PART I

MEDICAL PLAN

The Medical Plan provides benefits for medical coverage. Enrollment in the medical programs 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.
- Your eligible same-sex domestic partner and that partner's eligible child(ren). To be eligible, you must share a committed and exclusive arrangement that meets all of the following criteria:
  - — Both the enrollee and the domestic partner are eighteen years of age or older and unmarried, and
  - — Are of the same sex as each other, and
  - — Are not related by blood in any manner that would prohibit legal marriage, and
  - — Have assumed mutual obligations for the welfare and support of each other (proof of financial interdependence is required), and
  - — Have been sharing a common residence and living together as a couple in the same household for at least twelve months, and
  - — Are each other's sole domestic partner, and neither person has had a different partner less than twelve months before completion of BSA's Affidavit of Domestic Partnership.

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

  This section does not apply to active employees who are members of the SCSPA union.

- 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.

  — Under the Preferred Provider Organization (PPO) program, administered by CIGNA, an unmarried child is considered to be eligible for dependent coverage for the remainder of the calendar year in which his or her 19th birthday occurs.

  — Under the Health Maintenance Organizations (HMOs) (Aetna, Vytra and HIP), an unmarried child is considered to be eligible for dependent coverage through the end of the month in which his or her 19th birthday occurs.

- 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.

- Your unmarried children age 19 and over if they reside with you, are primarily supported by you, and attend an accredited college or university on a full-time basis.

  — For the PPO program, administered by CIGNA, dependent coverage is continued for three months from the date of graduation.
  — For the Aetna program, dependent coverage is continued through the earlier of (a) the end of the month in which he or she graduates or (b) the end of the month of attainment of age 23.
  — For the Vytra program, dependent coverage is continued through the earlier of (a) the end of the month in which he or she graduates or (b) the end of the month in which he or she attains age 25.
  — For the HIP program, dependent coverage is continued through the earlier of (a) the date of graduation or (b) the end of the year of attainment of age 25.

  Coverage will end for your unmarried children age 19 and over if they reside with you, are primarily supported by you, and are no longer attending an accredited college or university on a full-time basis as follows:

  — For the PPO program, administered by CIGNA, the Aetna, and the Vytra programs, dependent coverage ends as of the end of month in which he or she is no longer a full-time student.
  — For the HIP program, dependent coverage ends as of the date he or she is no longer a full-time student.

Dependents of Deceased Participants

If you are participating in the Medical Plan and die while in active service, while receiving Long Term Disability (LTD) Plan benefits, or while on retiree medical coverage, 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.

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.

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 will become ineligible for retiree medical coverage if eligible for coverage under another group medical insurance plan. Such subsequent employment will not preclude the retiree from again being eligible if he or she becomes ineligible for coverage under any other group medical plan.

Employees Hired Prior to January 1, 1988

All employees hired prior to January 1, 1988 who are participating in the Medical Plan and who terminate employment during the calendar year in which they attain age 55, 56, or 57 and have completed three or more years of Continuous Service may participate in the Medical Plan with their covered dependents by paying the COBRA cost of the plan, provided they do not become eligible for coverage under another group medical insurance plan.

At age 58, the following information applies. Employees who (1) terminate employment during the calendar year in which they attain age 58 or later and have at least three years of Continuous Service or (2) continue medical insurance in accordance with the provisions of the preceding paragraph, may participate in the Medical Plan with their covered dependents by paying the required retiree premiums.

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 Human Resources Division. 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 Human Resources Division within 30 days of your date of hire.

MEDICAL PROGRAMS AVAILABLE

Eligible employees and their dependents may enroll in the PPO, administered by CIGNA, or one of the non-Medicare HMOs.

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 the PPO, administered by CIGNA, or one of the non-Medicare HMOs.

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 the PPO, administered by CIGNA, or one of the Medicare HMOs.

Employees who were members of the International Brotherhood of Electrical Workers (IBEW) Union and either retire after 7/31/00 or terminate employment after 7/31/00 and are receiving LTD Plan benefits and become Medicare-eligible retirees, Medicare-eligible participants receiving LTD Plan benefits, or Medicare-eligible dependents of retirees and participants receiving LTD Plan benefits may enroll in the Indemnity program, administered by CIGNA, or one of the Medicare HMOs.

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

THE PREFERRED PROVIDER ORGANIZATION (PPO), ADMINISTERED BY CIGNA

Under the 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 CIGNA PPO network (thus is out-of-network), you have a deductible, must file claim forms, and most services are covered at 80% of the Reasonable and Customary (R&C) amount.

The 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.

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

THE INDEMNITY PROGRAM, ADMINISTERED BY CIGNA

The indemnity program provides basic and major medical benefits for covered expenses. Major medical expenses include many hospital and non-hospital charges not covered by the basic portion of the program. Under this medical program, you use the physician of your choice for medical care for you and your covered dependents and submit a claim form for reimbursement of Reasonable and Customary (R&C) covered medical expenses. It is a fee-for-service program. Major medical expenses are reimbursed at 80% of the R&C amount after a deductible is met. For expenses to be considered for reimbursement, 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 Human Resources Division.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

HMO programs are available for medical coverage. Currently, non-Medicare HMOs are provided through Aetna, HIP, and Vytra 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 Human Resources Division. 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 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

AETNA:	(800) 323-9930
CIGNA:	(800) 982-8958
HIP:	(800) 447-8255
VYTRA:	(631) 694-4000

PROVIDER DIRECTORY

Provider directories are available at no charge in the Human Resources Division or on the Web at:

AETNA:	www.aetna.com
CIGNA:	www.cigna.com
HIP:	www.hipusa.com
VYTRA:	www.vytra.com

COORDINATION OF BENEFITS

Coverage Under Other Employers' Plans

If you and your covered dependents are eligible to receive benefits under another group medical plan, the benefits from that plan will be coordinated with benefits from the PPO or indemnity programs, administered by

CIGNA, so that up to 100% of the "allowable expenses" incurred during a calendar year will be paid 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.

Coordination of benefits with the HMOs 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.

