

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

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.