

QUALIFYING EVENT

A Qualifying Event is a change in your family status and includes:

- a) Change in legal marital status
 - 1. marriage
 - 2. death of spouse
 - 3. divorce
 - 4. legal separation
 - 5. annulment
- b) Change in the number of dependents
 - 1. birth
 - 2. adoption
 - 3. placement for adoption
 - 4. death of a dependent
- c) Change in employment status
 - 1. termination or commencement of employment of the employee, spouse or dependent (other than for misconduct)
- d) Changes in work schedule
 - 1. an increase or decrease in the number of hours of employment by the employee, spouse or dependent
 - 2. a switch between full-time and part-time status
 - 3. a strike or lockout
 - 4. commencement or return from an unpaid leave of absence
- e) The dependent satisfies or ceases to satisfy the requirements for unmarried dependents
 - 1. attainment of age
- f) A change in the place of residence or work site of the employee, spouse or dependent

You have 31 days from the date of a Qualifying Event to make changes to your FSA coverage for all items indicated above except (a)(3), (a)(4), (e)(1) and (e)(2). You have 60 days from the date of a Qualifying Event to make changes to your FSA coverage for items (a)(3), (a)(4), (e)(1) and (e)(2). The change requested must relate to the change in your family status that affects eligibility for Flexible Spending Account coverage. Changes are made by completing an enrollment form, available through the Benefits

Office. The completed form must be submitted, with proof of the Qualifying Event, to the Benefits Office. Your contributions will then be changed for the remainder of the calendar year. Coverage will become effective as of the date of the event.

If you do not make a change to your contributions within the applicable period indicated above, you must wait until the next Open Enrollment Period.

MISCELLANEOUS

Claims Administrator

PayFlex Systems USA, Inc.
P.O. Box 3039
Omaha, NE 68103-4310
Telephone:(800) 284-4885
Fax: (402) 231-4310

General Information

Information regarding the plan identification number, plan year, plan funding, type of plan, plan sponsor, plan administrator, agent for legal process, your rights under ERISA, prudent actions by plan fiduciaries, and modification, suspension, or termination of the plan can be found in the General Information section of this booklet.

Leave of Absence

If you are on an approved Leave of Absence, you may continue your Flexible Spending Accounts coverage by paying your elected contributions for the remainder of the calendar year. If you discontinue contributions, only expenses incurred prior to the leave will be eligible for reimbursement. If you discontinued contributions at the time of your leave, upon return to work, you may elect to participate for the remainder of the calendar year by completing an enrollment form.

Restrictions

Flexible Spending Accounts are allowable under Section 125 of the Internal Revenue Code, and certain restrictions apply to them.

- Determination of your annual contributions to your Flexible Spending Account(s) must be made prior to the start of the plan year.
- To be eligible for reimbursement, expenses must be incurred in the same year that your salary reductions are credited to the Plan.
- Health care expenses cannot be reimbursed from a Dependent Day Care Reimbursement Account, nor dependent day care expenses from a Health Care Reimbursement Account.
- All unused Account balances remaining at the end of a plan year are forfeited.
- Expenses reimbursed from your Account(s) cannot be claimed as deductions or credits on your federal income tax return.
- Re-enrollment is required each year to have your before-tax contributions made to the Flexible Spending Accounts Plan.
- The IRS considers the two Flexible Spending Accounts totally separate and thus, does not allow you to transfer money from one account to the other.

Termination of Coverage

Flexible Spending Accounts Plan benefits will cease on the earlier of the date your employment terminates or the date you are no longer eligible for coverage. You may not continue your Dependent Day Care Reimbursement Account but you may continue your Health Care Reimbursement Account. Health Care Reimbursement Account coverage for terminated employees, who continue benefits under COBRA, will cease on the earlier of the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay the required premiums.

COBRA

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 members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

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 notice. 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 your coverage under the Plan because either one of the following qualifying 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 happens:

- 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 Benefits Office 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, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Benefits Office of the qualifying event.

Notification Requirements

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Benefits Office in writing within 60 days after the qualifying event occurs and provide documentation of the event.

When the Benefits Office has been notified that one of these events has occurred, they will in turn notify you and your dependents of the right to elect continuation coverage.

If you do not elect continuation coverage within 60 days from the date of loss of coverage due to one of the events described above, your group health insurance coverage will end retroactively to the date of the event that caused the loss of coverage.

If you elect continuation coverage, you will have the health insurance coverage you had before the event, although it may be modified if coverage changes for similarly situated participants.

How is COBRA Coverage Provided?

Once the Benefits Office 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 Benefits Office 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 notify the Benefits Office within 60 days after the qualifying event occurs and provide documentation of the event.

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.

COBRA Premium Requirements

You, or your dependents, will be required to pay 102% of the full cost of the continuation coverage under the provisions of COBRA. You will be billed for the required premium on a regular basis. COBRA premiums are indicated at the end of the Dental Plan section.