Both Spouses Covered by the PPO or Indemnity Programs, Administered by CIGNA (Dual Coverage)

When both spouses participate in the PPO or indemnity programs, they may elect to cover each other and their eligible dependents under the PPO or indemnity programs, administered by CIGNA, provided they both pay the required premiums. When claims are filed under such circumstances, benefits will be coordinated so that up to 100% of "allowable expenses" will be paid after each family member has satisfied the Individual Calendar Year Deductible. In-network PPO co-payments will also be reimbursed. Beginning January 1, 2002, Dual Coverage has been discontinued prospectively for couples who may have qualified for it. Participants with Dual Coverage on December 31, 2001 may retain such coverage, but if they discontinue it, they may not again elect it. They may also not add any dependents to their Dual Coverage after December 31, 2001. Dual Coverage is available only as indicated above for both spouses who participate in the PPO or Indemnity Programs, administered by CIGNA. It is not available to participants in the HMO programs.

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. To obtain maximum medical insurance coverage, 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, the participant is not eligible to enroll in a Medicare HMO and the PPO and indemnity programs, 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 indemnity program or the out-of-network portion of the PPO program, administered by CIGNA, you must complete a claim form that is available in the Human Resources Division or on the Web at:

www.bnl.gov/HR/Benefits/Medical.htm

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.

Completed PPO or indemnity program claim forms and copies of your bills 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 PPO or indemnity program claim, you should contact CIGNA. 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) 281-1122.

How to Appeal a Claim

Under the CIGNA programs, 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 60 days of the receipt of the notice of denial by following the instructions on the explanation of benefits. 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, the insurance company will render a decision within 60 days of the date your request for review is received. In special cases requiring a delay, CIGNA will render a decision no later than 120 days after your request for review is received.

Under the Aetna program, you may request a review of the denied claim by contacting the insurance company at (800) 233-3105. You will then receive a written acknowledgement that you must sign and return to the insurance company. Within 15 business 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 business 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 45 days after your request for review is received.

Under the HIP program, you may request a review of the denied claim within 45 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, P.O. Box 2844, New York, N.Y. 10016 or submit your request in person to the Customer Service Walk-In Unit, 6 West 35th Street, New York, N.Y. 10001. You will then receive a written acknowledgement within 5 business days of receipt of your request. The insurance company will request additional information which you should provide 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. In special cases requiring a delay, the insurance company will render a decision no later than 45 days after your request for review is received. Such decision may be delayed to a maximum of 60 business days from their receipt of all necessary information.

Under the Vytra program, you may request a review of the denied claim within 45 days of the receipt of the denied claim by contacting the insurance company at (800) 871-5281, or submit your request in writing to Vytra Health Plans, 395 North Service Road, Melville, NY 11747. Within 15 days of receipt, the insurance company will acknowledge your appeal. The insurance company will render a decision within 60 days of the date your request for review is received.

EXCLUSIONS

The PPO and indemnity programs, 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 Aetna, HIP, and Vytra 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.
- 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.

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. For employees who are not members of the IBEW union, 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. For employees who

are members of the IBEW union or the SCSPA union, your premiums are based on your Base Salary, 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

Currently, the following information on premiums applies.

Retirement Date	Category Prior To Retirement	Status Retired From	Premium
Prior to 10/1/95	Non-Union or Union	Employee or LTD	No premium
10/1/95 - 9/30/96	Non-Union or Union	Employee or LTD	½ of Employee premium on day immediately preceding your retirement
10/1/96 - 12/31/01	Not in IBEW Union	Employee or LTD	Employee premium on day immediately preceding your retirement
10/1/96 or later	IBEW Union	Employee	Employee premium on day immediately preceding your retirement
1/1/02 or later	Not in IBEW Union	Employee or LTD	Based on plan cost

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 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. Premiums are indicated at the end of the Medical Plan section.

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 Human Resources Division of a Qualifying Event within 31 days of the event.

QUALIFYING EVENT

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

- Change in legal marital status
  - — marriage
  - — death of spouse
  - — divorce
  - — legal separation
  - — annulment
- Change in the number of dependents
  - — birth
  - — adoption
  - — placement for adoption
  - — death of a dependent
- Change in employment status
  - — termination or commencement of employment of the employee, spouse or dependent (other than for misconduct)
- Changes in work schedule
  - — an increase or decrease in the number of hours of employment by the employee, spouse or dependent
  - — a switch between full-time and part-time status
  - — a strike or lockout
  - — commencement or return from an unpaid leave of absence
- The dependent satisfies or ceases to satisfy the requirements for unmarried dependents
  - — attainment of age
  - — student status

- 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 medical coverage. The change requested must relate to the change in your family status that affects eligibility for medical coverage. Changes are made by completing an enrollment form, available in the Human Resources Division. The completed form must be submitted, with proof of the Qualifying Event, to the Human Resources Division. 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 31 days of the Qualifying Event, you must wait until the next Open Enrollment Period.

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 PPO (out-of-network portion) and indemnity programs, administered by CIGNA, 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 non-IBEW union participants (and IBEW union participants who terminated employment before August 1, 2000):

- The annual Deductible for the PPO program, administered by CIGNA, is as follows:

	Annual Calendar Year Deductible Individual	Family
— For active employees	$500	$1500
— For retirees and participants who are receiving LTD plan benefits and who are not receiving Medicare benefits	$500	$1500
— For retirees who retired after 12/31/91 and are receiving Medicare benefits	$500	$1500
— For participants who are receiving LTD Plan benefits, terminated employment after 12/31/91 and are receiving Medicare benefits	$500	$1500
— For retirees who retired before 1/1/92 and are receiving Medicare benefits	$100	$300
— For participants who are receiving LTD Plan benefits and terminated employment prior to 1/1/92 and are receiving Medicarebenefits	$100	$300

For all active employees who are members of the IBEW union, IBEW union members who terminated employment on or after August 1, 2000, and active employees who are members of the SCSPA union:

- The annual Deductible for the indemnity program, administered by CIGNA, is $250 per individual ($650 per family) per calendar year.
- The annual Deductible for the PPO program, administered by CIGNA, is as follows:

	Annual Calendar Year Deductible Individual	Family
— For active employees	$250	$650
— For retirees and participants who are receiving LTD Plan benefits and who are not receiving Medicare benefits	$250	$650

- In-network 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.
- If you or a covered dependent does not meet the Deductible by the end of the calendar year, all covered medical expenses incurred during the last three months of the calendar year will be "carried over" and applied to the following year's Deductible.
- Only one Deductible applies to all covered medical expenses resulting from an accident in which two or more covered family members are injured.
- 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 PPO program, administered by CIGNA, and the Vytra HMO program. This applies, in total, to both the retail pharmacy and mail order portions of the program. This does not apply to active employees who are members of the IBEW union, IBEW union members who terminated employment on or after August 1, 2000, and active employees who are members of the SCSPA union.