Termination of Coverage Under COBRA

Continuation coverage will end when any of the following events occur:

- The Benefits Office is notified by you or your dependent to discontinue coverage.
- 18 months after continuation coverage begins (if coverage was continued due to termination or resignation of the employee).
- 29 months after continuation coverage begins (if coverage was continued due to disability).
- 36 months after continuation coverage begins (if coverage was continued because of death of the employee, divorce, legal separation or loss of dependent status).
- The individual becomes eligible for Medicare after the date of the COBRA election.
- An individual becomes covered under another group plan, unless a pre-existing condition prevents you or your dependent from being covered by the other plan.
- For a spouse or dependent child: If the Benefits Office is not notified within 31 days of the date of divorce or legal separation.
- For a dependent child: If the Benefits Office is not notified within 31 days of the date the dependent status ends.
- Payment for continuation coverage is not paid on time.
- The group health care plan is terminated for active employees.

TUITION ASSISTANCE PROGRAM

The Tuition Assistance Program encourages and supports the continuing education and training of employees. The program is designed to encourage attendance at credit courses and degree programs offered by accredited institutions and job relevant vocational courses. The program provides reimbursement for pre-approved courses that are intended to enhance an employee's professional skills and/or contribute to the employee's career growth at the Laboratory.

WHO IS ELIGIBLE FOR THE TUITION ASSISTANCE PROGRAM?

Active Employees

All regular employees who work at least 20 hours per week are eligible to participate in the Tuition Assistance Program on the first day of active employment.

ENROLLMENT

Eligible employees may enroll in the Tuition Assistance Program by completing a Tuition Assistance Request form which is available through the Tuition Office or online at <http://intranet.bnl.gov/staffdev/tuition.asp>

TUITION ASSISTANCE PROGRAM COVERAGE

Benefits Provided

The program provides reimbursement for all or part of the tuition fee paid upon successful completion of a formal course of study. Reimbursement is restricted to out-of-pocket tuition costs actually incurred by the employee.

Regular full-time employees are eligible for 9 credits per semester for three semesters per year. Regular part-time employees are eligible for a maximum of 4 credits per semester for three semesters per year. The maximum reimbursement provided by the program is \$4,000 per semester for full-time employees and \$2,000 per semester for part-time employees.

For undergraduate, correspondence or vocational level courses, reimbursement is 75% of the tuition cost.

Upon receipt of a baccalaureate degree, reimbursement may be made for the 25% difference between the previously reimbursed 75% and 100% of tuition costs. This reimbursement is made only for courses required for the degree and taken within ten years of receipt of the degree.

For graduate level courses, reimbursement is 100% of the tuition cost.

Allowable Courses

Courses must (a) be pertinent to the work that the employee is doing or may reasonably be expected to do or (b) be required for a degree in a field of study pertinent to the work of the Laboratory. Courses must begin and be completed while employed by the Laboratory.

Exclusions

The Tuition Assistance Program does not provide reimbursement for:

- College fees.
- Registration charges.
- Books.
- Any items other than out-of-pocket tuition costs.
- Short courses, workshops, or seminars for which continuing education units may be earned.

Approvals

For a course to be eligible for reimbursement it must be approved, by signatures, on the Tuition Assistance Request form. Approvals must include (a) the employee's Supervisor, and (b) the employee's Department Chair, Division Manager, or designee.

How to Request Reimbursement

To request reimbursement for an approved course, the employee must satisfactorily complete the course, normally with a grade of "C" or equivalent or better. Proof of payment, bursar's receipt, paid invoice from the school, or payment report from the school website and a copy of the final grade report from the college or university must be submitted to the Tuition Office. Request for reimbursement must be submitted within 12 months of course completion.

Advance tuition is also available. If a tuition advance is requested, it will be considered an advance until proof of payment and a final grade report are submitted to the Tuition Office.

The employee must repay the tuition advance immediately if the employee:

- Does not complete the course(s) with a grade "C" or equivalent or better; or
- Does not submit the required documentation within 60 days after the completion date of the course(s); or
- Drops or withdraws from a class; or
- Terminates employment with the Laboratory before completing course(s). Advances must be repaid to the Laboratory prior to their termination date.

Questions About the Program

If you have a question about the Tuition Assistance Program, contact the Tuition Office.

MISCELLANEOUS

Course Schedules

Course schedules should not interfere with the employee's work attendance.

General Information

Information regarding the plan identification number, plan year, plan funding, type of plan, plan sponsor, plan administrator, agent for legal process, your rights under ERISA, prudent actions by plan fiduciaries, and modification, suspension, or termination of the plan can be found in the General Information section of this booklet.

Leave of Absence

Tuition Assistance Program coverage will cease on the date your approved Leave of Absence takes effect. If the employee is currently approved for and attending a one-semester course, the employee will be eligible for reimbursement at the completion of the course or if an advance was granted, the employee will be required to submit a grade and paid statement to close out their paperwork at the end of the semester.

Long Term Disability Benefits

Employees who are receiving Long Term Disability Plan benefits are not eligible for the Tuition Assistance Program.

Termination of Coverage

Tuition Assistance Program coverage will cease on the earlier of the date your employment terminates or the date you are no longer eligible for coverage. Tuition advances must be repaid prior to an employee's termination date unless he or she is part of a layoff. If employment is terminated due to a layoff and the employee is approved for and attending a one-semester course, the employee will be eligible for reimbursement at the completion of the course even though he or she is no longer employed. Normal refund and pre-payment procedures and requirements will apply.

SEVERANCE PAY PLAN

The Severance Pay Plan is designed to assist employees whose earnings are unexpectedly canceled by layoff due to a reduction-in-force. Severance Pay Plan provisions for bargaining unit employees will be in accordance with applicable provisions of the collective bargaining agreements.