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 PPO and indemnity programs, administered by CIGNA, 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 precertify your hospital admission.

If Hospital Preadmission Certification is not obtained, a $300 penalty will be applied. In addition, 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.

Expectant mothers must call before the end of their first trimester to precertify their maternity admission. They or a family member must also call within 24 hours following admission into the hospital for the delivery.

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 PPO program, administered by CIGNA and the HMOs.

Under the indemnity program, administered by CIGNA, the lifetime maximum amount of major medical benefits for which the program will provide reimbursement is $1,000,000 per covered participant.

Out-Of-Pocket Maximum

Under the PPO (out-of-network portion) and indemnity programs, administered by CIGNA, 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. This does not apply to outpatient expenses for the care of mental illness, functional nervous disorders or substance abuse for dependents. In-network PPO expenses do not count toward the out-of-pocket maximum.

	Annual Calendar Year Out-Of-Pocket Maximum Individual	Family
■ PPO Program	$2500	$7500
(for participants who are not active members of the IBEW union or members of the IBEW union who terminated employment on or after 8/1/00)		
■ PPO Program	$1200	$2400
(for participants who are active members of the IBEW union, or members of the IBEW union who terminated employment on or after 8/1/00, or active members of the SCSPA union)		
■ Indemnity Program	$900 per covered participant	
■ An annual out-of-pocket maximum does not apply to the HMOs.		

Participants Receiving Long Term Disability Plan Benefits

Participants who are receiving LTD Plan benefits may continue medical coverage for themselves and their eligible dependent(s). Currently, no premium is required to continue this coverage while receiving LTD Plan benefits. 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.

Qualified Medical Child Support Order

Information on the administration of a qualified medical child support order can be obtained at no charge from the Human Resources Division.

Reasonable and Customary (R&C)

Under the PPO and indemnity programs, administered by CIGNA, 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 CIGNA.

Second Surgical Opinion

Under the PPO and indemnity programs, administered by CIGNA, if you or your dependents would like a second surgical opinion, you may call the toll-free number provided on your medical identification card. They will

provide you with the names of three qualified physicians near your home, whom you may contact to arrange for a second opinion appointment.

Under the PPO program, if you use a provider who is not in CIGNA's network, the program will pay the full Reasonable and Customary cost of a second surgical opinion after one surgeon has recommended surgery—including any necessary diagnostic exams and laboratory fees. In addition, the program will pay 100% of the Reasonable and Customary cost of a third opinion if the first two opinions conflict. You do not have to satisfy the Deductible in order to receive 100% reimbursement under this section. Under the PPO program, if you use a provider who is in CIGNA's network, you are required to pay a small co-payment for diagnostic exams and laboratory fees.

Under the HMOs, second surgical opinions are based on the terms of the 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, such as due to graduation or attainment of age 19 and no longer attending an accredited college or university on a full-time basis.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides that employees and their eligible dependents may continue their group medical coverage if any of the following events occur:

- Termination or Reduction in Hours: If your employment terminates, (for reasons other than gross misconduct), or your work schedule is reduced to less than 20 hours per week, you are eligible to continue existing group medical care coverage for yourself and/or your covered dependents up to 18 months*.
- Divorce or Legal Separation: If you become divorced or legally separated, your covered spouse and/or dependent children are eligible to continue their existing group medical care coverage up to 36 months.
- Loss of Dependent Status: If your covered dependent child becomes ineligible under plan rules, existing group medical care coverage may be continued up to 36 months.
- Death: If you die, your covered spouse and/or dependent children are eligible to continue their group medical care coverage for up to 36 months beyond the time coverage would normally terminate.

*This 18-month period may be extended to 36 months if the employee becomes divorced, legally separated, entitled to Medicare or dies during the 18-month period.

Notification Requirements

You or your covered dependents are responsible for notifying the Human Resources Division in writing within 31 days of the loss of coverage due to the occurrence of divorce, legal separation, or loss of dependent status. In the event of termination of employment, reduction in work schedule, or death of the employee, information regarding continuation coverage will be provided automatically by the Human Resources Division. When the Human Resources Division 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 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.

If you have continuation coverage due to termination of employment or reduction in hours worked, your dependents may extend medical coverage for up to 36 months, instead of 18 months, if you become divorced, legally separated, entitled to Medicare or die during the 18-month period.

If you or a dependent is found by Social Security to be disabled at the time (or within 60 days of the time) your employment terminates or your

hours are reduced, you may extend medical insurance coverage for up to 29 months, instead of 18 months. To get this additional 11 months of coverage, you must notify the Human Resources Division within 60 days of the date Social Security made the disability determination and before the end of the initial 18-month period. You must also notify the Human Resources Division within 31 days if the Social Security disability determination expires. During the 11 months of extended coverage, you may be charged an additional premium above the 102% amount, indicated below.

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 Human Resources Division 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 Human Resources Division is not notified within 31 days of the date of divorce or legal separation.
- For a dependent child: If the Human Resources Division 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 PPO or indemnity programs, administered by CIGNA, 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 31 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 31 days from the date your group medical insurance coverage ceased. The necessary application forms for the HMOs are available directly from the HMOs. Forms for the PPO and indemnity programs, administered by CIGNA, are available in the Human Resources Division.

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

FOR EMPLOYEES WHO ARE NOT IN THE IBEW UNION OR THE SCSPA UNION (January 1, 2004)

Monthly Contribution

For monthly paid employees:

Annual Base Salary*	Medical Plan	Coverage		
		Employee Only	Employee + 1 Dependent	Employee + 2 or More Dependents
Less than $39,999.99	Aetna HMO	$ 35.39	$ 66.01	$ 99.95
	CIGNA PPO	$ 43.79	$ 92.14	$ 126.40
	HIP HMO	$ 29.70	$ 54.22	$ 86.32
	Vytra HMO	$ 33.15	$ 66.33	$ 95.67
$40,000 - $69,999.99	Aetna HMO	$ 53.09	$ 99.02	$ 149.93
	CIGNA PPO	$ 65.68	$ 138.21	$ 189.60
	HIP HMO	$ 44.55	$ 81.33	$ 129.48
	Vytra HMO	$ 49.73	$ 99.50	$ 143.51
$70,000 - $99,999.99	Aetna HMO	$ 67.24	$ 125.42	$ 189.91
	CIGNA PPO	$ 83.19	$ 175.06	$ 240.17
	HIP HMO	$ 56.42	$ 103.01	$ 164.01
	Vytra HMO	$ 62.99	$ 126.03	$ 181.78
$100,000 and over	Aetna HMO	$ 84.94	$ 158.42	$ 239.88
	CIGNA PPO	$105.09	$ 221.13	$ 303.37
	HIP HMO	$ 71.27	$ 130.12	$ 207.17
	Vytra HMO	$ 79.57	$ 159.19	$ 229.61

Weekly Contribution

For weekly paid employees:

Annual Base Salary*	Medical Plan	Coverage		
		Employee Only	Employee + 1 Dependent	Employee + 2 or More Dependents
Less than $39,999.99	Aetna HMO	$ 8.17	$ 15.23	$ 23.07
	CIGNA PPO	$ 10.10	$ 21.26	$ 29.17
	HIP HMO	$ 6.85	$ 12.51	$ 19.92
	Vytra HMO	$ 7.65	$ 15.31	$ 22.08
$40,000 - $69,999.99	Aetna HMO	$ 12.25	$ 22.85	$ 34.60
	CIGNA PPO	$ 15.16	$ 31.89	$ 43.75
	HIP HMO	$ 10.28	$ 18.77	$ 29.88
	Vytra HMO	$ 11.48	$ 22.96	$ 33.12
$70,000 - $99,999.99	Aetna HMO	$ 15.52	$ 28.94	$ 43.82
	CIGNA PPO	$ 19.20	$ 40.40	$ 55.42
	HIP HMO	$ 13.02	$ 23.77	$ 37.85
	Vytra HMO	$ 14.54	$ 29.08	$ 41.95
$100,000 and over	Aetna HMO	$ 19.60	$ 36.56	$ 55.36
	CIGNA PPO	$ 24.25	$ 51.03	$ 70.01
	HIP HMO	$ 16.45	$ 30.03	$ 47.81
	Vytra HMO	$ 18.36	$ 36.74	$ 52.99

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

These premiums are subject to change.

EMPLOYEE PREMIUMS

FOR IBEW UNION EMPLOYEES
(January 1, 2004)

Weekly Premium

For weekly paid employees:

Medical Plan	Coverage		
	Employee Only	Employee + 1 Dependent	Employee + 2 or More Dependents
All Plans	3% of Base Salary*	3.5% of Base Salary*	4% of Base Salary*

FOR SCSPA UNION EMPLOYEES
(January 1, 2004)

Weekly Premium

For weekly paid employees:

Annual Base Salary*	Medical Plan	Coverage		
		Employee Only	Employee + 1 Dependent	Employee + 2 or More Dependents
Less than $30,000	All Plans	$ 5.22	$ 7.98	$ 10.73
$30,000 - $39,999.99	All Plans	$ 7.43	$ 11.00	$ 14.85
$40,000 - $59,999.99	All Plans	$ 9.63	$ 14.30	$ 19.25
$60,000 - $79,999.99	All Plans	$ 12.67	$ 19.03	$ 25.37
$80,000 and over	All Plans	$ 16.48	$ 24.74	$ 32.98

*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 (March 1, 2004)

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 HMO CIGNA PPO HIP HMO HIP VIP HMO Vytra HMO	N/A	$ 0.00	$ 0.00	$ 0.00
10/1/95 – 9/30/96	No	Aetna HMO CIGNA PPO HIP HMO Vytra HMO	Less than $30,000	$10.29	$ 15.71	$ 21.13
			$30,000 - $39,999.99	$14.63	$ 21.67	$ 29.25
			$40,000 - $59,999.99	$18.96	$ 28.17	$ 37.92
			$60,000 and over	$24.97	$ 37.48	$ 49.97
10/1/95 – 12/31/01	Yes	CIGNA PPO HIP VIP HMO	N/A	$ 0.00	$ 0.00	$ 0.00
10/1/96 – 12/31/01	No	Aetna HMO CIGNA PPO HIP HMO Vytra HMO	Less than $30,000	$20.58	$ 31.42	$ 42.25
			$30,000 - $39,999.99	$29.25	$ 43.33	$ 58.50
			$40,000 - $59,999.99	$37.92	$ 56.33	$ 75.83
			$60,000 and over	$49.93	$ 74.95	$ 99.94
1/1/02 or later	Yes	CIGNA PPO	N/A	$48.85	$ 97.71	
		HIP VIP (Suffolk)	N/A	$63.33	$126.66	
1/1/02 or later	No	Aetna HMO	N/A	$70.78	$132.02	$199.90
		CIGNA PPO	N/A	$87.57	$184.28	$252.81
		HIP HMO	N/A	$59.39	$108.43	$172.64
		Vytra HMO	N/A	$66.31	$132.66	$191.34

**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.*

These premiums are subject to change.