WHO IS ELIGIBLE FOR THE SEVERANCE PAY PLAN?

Active Employees

All regular employees who work at least 20 hours per week are eligible for the Severance Pay Plan on the first day of active employment. Employees who are on a temporary appointment or a leave of absence are not eligible for this plan.

ENROLLMENT

If you are eligible for the Severance Pay Plan, you do not need to enroll.

SEVERANCE PAY PLAN COVERAGE

Benefits Provided

For active employees, the plan provides the following benefits, subject to the Maximum Benefits Provision, based on Base Pay and Continuous Service for a reduction-in-force.

Years of Continuous Service	Severance Benefit
First 10 years	1 week of Base Pay for each year of Continuous Service
Over 10 years through 15 years	1 1/2 weeks of Base Pay for each year of Continuous Service over 10 and through 15 years
Over 15 years	2 weeks of Base Pay for each year of Continuous Service over 15 years

Maximum Benefits

Effective September 1, 2011, for active employees who are not members of the IBEW or SCSPA unions, the maximum severance benefit provided by the plan is 39 weeks of Base Pay with a cap of \$50,000.

For active employees who are members of the IBEW or SCSPA unions, the maximum severance benefit provided by the plan will be in accordance with the applicable provisions of their collective bargaining agreements.

Example of Severance Benefit

Full-time Regular Employee
 Annualized Base Pay: \$78,000 (\$1,500 per week)*
 Continuous Service: 27 years**

	# of weeks of severance per year of service	x service in years	x weekly pay rate	= severance pay	
First 10 years of Continuous Service	1	10	\$1,500.00	\$15,000.00	
Next 5 years of Continuous Service	1.5	5	\$1,500.00	\$11,250.00	
Continuous years of Service above 15 years	2	12	\$1,500.00	\$36,000.00	
		27		\$62,250.00	Total severance pay before application of maximum benefits
				41.50	Weeks of severance pay before application of 39-week maximum
				39.00	Weeks of severance pay after application of 39-week maximum
				\$58,500.00	Severance pay after application of 39-week maximum but before \$50,000 maximum
				\$50,000.00	Total severance pay after application of maximum benefits

*Use the 100% full-time equivalent Base Pay in the calculation even if it is a part-time employee. (i.e. If an employee is scheduled to work 50% time and has an actual Base Pay of \$25,000, use the 100% full-time equivalent Base Pay rate of \$50,000 for the calculation.)

**Continuous Service is prorated for part-time employees (i.e. If an employee is scheduled to work 50% time during a particular year, use 0.50 for that year’s service, not 1.00 for the calculation.)

Payment of Benefits

Severance benefits will be paid in either one or two lump sum payments. If payment of the severance benefit plus compensation for unused vacation would cause an employee to receive an amount in excess of one year’s Base Pay during the calendar year, that portion of vacation and/or severance which causes the excess is deferred for payment during January of the following calendar year.

Recall to Work

If an employee is recalled to work before the end of the period for which severance pay was received, the amount of overpayment will be considered an advance of future earnings.

Exclusions

The Severance Pay Plan does not provide benefits to employees who voluntarily terminate because of resignation, retirement, disability, death, or for cause.

Questions About the Plan

If you have a question about the Severance Pay Plan, contact the Human Resources and Occupational Medicine Division.

MISCELLANEOUS**Base Pay**

Base Pay for the purpose of the Severance Pay Plan means your annual full-time equivalent basic rate of pay, before any salary reductions. This means that for a part-time employee, such as a person who is scheduled to work 50% time, the 100% rate is used. It does not include overtime, bonuses, or any other compensation.

Continuous Service

Continuous Service means service from your most recent hire date. Service performed prior to a break in employment is not included in Continuous Service. Continuous service is pro-rated for part-time employees.

For the final year of employment, service is computed in quarterly, three-month, increments with a full quarter's credit given for any fraction of a quarter attained.

Employees with less than one year of Continuous Service will be credited with a full year's service for the purpose of this plan.

If an employee was previously laid off with severance benefits, service used in the prior calculation will not be included for the purpose of another layoff.

Continuous Service will be reduced by time spent on approved leave of absence or in any employment category ineligible for severance benefits, such as part-time employment of less than 20 hours per week.

Continuous Service shall include continuous service, if any, with Associated Universities, Inc., Battelle Memorial Institute (and Battelle-related entities, excluding Department of Energy laboratories managed by Battelle except as indicated below), Research Foundation of the State University of New York or the State University of New York at Stony Brook immediately prior to a transfer of employment to Brookhaven Science Associates, LLC.

Continuous Service for employees hired for the NSLS II project shall include continuous service, if any, with other Department of Energy contractors immediately prior to a transfer of employment to Brookhaven Science Associates, LLC.

General Information

Information regarding the plan identification number, plan year, plan funding, type of plan, plan sponsor, plan administrator, agent for legal process, your rights under ERISA, prudent actions by plan fiduciaries, and modification, suspension, or termination of the plan can be found in the General Information section of this booklet.

Part-Time Employees

Severance benefits for eligible part-time employees, or employees whose Continuous Service contains periods of eligible part-time employment, will be prorated in accordance with the employee's official work schedule for the period of part-time employment.