RETIREE PREMIUMS

FOR PARTICIPANTS WHO WERE IN THE IBEW UNION (January 1, 2004)

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 HMO CIGNA PPO HIP HMO HIP VIP HMO Vytra HMO	N/A	$ 0.00	$ 0.00	$ 0.00
10/1/95 – 9/30/96	No	No	Less than $30,000	$10.29	$15.71	$ 21.13
			$30,000 - $39,999.99	$14.63	$21.67	$ 29.25
			$40,000 - $59,999.99	$18.96	$28.17	$ 37.92
			$60,000 and over	$24.97	$37.48	$ 49.97
10/1/95 – 7/31/00	Yes	CIGNA PPO HIP VIP	N/A	$ 0.00	$ 0.00	$ 0.00
10/1/96 – 7/31/00	No	Aetna HMO CIGNA PPO HIP HMO Vytra HMO	Less than $30,000	$20.58	$31.42	$ 42.25
			$30,000 - $39,999.99	$29.25	$43.33	$ 58.50
			$40,000 - $59,999.99	$37.92	$56.33	$ 75.83
			$60,000 and over	$49.93	$74.95	$ 99.94
8/1/00 – 12/31/03	No	Aetna HMO CIGNA PPO HIP HMO Vytra HMO	Less than $30,000	$22.64	$34.56	$ 46.48
			$30,000 - $39,999.99	$32.18	$47.66	$ 64.35
			$40,000 - $59,999.99	$41.71	$61.96	$ 83.41
			$60,000 and over	$54.92	$82.45	$109.93
8/1/00 or later	Yes	CIGNA Indemnity HIP VIP	N/A	$ 0.00	$ 0.00	$ 0.00
1/1/04 or later	No	Aetna HMO CIGNA PPO HIP HMO Vytra HMO	Actual Monthly Base Salary*	3% of Monthly Base Salary*	3.5% of Monthly Base Salary*	4% of Monthly Base Salary*

**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. If you terminated employment prior to 8/1/00 and retired immediately after you were no longer eligible for LTD Plan benefits, your premiums are based on the cost of the plan. If you terminated employment on or after 8/1/00 and retired immediately after you were no longer eligible for LTD Plan benefits, your premiums are based on the employee premiums.*

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

FOR PARTICIPANTS WHO WERE NOT IN THE IBEW UNION OR THE SCSPA UNION (January 1, 2004)

Monthly Premium

Medical Plan	Coverage		
	One Person	2 People	3 or More People
Aetna HMO	$ 360.98	$ 673.30	$ 1,019.49
CIGNA PPO	$ 446.62	$ 939.82	$ 1,289.31
HIP HMO	$ 302.91	$ 553.01	$ 880.45
Vytra HMO	$ 338.17	$ 676.57	$ 975.85

FOR PARTICIPANTS WHO WERE IN THE IBEW UNION (January 1, 2004)

Monthly Premium

Medical Plan	Coverage		
	One Person	2 People	3 or More People
Aetna HMO	$ 376.99	$ 703.19	$ 1,064.88
CIGNA PPO	$ 468.95	$ 986.81	$ 1,353.77
HIP HMO	$ 311.99	$ 569.62	$ 906.88
Vytra HMO	$ 375.83	$ 751.80	$ 1,084.31

FOR PARTICIPANTS WHO WERE IN THE SCSPA UNION (January 1, 2004)

Monthly Premium

Medical Plan	Coverage		
	One Person	2 People	3 or More People
Aetna HMO	$ 360.98	$ 673.30	$ 1,019.49
CIGNA PPO	$ 446.62	$ 939.82	$ 1,289.31
HIP HMO	$ 302.91	$ 553.01	$ 880.45
Vytra HMO	$ 346.80	$ 693.80	$ 1,000.71

These premiums are subject to change.

BROOKHAVEN SCIENCE ASSOCIATES MEDICAL PLAN COMPARISON FOR EMPLOYEES, NON-MEDICARE-ELIGIBLE RETIREES, PARTICIPANTS ON LTD, AND SPOUSES (EMPLOYEES *NOT* IN IBEW UNION)

	CIGNA Preferred Provider Option (PPO)				
	In-Network	Out-of-Network	Aetna (HMO)	Vytra (HMO)	HIP (HMO)
Medical Care Provider	Participating physician/facility	Any physician/facility	Participating physician/facility	Participating physician/facility	Participating physician/facility
Payment of Benefits	No claim forms	Submit claim forms	No claim forms	No claim forms	No claim forms
Age Limit for Dependent Children/ Full-Time Student	To age 19/ No age limit	To age 19/ No age limit	To age 19/To age 23	To age 19/To age 25	To age 19/To age 25
Annual Deductible (Individual/Family)	N/A	$500/$1500**	N/A	N/A	N/A
Annual Out-of-Pocket Maximum (Individual/Family) (Excluding Deductible)	N/A	$2500/$7500***	N/A	N/A	N/A
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Pre-Existing Condition Limitation	N/A	N/A	N/A	N/A	N/A
Office Visits (Illness)	Covered in full after $15 co-pay	80% of R&C after deductible	Covered in full after $15 co-pay	Covered in full after $15 co-pay	Covered in full after $15 co-pay
(Injury)	Covered in full after $15 co-pay	80% of R&C after deductible	Covered in full after $15 co-pay	Covered in full after $15 co-pay	Covered in full after $15 co-pay
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)	Covered in full after $50 co-pay (waived if admitted)
Inpatient Hospital (Semi-Private Room, Board, Services, Supplies)	Covered in full Pre-admission certification required or $300 penalty plus 50% reduction in benefits on any days not approved.	Covered in full	Covered in full	Covered in full	Covered in full
(Physician)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	Covered in full
(Surgeon)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	Covered in full
Second Surgical Opinion (Office Visit)	Covered in full after $15 co-pay	100% of R&C	Covered in full after $15 co-pay	Covered in full after $15 co-pay	Covered in full
Laboratory/X-Ray	Covered in full	80% of R&C after deductible	Covered in full after $15 co-pay	Covered in full	Covered in full after $15 co-pay
Maternity (Initial Visit To Determine Pregnancy)	Covered in full after $15 co-pay	80% of R&C after deductible	Covered in full after $15 co-pay	Covered in full after $15 co-pay	Covered in full after $15 co-pay
(Subsequent Visits/Delivery)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	Covered in full
Prescription Medication (Retail)	*$5 generic/$15 brand formulary/$30 brand non-formulary (up to 30-day supply)	Must use in-network pharmacy	$5 generic/$10 brand formulary/ $25 brand non-formulary (up to 34-day supply)	*$5 generic/$12 brand formulary/ $35 brand non-formulary (up to 31-day supply)	$5 generic/$10 brand formulary/ $35 brand non-formulary (up to 30-day supply)
(Mail Order)	*$10 generic/ $30 brand formulary/ $60 brand non-formulary (up to 90-day supply)	Use in-network benefit	$10 generic/$20 brand formulary/ $50 brand non-formulary (31 to 90-day supply)	*$10 generic/$24 brand formulary/$70 brand non-formulary (up to 90-day supply)	Half of above co-pay (up to 90-day supply)

*After meeting a $100 per person/$300 per family annual drug deductible (does not apply to active employees in the SCSPA Union. **$250/$650 for active employees in the SCSPA Union.
***$1200/$2400 for active employees in the SCSPA Union.
This is a brief summary and thus is not an all-inclusive description of services. Only covered expenses are provided/reimbursed through the programs. (R&C = Reasonable & Customary)

1-1-2004

BROOKHAVEN SCIENCE ASSOCIATES MEDICAL PLAN COMPARISON FOR EMPLOYEES, NON-MEDICARE-ELIGIBLE RETIREES, PARTICIPANTS ON LTD, AND SPOUSES (EMPLOYEES *NOT* IN IBEW UNION)

	CIGNA Preferred Provider Option (PPO) In-Network	CIGNA Preferred Provider Option (PPO) Out-of-Network	Aetna (HMO)	Vytra (HMO)	HIP (HMO)
Preventive Care					
(Routine Care For Children Including Immunizations)	Covered in full (in NY) Covered in full after $15 co-pay (non-NY) (to age 19)	80% of R&C after deductible (to age 19)	Covered in full after $15 co-pay (to age 19)	Covered in full (to age 17)	Covered in full (to age 19)
(Well Woman Exam)	Covered in full after $15 co-pay	80% of R&C after deductible	Covered in full after $15 co-pay	Covered in full after $15 co-pay	Covered in full after $15 co-pay
(Pap Test)	Covered in full	80% of R&C after deductible	Covered in full after $15 co-pay	Covered in full with office visit co-pay	Covered in full after $15 co-pay
(Mammogram)	Covered in full	80% of R&C after deductible	Covered in full after $15 co-pay	Covered in full	Covered in full after $15 co-pay
(Physical Exam)	Covered in full after $15 co-pay	Not covered	Covered in full after $15 co-pay	Covered in full after $15 co-pay	Covered in full after $15 co-pay
(Routine Eye Exam)	Not covered	Not covered	Covered in full after $15 co-pay	Covered in full after $15 co-pay (1 exam/year)	Covered in full (for optometrist)
Mental Health Care					
(Inpatient)	Covered in full	Same as inpatient hospital	Covered in full (Max: 35 days/year)	Covered in full (Max: 30 days/year)	Covered in full (Max: 30 days/year)
(Outpatient)	Covered in full after $15 co-pay/ visit	80% of R&C after deductible	$25 co-pay/visit (Max: 20 visits/year)	$15 co-pay visits 1-3 $25 co-pay visits 4-20 (Max: 20 visits/year)	$25 co-pay/visit (Max: 20 visits/year)
Substance Abuse Treatment					
(Inpatient Detoxification)	Covered in full	Same as inpatient hospital	Covered in full	Covered in full (Max: 3 periods/year)	Covered in full (Max: 7 days/year)
(Outpatient Rehabilitation)	Covered in full after $15 co-pay/ visit	80% of R&C after deductible	$15 co-pay/visit (Max: 60 visits/year)	$15 co-pay/visit (Max: 60 visits/year)	Covered in full (Max: 60 visits/year)
Alternate Care					
(Home Health Care)	Covered in full (Max: 40 visits/year combined in-and out-of-network)	80% of R&C after deductible	Covered in full	Covered in full (Max: 40 visits/year)	Covered in full (Max: 200 visits/year)
(Skilled Nursing Facility)	Covered in full (Max: 60 days/year combined in-and out-of-network)	80% of R&C after deductible	Covered in full	Covered in full (Max: 45 days/year)	Covered in full
(Outpatient Short-Term Rehabilitation: Physical Therapy)	Covered in full after $15 co-pay	80% of R&C after deductible	$15 co-pay (Max: 60 consecutive days/injury/lifetime)	$15 co-pay (Max: 60 consecutive days/injury/lifetime)	Covered in full after $15 co-pay (Max: 90 visits/year)
Durable Medical Equipment	Covered in full	80% of R&C after deductible	Not covered	Covered in full	Covered in full
External Prosthetic Devices	Covered in full	80% of R&C after deductible	Covered in full for initial device only	Covered in full	Covered in full
Hearing Aids	Covered in full (Max: $1000/hearing aid/ear/3yrs)	80% of R&C after deductible	Not covered	Not covered	Not covered

This is a brief summary and thus is not an all-inclusive description of services. Only covered expenses are provided/reimbursed through the programs. (R&C = Reasonable & Customary) **1-1-2004**