Termination of Coverage

Severance Pay Plan coverage will cease when an employee is no longer eligible.

LONG TERM CARE PLAN

The Long Term Care (LTC) Plan provides benefits for specific types of medical care and assistance not covered by the medical plan. Long term care refers to a wide range of personal care, health care, and social services for people who suffer a chronic disease or long-lasting disability. This type of care is referred to as “custodial care” and provides help with normal activities of daily living such as bathing, eating or dressing. Services can take place in a nursing care facility, an assisted living facility, an adult day care center, or at home. Enrollment in the Long Term Care Plan is optional.

WHO IS ELIGIBLE FOR THE LONG TERM CARE PLAN?

Active Employees

All regular employees who work at least 20 hours per week are eligible to apply for the LTC Plan on the first day of active employment.

Eligible Dependents

The spouse, same-sex domestic partner, parents, parents-in-law, grandparents, grandparents-in-law, surviving spouses, and adult children age 18 and older of an employee are eligible to apply for this plan.

Retirees

All employees who retire and their spouses or same-sex domestic partners are eligible to apply for this plan.

APPLYING FOR COVERAGE

Employees may apply for LTC Plan coverage within 31 days of their date of hire. Eligible dependents may apply at the same time as the employee but must submit evidence of insurability and be approved by Prudential before coverage can become effective. If an employee applies more than 31 days after his or her date of hire or if a retiree or eligible dependent applies for coverage, he or she must submit evidence of insurability and be approved by Prudential before coverage can become effective.

If an employee is disabled and away from work on the date coverage would otherwise become effective, the effective date will be delayed until the first of the month following the date the employee returns to work as an active employee.

LONG TERM CARE PLAN COVERAGE

Benefits Provided

If a participant suffers a Loss of Functional Capacity and a Benefit Period commences while he or she is a participant, the LTC Plan will provide a benefit for each day of the Loss of Functional Capacity after the applicable Waiting Period. The benefit will be based on the Daily Benefit Amount and the place of confinement.

Benefit Eligibility Criteria

In order to receive benefits, you must first be assessed by an assessor and be confirmed as having a Chronic Illness or Disability. A Chronic Illness or Disability is one in which there is:

- 1) A loss of the ability to perform, without substantial assistance, at least two Activities of Daily Living. This loss must be expected to continue for 90 days. Activities of Daily Living are bathing, continence, dressing, eating, toileting and transferring. Or
- 2) A severe cognitive impairment which requires substantial supervision to protect you from threats to health or safety.

Preexisting Conditions Limitation

There is no preexisting conditions limitation.

Lifetime Maximum Benefit

A participant may elect either a 3 or 5 year maximum benefit.

EXCLUSIONS

The following charges are not covered:

- 1) Work-connected Conditions Charge. A charge covered by a workers' compensation law, occupational disease law or similar law.
- 2) Government Plan Charge: A charge for a service or supply:
 - a) furnished by or for the United States government or any other government, unless payment of the charge is required by law. Or
 - b) to the extent that the service or supply, or any benefit for the charge, is provided by any law or governmental plan under which the patient is or could be covered. This (b) does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program. When this (b) applies to Medicare, the benefits provided by Medicare will be deemed to include any amount that would have been payable by Medicare in the absence of a deductible or coinsurance requirement under that program.
- 3) War, Felony, Riot or Insurrection. Charges for a condition due to war or any act of war while you are insured or due to your participation in an act of felony, riot or insurrection. "War" means declared or undeclared war and includes resistance to armed aggression. "Riot" means a wild, violent, public disturbance of the peace.
- 4) Self-inflicted Injury or Suicide. Charges arising from intentionally self-inflicted injury or attempted suicide.
- 5) Services and Supplies Outside the United States. Charges for services or supplies outside of the United States and its possessions.
- 6) Treatment for Chronic Alcoholism or Chemical Dependency. Charges in connection with the treatment of chronic alcoholism or chemical dependency.

CLAIMS

How to File a Claim

To file a claim under the LTC Plan, you must complete a LTC Claim Form which is available through Prudential. The completed claim form must be submitted to Prudential within 90 days of the date of the Loss of Functional Capacity.

Questions About Claims

If you have a question about your LTC claim, you should contact Prudential at 1-800-732-0416.

How to Appeal a Claim

If your claim is denied, you have the right to appeal the decision made about your claim. The explanation of benefits notice will explain the procedure you should follow if you choose to appeal a claim decision.

Prudential will send you a written acknowledgement of your appeal. If no additional information is required and the appeal is denied, the acknowledgement will include a detailed explanation of the reasons for the denial. If additional information is required, Prudential will explain what information is needed. Upon receipt and review of the additional information, Prudential will notify you in writing of the results of the review.

If you still disagree with the appeal decision, you can request in writing within 60 days of the decision that the matter be submitted to the claim appeal committee. This committee includes, but is not limited to, clinical consultants, legal consultants and product management staff. After a thorough review, the committee will send you a written notification of its decision.

EMPLOYEE PREMIUMS

When participating in the LTC Plan, employees have the option of after-tax payroll deductions or being billed directly from Prudential.

ELIGIBLE DEPENDENT PREMIUMS

Coverage for eligible spouses must be paid for through the employee's payroll deductions or billed directly from Prudential. Coverage for all other eligible dependents will be billed directly from Prudential.

RETIREE PREMIUMS

Retirees and spouses of retirees and same-sex domestic partners of retirees will be billed directly from Prudential.

RETURN OF PREMIUMS

If a participant who is enrolled in the plan dies while covered under the plan, a refund or partial refund of premiums may be provided.

WAIVER OF PREMIUMS

A participant's LTC Plan premiums will be waived if he or she has satisfied the Waiting Period and is receiving plan benefits. Premiums will again be required when the Benefit Period ends.

MISCELLANEOUS

Benefit Period

A Benefit Period is the period of days of a covered Loss of Functional Capacity beginning on the first day of the loss and ending 90 consecutive days after which the participant has not had a Loss of Functional Capacity. It does not include any day prior to the participant's effective date of coverage.

Changes in the Amount of LTC Coverage

Every three years you will be offered the opportunity to increase your benefits to keep up with

inflation. If you accept the offer, the amount of the additional benefit shall be the difference between your existing benefits and those benefits compounded annually at a rate of five percent for the period beginning with the purchase of your existing benefits and extending until the year in which the offer is made. Benefits will be rounded to the nearest dollar.

Your age on the effective date of the increase will be used to determine the additional separate premium for the increased coverage. Therefore, your premium will increase each time you accept an inflation protection offer.

You do not have to provide evidence of insurability to take inflation increases. However, if you decline the previous two offerings made to you, and then want to increase coverage, you will be required to submit satisfactory evidence of insurability the next time you accept an offer.

Daily Benefit Amount

The Daily Benefit Amount for a Nursing Care Facility is \$100, \$150, \$200 or \$250 and is based on the participant's coverage election.

The home health care Daily Benefit Amount is 75% of the Daily Benefit Amount the participant elected for a Nursing Care Facility.

General Information

Information regarding the plan identification number, plan year, plan funding, type of plan, plan sponsor, plan administrator, agent for legal process, your rights under ERISA, prudent actions by plan fiduciaries, and modification, suspension, or termination of the plan can be found in the General Information section of this booklet.

Home Care Unit

A Home Care Unit is any unit, including a private home, that does not qualify as a Nursing Care Facility or Hospital.

Hospital

A Hospital is a short-term duly licensed, acute general hospital which meets certain requirements as indicated in the Prudential Insurance Certificate.

Leave of Absence

If you are on an approved Leave of Absence, you may continue your LTC coverage during the term of the approved leave by written request and payment of the required premium to Prudential within 30 days of the starting date of your leave.

Loss of Functional Capacity

For tax-qualified Long Term Care contracts, federal law (HIPAA) establishes a definition of a Chronically Ill individual as any individual certified by a licensed health care practitioner as:

- Being unable to perform (without substantial assistance from another person) at least two Activities of Daily Living (ADL) for at least 90 days, or
- Requiring Substantial Supervision to protect the individual from harm due to severe cognitive impairment.

As a result, there are two separate benefit triggers — ADL deficiency or severe cognitive impairment.

Generally, Prudential measures severe cognitive impairment in accordance with IRS Notice 97-31:

“Severe cognitive impairment means a loss or deterioration in intellectual capacity that is:

- Comparable to (and includes) Alzheimer’s disease and similar forms of irreversible dementia, and
- Measured by clinical evidence and standardized tests that reliably measure impairment in the individual’s:
 - Short-term or long-term memory,
 - Orientation as to people, places, or time, and
 - Deductive or abstract reasoning.

Substantial Supervision means continual supervision (which may include cuing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired individual from threats to his or her health or safety (such as may result from wandering).”

Nursing Care Facility

A Nursing Care Facility is an institution, or distinct part of one, which is duly licensed and meets certain requirements as indicated in the Prudential Insurance Certificate.

Termination of Coverage

LTC Plan coverage will cease on the day you decease, are no longer eligible for coverage, or fail to pay the required premiums.

Waiting Period

The Waiting Period is 60 days. Benefits will not be paid from the date of a Loss of Functional Capacity through the Waiting Period. The Waiting Period will not include days prior to plan participation.

CONTINUATION COVERAGE

If a participant’s coverage ceases due to ineligibility, coverage may be continued by written request and payment of the required premium to Prudential within 60 days of the date coverage ceased. For additional information on continuation coverage, contact Prudential at 1-800-732-0416.

VACATION BUY PLAN

The Vacation Buy Plan allows you to purchase additional vacation time on a pre-tax basis and spread the cost of doing so over the calendar year. Enrollment in the Vacation Buy Plan is optional.

WHO IS ELIGIBLE FOR THE VACATION BUY PLAN?

Active Employees

All regular employees who work at least 20 hours per week are eligible for the Vacation Buy Plan on the first day of active employment. Employees who are on a temporary assignment or a leave of absence are not eligible for this plan.

ENROLLMENT

Eligible employees may enroll in the Vacation Buy Plan within 30 days of their date of hire. Once you enroll, you must continue participation in the plan until the end of the calendar year. If you do not enroll within 30 days of your date of hire, you will be required to wait until the next Open Enrollment Period to elect the benefit.

VACATION BUY PLAN COVERAGE

Benefits Provided

You may purchase a minimum of 8 hours (up to a maximum of 40 hours) of vacation time in 1-hour increments each calendar year in addition to the vacation time you are eligible to receive from the Laboratory. Vacation buy benefits for eligible part-time employees will be prorated according to your official work schedule. Additional vacation time is paid for through pre-tax payroll deductions taken equally from your paychecks throughout the year.