BROOKHAVEN SCIENCE ASSOCIATES MEDICAL PLAN COMPARISON FOR EMPLOYEES IN IBEW UNION

	CIGNA Preferred Provider Option (PPO)				
	In-Network	Out-of-Network	Aetna (HMO)	Vytra (HMO)	HIP (HMO)
Medical Care Provider	Participating physician/facility	Any physician/facility	Participating physician/facility	Participating physician/facility	Participating physician/facility
Payment of Benefits	No claim forms	Submit claim forms	No claim forms	No claim forms	No claim forms
Age Limit for Dependent Children/ Full-Time Student	To age 19/ No age limit	To age 19/ No age limit	To age 19/To age 23	To age 19/To age 25	To age 19/To age 25
Annual Deductible (Individual/Family)	N/A	$250/$650	N/A	N/A	N/A
Annual Out-of-Pocket Maximum (Individual/Family) (Excluding Deductible)	N/A	$1200/$2400	N/A	N/A	N/A
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Pre-Existing Condition Limitation	N/A	N/A	N/A	N/A	N/A
Office Visits (Illness)	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full after $5 co-pay	Covered in full
(Injury)	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full after $5 co-pay	Covered in full
Emergency Room (Accident/Illness)	Covered in full	Emergency: Covered in full Non-emergency: 80% of R&C after deductible	Covered in full after $35 co-pay (waived if admitted)	Covered in full after $25 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	Covered in full
	Pre-admission certification required or $300 penalty plus 50% reduction in benefits on any days not approved.				
(Physician)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	Covered in full
(Surgeon)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	Covered in full
Second Surgical Opinion (Office Visit)	Covered in full after $10 co-pay	100% of R&C	Covered in full after $5 co-pay	Covered in full after $5 co-pay	Covered in full
Laboratory/X-Ray	Covered in full	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full	Covered in full
Maternity (Initial Visit To Determine Pregnancy)	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full after $5 co-pay	Covered in full
(Subsequent Visits/Delivery)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	Covered in full
Prescription Medication (Retail)	$5 generic/$10 brand (up to 30-day supply)	80% of R&C after deductible	$5 generic/$10 brand formulary/ $25 brand non-formulary (up to 34-day supply)	$5/prescription (up to 31-day supply)	$5 generic/$10 brand (up to 30-day supply)
(Mail Order)	$10 generic/ $20 brand (up to 90-day supply)	Use in-network benefit	$10 generic/$20 brand formulary/ $50 brand non-formulary (up to 90-day supply)	$10 (up to 90-day supply)	Half of above co-pay (up to 90-day supply)

This is a brief summary and thus is not an all-inclusive description of services. Only covered expenses are provided/reimbursed through the programs. (R&C = Reasonable & Customary) **1-1-2004**

BROOKHAVEN SCIENCE ASSOCIATES MEDICAL PLAN COMPARISON FOR EMPLOYEES IN IBEW UNION

	CIGNA Preferred Provider Option (PPO) In-Network	CIGNA Preferred Provider Option (PPO) Out-of-Network	Aetna (HMO)	Vytra (HMO)	HIP (HMO)
Preventive Care (Routine Care For Children Including Immunizations)	Covered in full (in NY) Covered in full after $10 co-pay (non-NY) (to age 19)	80% of R&C after deductible (to age 19)	Covered in full after $5 co-pay (to age 19)	Covered in full (to age 17)	Covered in full (to age 19)
(Well Woman Exam)	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full after $5 co-pay	Covered in full
(Pap Test)	Covered in full	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full with office visit co-pay	Covered in full
(Mammogram)	Covered in full	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full	Covered in full
(Physical Exam)	Covered in full after $10 co-pay	Not covered	Covered in full after $5 co-pay	Covered in full after $5 co-pay	Covered in full
(Routine Eye Exam)	Not covered	Not covered	Covered in full after $5 co-pay	Covered in full after $5 co-pay (1 exam/year)	Covered in full (for optometrist)
Mental Health Care (Inpatient)	Covered in full	Same as inpatient hospital	Covered in full (Max: 35 days/year)	Covered in full (Max: 30 days/year)	Covered in full (Max: 30 days/year)
(Outpatient)	Covered in full after $10 co-pay/ visit	80% of R&C after deductible	$25 co-pay/visit (Max: 20 visits/year)	$5 co-pay visits 1-3 $25 co-pay visits 4-20 (Max: 20 visits/year)	$25 co-pay (Max: 20 visits/year)
Substance Abuse Treatment (Inpatient Detoxification)	Covered in full	Same as inpatient hospital	Covered in full	Covered in full (Max: 3 periods/year)	Covered in full (Max: 7 days/year)
(Outpatient Rehabilitation)	Covered in full after $10 co-pay/ visit	80% of R&C after deductible	$5 co-pay/visit (Max: 60 visits/year)	$5 co-pay/visit (Max: 60 visits/year)	Covered in full (Max: 60 visits/year)
Alternate Care (Home Health Care)	Covered in full (Max: 40 visits/year combined in-and out-of-network)	80% of R&C after deductible	Covered in full	Covered in full (Max: 40 visits/year)	Covered in full (Max: 200 visits/year)
(Skilled Nursing Facility)	Covered in full (Max: 60 days/year combined in-and out-of-network)	80% of R&C after deductible	Covered in full	Covered in full (Max: 45 days/year)	Covered in full
(Outpatient Short-Term Rehabilitation: Physical Therapy)	Covered in full after $10 co-pay	80% of R&C after deductible	$5 co-pay (Max: 60 consecutive days/injury/lifetime)	$5 co-pay (Max: 60 consecutive days/injury/lifetime)	Covered in full (Max: 90 visits/year)
Durable Medical Equipment	Covered in full	80% of R&C after deductible	Not covered	Covered in full	Covered in full
External Prosthetic Devices	Covered in full	80% of R&C after deductible	Covered in full for initial device only	Covered in full	Covered in full
Hearing Aids	Covered in full (Max: $1000/hearing aid/ear/3 yrs)	80% of R&C after deductible	Not covered	Not covered	Not covered

This is a brief summary and thus is not an all-inclusive description of services. Only covered expenses are provided/reimbursed through the programs. (R&C = Reasonable & Customary) **1-1-2004**