The hours of vacation you purchase become available to you as of your date of employment. Each year thereafter, if you buy vacation time, the hours of vacation you purchase become available to you as of January 1 of the following year.

Use of Vacation Buy Time

The use of all vacation time requires the approval of your supervisor and must be in accordance with Laboratory vacation policies. When you record the vacation buy hours on your timecard, you will use a special vacation buy code. Vacation buy hours can only be used after your regular accrued vacation time has been exhausted. The cutoff date for the use of vacation buy hours varies from year to year. Contact the Benefits Office for further information.

Determining the Cost of Purchased Vacation Time

To determine the hourly cost of purchased vacation time for a full calendar year, divide your full-time Annual Base Salary by 2080. You can prorate this accordingly for a partial year.

Unused Purchased Vacation Time

If you do not use up all of the vacation time that you have purchased, it will not be carried over to the next calendar year. Those extra hours will be paid back to you in your last paycheck in December based on the rate at which they were purchased. The amount you are reimbursed will be taxable in your paycheck.

OPEN ENROLLMENT PERIOD

Open enrollment is held once a year. During an Open Enrollment Period, you may elect your Vacation Buy benefit for the following calendar year. Your election during the Open Enrollment Period will be effective January 1 of the following calendar year. Vacation Buy benefits do not automatically carry forward from year to year. You must elect the benefit during the Open Enrollment Period for the following calendar year.

MISCELLANEOUS

Base Salary

Your Base Salary is the amount that will be reflected on your W-2 statement, before exercise of any salary reductions. Overtime payments, shift premiums, termination payments, severance pay, and other forms of compensation are not included in Base Salary. For union employees, Base Salary is based on the terms of their collective bargaining agreements.

General Information

Additional information is available on the Web at www.bnl.gov/hr/Benefits/ or through the Benefits Office at (631) 344-2877 or (631) 344-5126.

Leave of Absence

If you are on an approved Leave of Absence, your vacation buy benefits will be discontinued. Your last paycheck when you were eligible for the benefit will be adjusted the same as it would upon termination of employment. You may elect the vacation buy plan benefits upon your return to work as an eligible employee.

Termination of Employment

Vacation Buy Plan benefits will cease on the earlier of the date your employment terminates or the date you are no longer eligible for coverage. Your final paycheck will be adjusted for:

- Hours purchased but not used. You will be reimbursed for these in your final paycheck based on the rate at which they were purchased and the applicable tax.
- Hours purchased and used but not yet paid for. These will be deducted from your final paycheck based on the rate at which they were purchased.

ADOPTION ASSISTANCE PROGRAM

The Adoption Assistance Program provides financial assistance for certain expenses related to the adoption of an unrelated minor child.

WHO IS ELIGIBLE FOR THE ADOPTION ASSISTANCE PROGRAM?

Active Employees

All regular employees who work at least 20 hours per week and have completed one year of continuous service are eligible for the Adoption Assistance Program. Employees who are on a temporary assignment or a leave of absence are not eligible for this plan.

ENROLLMENT

You do not need to enroll for this program, but you must notify the Benefits Office in writing within 30 days of the time an adoption proceeding has commenced.

ADOPTION ASSISTANCE PROGRAM COVERAGE

Benefits Provided

The adoption assistance program provides eligible employees financial assistance (up to a maximum of \$5000 per adopted child) for certain expenses related to the adoption of an unrelated minor child under the age of eighteen (18). BNL spouses or same-sex domestic partners are eligible for a combined maximum reimbursement of \$10,000 per adopted child. The adoptive child may not be a relative or stepchild.

What Adoption-Related Expenses are Reimbursable?

The following expenses are reimbursable:

- Licensed adoption agency fees (including fees for placement and parental counseling).
- Legal costs (including attorney's fees and court costs).
- Charges for transportation to obtain physical custody of the adoptive child (including reasonable and customary travel expenses for both the adoptive parents and the adoptive child).

How to Request Reimbursement

To request a reimbursement for eligible expenses, you must submit a request for reimbursement form, itemized bills, proof of payment, and a certified copy of the judicial order of adoption to the Benefits Office within 90 days after the adoption is final. Financial assistance reimbursement will be made only after the adoption is final. Reimbursements are made directly to the employee, are considered taxable income, and are subject to withholdings at the time of payment.

MISCELLANEOUS

General Information

Additional information is available through the Benefits Office at (631) 344-2881.

Termination of Employment

Adoption Assistance Program benefits will cease on the earlier of the date your employment terminates or the date you are no longer eligible for coverage.

TRANSIT COMMUTER BENEFIT PLAN

The Transit Commuter Benefit Plan allows you to use pre-tax dollars to pay for Eligible Transportation Expenses on a before-tax basis. By paying for expenses on a before-tax basis, you reduce your income for the purpose of state, federal and Social Security taxes. Enrollment in the Transit Commuter Benefit Plan is optional.

WHO IS ELIGIBLE FOR THE TRANSIT COMMUTER BENEFIT PLAN?

Active Employees

All regular employees who work at least 20 hours per week are eligible to participate in the Transit Commuter Benefit Plan on the first day of active employment.

ENROLLMENT

Eligible employees may enroll in the Transit Commuter Benefit Plan at any time.

To enroll, you must complete an enrollment form and indicate the amount you want to contribute to the Transit Commuter Benefit Plan. Enrollment forms are available through the Benefits Office. By completing the form, you will authorize an annual salary reduction amount. Your actual contributions will be made from your paycheck in equal monthly or weekly installments depending on your pay status.

Coverage begins on the day you elect it on the enrollment form and submit it to the Benefits Office.

TRANSIT COMMUTER BENEFIT PLAN COVERAGE

Benefits Provided

You can use the plan to set aside money on a pre-tax basis into a reimbursement account to pay for qualified commuting expenses such as vanpooling, trains, and buses to and from work. It excludes parking, gasoline and telecommuting expenses. You determine what types of expenses you expect to have during the year and fund your Transit Commuter Benefit Plan Account through automatic salary reduction. Throughout the year, you draw money out of your Account and reimburse yourself for the transit commuter expenses you have paid.

How Much May You Contribute Each Year to the Transit Commuter Benefit Plan?

You may contribute any amount from a minimum of \$25 to a maximum of \$2,760 for calendar year. The maximum monthly contribution is \$240. This amount may change from year to year based on IRS limits.

Does the Use of Before-Tax Contributions to the Transit Commuter Benefit Plan Affect Any Other Benefits?

It may. If your annual salary is below the Social Security wage base, your future Social Security benefit may be reduced, but only minimally.

CLAIMS/PAYMENT OF EXPENSES

How to File a Claim or Pay for Expenses

You must either:

- use your PayFlex card (which is similar to a debit card) at the point of purchase for your commuting expenses where the expenses are debited directly from your Account, or
- complete a PayFlex Transportation Claim Form, available in the Benefits Office or through the Benefits Office website at <http://www.bnl.gov/hr/Benefits/ReimbursementAccounts.asp>, or
- go online to www.bnl.payflex.com and submit your claim electronically.

In general, when submitting a claim for reimbursement, you must submit a receipt along with your claim form including provider name and address, date of service, type of service provided, and dollar amount charged for the service.

You can pay for your eligible expenses with the PayFlex card or submit for reimbursement for up to the amount of funds in your Account. If you submit for reimbursement of your claims, you may either set up a direct deposit option with PayFlex or receive a check which is mailed to your home.

Payments will be issued daily for eligible expenses. You can only be reimbursed for up to the total amount that is in your Account at the time of your claims submission or when you use your PayFlex card. You cannot be reimbursed for expenses incurred prior to your participation in the plan.

How Long Do You Have to Submit Claims for Reimbursement?

You have until March 31 following the calendar year in which you incurred expenses to submit claims for reimbursement. So, for example, if you buy a train ticket in December, you would still have up to March 31 to claim the expense, provided there is money remaining in your Transit Commuter Benefit Plan Account.

If you have any funds in your Account at the time you terminate employment, terminate participation or cease to be eligible to participate, these funds will be forfeited if they are not used for expenses incurred prior to these dates and you do not submit them for reimbursement within the applicable timeframes. Any expenses incurred after these dates are not eligible for reimbursement.

Questions About Claims

If you have a question about your Transit Commuter Benefit Plan claim, you should contact PayFlex at (800) 284-4885.

How to Appeal a Claim

If your claim is denied, you will receive a written notice of the denial from the Claims Administrator. The notice will explain the reason for the denial and indicate the review procedures. You may request a review of the denied claim. The request must be submitted in writing to the Claims Administrator within 60 days after you receive the denial notice. Submit your request, including your reasons for requesting the review and any additional documents which you believe support your claim. The Claims Administrator will review the claim and ordinarily notify you within 60 days of the date your request for review is received. In special cases requiring a delay, the Claims Administrator will render a decision no later than 120 days after your request for review is received.

CHANGES IN CONTRIBUTION AMOUNTS

The amount of pre-tax dollars you elect to contribute to your Transit Commuter Benefit Plan Account will remain in effect until you make another election and either change the amount you are contributing or terminate the Account. You may do this at any time for any future pay period.

MISCELLANEOUS

Claims Administrator

PayFlex Systems USA, Inc.
P.O. Box 3039
Omaha, NE 68103-4310
Telephone: (800) 284-4885

Fax: (402) 231-4310

Eligible Transportation Expenses

Eligible Transportation Expenses include:

- **Transit Pass Expenses:** expenses incurred for a pass, token, fare card, voucher, or similar item (a “Pass”) for transportation
 - On mass transit facilities, whether or not publicly owned, or
 - Provided by any person in the business of transporting persons for compensation or hire if such transportation is provided in a vehicle with seating capacity of at least six adults (excluding the driver)
- **Commuter Highway Vehicle (Vanpool) Expenses:** expenses incurred for transportation in a “commuter highway vehicle” if such transportation is in connection with travel between your residence and place of employment. A Commuter Highway Vehicle is any highway vehicle with a seating capacity of at least six adults (not including the driver), and for which at least 80% of the mileage is for the purpose of transporting employees in connection with travel between their residence and their places of employment, and on trips during which the number of employees transported for such purposes is, on average, at least half of the adult seating capacity of the vehicle (not including the driver).