BROOKHAVEN SCIENCE ASSOCIATES MEDICAL PLAN COMPARISON FOR MEDICARE-ELIGIBLE RETIREES, PARTICIPANTS ON LTD, AND SPOUSES

	CIGNA Preferred Provider Option (PPO)***		HIP VIP (HMO)	CIGNA Indemnity***
	In-Network	Out-of-Network		
Medical Care Provider	Participating physician/facility	Any physician/facility	Participating physician/facility	Any physician/facility
Payment of Benefits	No claim forms	Submit claim forms	No claim forms	Submit claim forms
Annual Deductible (Individual /Family)	N/A	$500/$1500 $100/$300 for pre-1/1/92 terminations	N/A	$250/$650
Annual Out-of-Pocket Maximum (Individual /Family)	N/A	$2500/$7500 excluding deductible	N/A	$900 per person excluding deductible
Lifetime Benefit Max	Unlimited	Unlimited	Unlimited	$1,000,000
Pre-Existing Condition Limitation	N/A	N/A	N/A	N/A
Office Visits (Illness/Injury)	Covered in full after $15 co-pay	80% of R&C after deductible	Covered in full for PCP** ($10 for Specialist)	Illness: 80% of R&C after deductible. Injury: 100% of 1st $100 of R&C if within 48 hours, then 80% of R&C after deductible
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 (Doctors/Specialists: $10 co-pay)	Accident: 100% of R&C if within 48 hours. Illness: 80% of R&C after deductible
Inpatient Hospital (Semi-Private Room, Board, Services, Supplies)	Covered in full Pre-admission certification required or $300 penalty plus 50% reduction in benefits on any days not approved.	Covered in full	Covered in full	100% of R&C for 365 days. Then, 80% of R&C after deductible. Pre-admission certification required or penalty of the lesser of the first $500 or 50% of R&C charges.
(Physician/Surgeon)	Covered in full	80% of R&C after deductible	Covered in full	Physician $15/day (1MD limit) 31-day maximum. Then, 80% of R&C after deductible. Surgeon: based on schedule ($2400 maximum). Then, 80% of R&C after deductible.
Second Surgical Opinion (Office Visit)	Covered in full after $15 co-pay	100% of R&C	Covered in full	100% of R&C
Laboratory/X-Ray	Covered in full	80% of R&C after deductible	Covered in full	100% of R&C up to Limit. Then, 80% of R&C after deductible. Limit: $250/accident; $250/year for illness
Prescription Medication (Retail: up to 30-day supply)	$5 generic/$15 brand name formulary/ $30 brand name non-formulary****	Must use in-network pharmacy	$5 formulary/ $45 non-formulary	Non-participating pharmacies: 80% of R&C after deductible. Participating pharmacies: $5 generic/$10 brand name
(Mail Order: 90-day supply)	$10 generic/$30 brand name formulary/ $60 brand name non-formulary****	Use in-network benefit	Half of above co-pay if formulary	$10 generic/$20 brand name
	****After $100 per person/$300 per family annual drug deductible			

**Primary Care Physician. ***The CIGNA PPO is not available to participants who were members of the IBEW union who terminated employment on or after 8/1/00.
CIGNA Indemnity is only available to IBEW union members who terminated employment on or after 8/1/00.
This is a brief summary and thus is not an all-inclusive description of services. Only covered expenses are provided/reimbursed through the programs. (R&C = Reasonable & Customary)

BROOKHAVEN SCIENCE ASSOCIATES MEDICAL PLAN COMPARISON FOR MEDICARE-ELIGIBLE RETIREES, PARTICIPANTS ON LTD, AND SPOUSES

	CIGNA Preferred Provider Option (PPO)***		HIP VIP (HMO)	CIGNA Indemnity***
	In-Network	Out-of-Network		
Preventive Care (Well Woman Exam)	Covered in full after $15 co-pay	80% of R&C after deductible	Covered in full	Covered in full
(Pap Test)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full
(Mammogram)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full
(Annual Physical Exam)	Covered in full after $15 co-pay	Not covered	Covered in full	Not covered
(Routine Eye Exam)	Not covered	Not covered	Covered in full after $10 co-pay (optometrist:1/year)	80% of R&C after deductible if performed by MD
Mental Health Care (Inpatient)	Covered in full	Same as inpatient hospital	Covered in full (190 day lifetime maximum)*	Same as inpatient hospital
(Outpatient)	Covered in full after $15 co-pay	80% of R&C after deductible	$20 co-pay/visit*	80% of R&C after deductible
Substance Abuse Treatment (Inpatient Detoxification)	Covered in full	Same as inpatient hospital	Covered in full (190 day lifetime max)*	Same as inpatient hospital
(Outpatient Rehabilitation)	Covered in full after $15 co-pay/visit	80% of R&C after deductible	$20 co-pay/visit*	80% of R&C after deductible
Alternate Care (Home Health Care)	Covered in full	80% of R&C after deductible	Covered in full (Max: 200 visits/year)	80% of R&C after deductible (Max: 40 visits/year)
	———(Max: 40 visits/year combined in-and out-of-network)———			
(Skilled Nursing Facility) Non-Custodial	Covered in full	80% of R&C after deductible	Covered in full (days 1-20) $25 co-pay (days 21-100) (Max: 100 days per benefit period)	80% of R&C after deductible (Max: 60 days/year)
	———(Max: 60 days/year combined in-and out-of-network)———			
(Outpatient Short-Term Rehab: Physical Therapy)	Covered in full after $15 co-pay	80% of R&C after deductible	Covered in full after $10 co-pay (Max: 90 visits/year)	80% of R&C after deductible
Hearing Aids	Covered in full	80% of R&C after deductible	1 hearing aid (Max: $500 every 36 months)	80% of R&C after deductible
	———(Max: $1000/hearing aid/ear/3yrs)———			
Durable Medical Equipment	Covered in full	80% of R&C after deductible	Covered in full	80% of R&C after deductible
External Prosthetic Devices	Covered in full	80% of R&C after deductible	Covered in full	80% of R&C after deductible

* Based on medical necessity up to Medicare limit. ***The CIGNA PPO is not available to participants who were members of the IBEW union who terminated employment on or after 8/1/00.
CIGNA Indemnity is only available to IBEW union members who terminated employment on or after 8/1/00.
This is a brief summary and thus is not an all-inclusive description of services. Only covered expenses are provided/reimbursed through the programs. (R&C = Reasonable & Customary)