General Information

Information regarding the plan identification number, plan year, plan funding, type of plan, plan sponsor, plan administrator, agent for legal process, your rights under ERISA, prudent actions by plan fiduciaries, and modification, suspension, or termination of the plan can be found in the General Information section of this booklet.

Leave of Absence

If you are on an approved Leave of Absence, your contributions to this plan will cease and your Account will be terminated. Only expenses incurred prior to the leave will be eligible for reimbursement. Upon return to work, you may once again elect to participate by completing an enrollment form.

Participants Receiving Long Term Disability Plan Benefits

Contributions to this plan cease when a participant qualifies for BSA Long Term Disability Plan benefits.

Restrictions

Transit Commuter Benefit Plan Accounts are allowable under Section 132(f) of the Internal Revenue Code, and certain restrictions apply to them.

All unused Account balances remaining when you are no longer a participant in the plan are forfeited.

Termination of Coverage

Transit Commuter Benefit Plan benefits will cease on the earlier of the date your employment terminates, the date you cease participation in the plan, or the date you are no longer eligible for coverage.

GENERAL INFORMATION

This booklet contains only a summary of the benefit plans. Nothing herein should be deemed to waive or alter any of the terms or conditions of the Plans.

Plan Identification Numbers

The following are the Plan names and numbers:

Plan Name	Plan Number
BSA Retirement Plan	001
BSA 401(k) Plan	002
BSA Comprehensive Welfare Benefits Plan	501

The Employer Identification Number is 11-3403915.

Plan Year

The plan year for each of the Plans indicated above is the calendar year, January 1 through December 31.

Plan Funding

The Plans indicated above are paid for by the employer and, in some cases, also by employee contributions or premiums.

Type of Plan

Plans 001 and 002 indicated above are classified as pension benefit plans for the purpose of providing retirement benefits. Plan 501 is classified as a welfare plan for the purpose of providing medical insurance, life insurance, long term disability insurance, travel accident insurance, dental insurance, reimbursement account benefits, severance pay benefits, tuition refund benefits, long term care insurance and transit commuter benefits.

Normal Retirement Age

Under plans 001 and 002, your normal retirement age is 65 years old.

Plan Sponsor

The name, address, and phone number of the employer who is the Plan Sponsor are as follows:

Brookhaven Science Associates, LLC
Brookhaven National Laboratory
P.O. Box 5000
Upton, New York 11973
(631) 344-8000

Plan Administrator

The Plan Administrator for Plans 001 and 002 is the Retirement Committee and for Plan 501 is Brookhaven Science Associates, LLC. The Plan Administrator can be reached at the address and phone number indicated above.

Agent for Legal Process

The agent for service of legal process is:

General Counsel
Brookhaven Science Associates, LLC
Brookhaven National Laboratory
P.O. Box 5000
Upton, New York 11973
(631) 344-8000

Service of process may be made upon a plan trustee or plan administrator.

Trustees

You choose to allocate your contributions in the Retirement Plan and the 401(k) Plan to be invested with TIAA-CREF, Fidelity Investment Services, or Vanguard Group. You may contact them at the following addresses and telephone numbers:

For TIAA-CREF and/or Vanguard funds:

TIAA-CREF
730 Third Avenue
New York, NY 10017
(800) 842-2776

For Fidelity funds:

Fidelity Investments
P.O. Box 770002
Cincinnati, OH 45277-0090
(800) 343-0860

Filing Claims for Benefits

To file a claim for benefits under the Retirement Plan or the 401(k) Plan, contact the Trustee(s) with whom you have invested your accounts at the telephone number listed above. Each Trustee may require you to complete certain forms to process your request for benefits. If you need assistance, contact the Benefits Office.

To file a claim under any other plan, contact the insurance company or other provider who administers the benefits under the plan. If you need assistance, contact the Benefits Office.

Claims Appeal Procedure

When a claim is denied, you will receive a written notification of the denial. The notification will explain the reasons for the denial, the additional information or material needed to further review the claim, and the procedure for requesting a review of the denial.

Privacy of Information

Your protected health information will not be disclosed without your written authorization, unless such disclosure is permitted by law. Protected health information is individually identifiable information that is maintained relating to the provision of your health care, such as your medical records, claims payment information, and health care visit and treatment patterns.

Your Rights Under ERISA

As a participant in the Plans, 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 Plans and Benefits

- Examine without charge, at the Plan Administrator's office, all documents governing the plan, including insurance contracts, collective bargaining agreements, and copies 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, copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan 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.
- Obtain a statement telling you whether you have a right to receive a benefit in the Retirement and 401(k) Plans and if so, what your benefits would be if you stop working now. If you do not have the right to a benefit, the statement will tell you how many more years you have to work to get the right to a benefit. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

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 pre-existing 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 pre-existing 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 plans. 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 benefit or exercising your right under ERISA.

Enforce Your Rights

- If your claim for a 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 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 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 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 that your claim is frivolous.

Assistance With Your Questions

- If you have any questions about your plans, 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.

The information in this booklet is intended to provide only a summary of BSA's benefits program. Nothing contained in any section of this booklet should be construed as a promise of employment or continued employment, or to constitute contractual obligations. If questions arise, official plan documents and insurance agreements are controlling and govern final determination of benefits consistent with applicable laws and regulations.

BSA maintains the right to modify, suspend, or terminate benefit plans in whole or in part at any time.