BROOKHAVEN NATIONAL LABORATORY

2017

BSA BENEFITS PROGRAM

BSA Benefits Program

At Brookhaven Science Associates, LLC (BSA), we know that benefits are an important part of employment. We're pleased to offer benefits that address immediate and long-term needs for you and your family - from insurance coverage to retirement income, and more.

This booklet provides you with an overview of your BSA benefits. Eligible employees can choose from a wide variety of programs designed to offer you the benefits that make the most sense for you and your family. Please review this booklet carefully before making your benefit choices.

Additional information on the benefit programs, including Summary Plan Descriptions, is available on the Benefits website at www.bnl.gov/hr/Benefits/.

New Employees

New employees who are eligible for benefits may elect benefits during their "new employee" orientation. Information on the benefits program for new employees begins on page 7. You may also be eligible to make changes to your benefits if you have a Qualifying Event. See page 28 for information on Qualifying Events.

All Employees

All eligible employees may make changes to their benefits during the Open Enrollment period. You may also be eligible to make changes to your benefits if you have a Qualifying Event.

> The Open Enrollment period for benefits for 2017 will be held from **Monday, November 7, 2016 through Friday, November 18, 2016 at 5 p.m.** If you want to participate in the reimbursement accounts (health care, dependent day care, or transit commuter) and/or the vacation buy plan for 2017, you must reenroll each year. Representatives from the Benefits Office, the Aetna medical and Delta Dental programs, and PayFlex (for the reimbursement accounts and health savings account) will be available to answer any questions you may have on **Thursday, November 10, 2016 in the lobby of Building 400 11:00 a.m. – 1:30 p.m.**

See pages 4 through 6 for changes to the benefit programs, effective January 1, 2017 and more information on Open Enrollment. See page 28 for information on Qualifying Events.

ALEX, BSA's BENEFITS MODELLING TOOL, CAN ASSIST YOU IN MAKING INFORMED DECISIONS ABOUT YOUR BENEFITS.

This year, ALEX has been expanded to include information on the medical, dental, life AD&D, and long term disability plans – as well as reimbursement accounts, vision care and retirement programs.

Once you've reviewed the information in this booklet, we encourage you to use the modelling tool available at www.bnl.gov/hr/Benefits/ to determine which programs will best meet your needs.

This booklet describes the benefits program as of January 1, 2017 and is subject to change. The information in this booklet is intended to provide only a summary of the benefit programs. Nothing contained in 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. Benefits, including eligibility and plan provisions, for employees covered under a collective bargaining agreement are specified in the union contract.

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Here's What You'll Find In This Booklet

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Benefit Program Changes Effective January 1, 2017

Medical Program	• There have been no changes to the medical plan designs (coverage, copayments, coinsurance, etc.) for 2017, including BSA's contribution to the Health Savings Account. • Contributions for medical coverage are based on the medical program you elect and the number of people you enroll. The contributions have changed from 2016 to 2017 so it is important for you to review the 2017 medical contributions on page 9. • If you are enrolled in Aetna Plan 4 High Deductible Health Plan with Health Savings Account (HSA), the annual amount you may contribute to the HSA if you have "employee-only" coverage has increased from $2,850 to $2,900 for 2017. The annual amount you may contribute if you have "family" coverage remains at $5,750 for 2017. If you are 55 or older, the maximum annual catch-up contribution for 2017 remains at $1,000. See pages 8 - 11 for additional information regarding coverage through the Aetna medical programs.
Dental Program	• The Delta Dental PPO maximum benefit has been increased from $1,000 to $1,500 per person per calendar year. • Contributions for dental coverage are based on the dental program you elect and the number of people you enroll. The contributions have not changed from 2016 to 2017 and are page 12. See pages 12 - 14 for additional information regarding coverage through the Delta Dental programs.
Other Programs	• The 2017 annual limit is $18,000. And, if you are age 50 or older, you may contribute an additional $6,000 for catch-up contributions. You can enroll in the 401(k) Plan at any time. You can make changes to the amount you contribute once per month. • There have been no changes to the life, Accidental Death & Dismemberment (AD&D), long term disability and vacation buy plans.
Health Care Reimbursement Account, Dependent Day Care Reimbursement Account ,Transit Commuter Reimbursement Account and Health Savings Account	• The Health Care Reimbursement Account limit for 2017 is $2,600 per year. • You cannot be enrolled in both the Health Care Reimbursement Account and the Health Savings Account (HSA). The HSA is part of the Aetna Plan 4 High Deductible Health Plan • The Dependent Day Care Reimbursement Account limit for 2017 is $5,000 per year (or $2,500 if you are single or are married and file separate income tax returns). • The Transit Commuter Reimbursement Account limit for 2017 is $3,060 per year. .

Open Enrollment For 2017 Benefits

Open Enrollment Dates	The Open Enrollment period will be held from **Monday, November 7, 2016 through Friday, November 18, 2016**.
Open Enrollment Deadline	The deadline for enrollments/changes is **Friday, November 18, 2016 at 5 p.m.** Elections must be entered into PeopleSoft HR or received by the Benefits Office, Bldg. 400B by this date to be eligible for the Open Enrollment period.
Effective Date For Open Enrollment Elections	Changes and elections made during the Open Enrollment period will be effective on **January 1, 2017**.
Representatives And Literature	Representatives from the Benefits Office, the Aetna medical programs, Delta Dental programs, PayFlex (for the reimbursement accounts), Bright Horizons (for the onsite Child Development Center), and TIAA will be available to answer any questions you may have on: **Date: Thursday, November 10, 2016** **Location: Lobby of Building 400 11:00 a.m. – 1:30 p.m.**

Open Enrollment For 2017 Benefits

Changes You Can Make To Your Benefits During The Open Enrollment Period	**Medical and Dental Programs**
	• During the Open Enrollment period you may make the following changes to your medical and/or dental coverage:
	  • Join the Medical and/or Dental Programs
	  • Drop medical and/or dental coverage
	  • Change from one Medical and/or Dental Program to another
	  • Add eligible family members to your coverage
	  • Drop family members from your coverage.
	
	• The elections you have in place for the medical and/or dental programs will roll forward from one year to the next for you and your eligible family members only if (1) the program continues to be available on January 1 of the following year and (2) premiums are paid and all criteria for eligibility are met. For additional information, please refer to the Summary Plan Descriptions available on the Benefits website at www.bnl.gov/hr/Benefits/.
	
	• You may only make changes to your coverage during the Open Enrollment period or when a Qualifying Event occurs.
	
	Vacation Buy Plan
	• You can elect to participate in the Vacation Buy Plan. See page 15 for more information.
	
	• If you want to participate each year, you must re-enroll in the Vacation Buy Plan each year. Your election will not roll forward from one year to the next.
	
	• Vacation buy time can only be used after your regular accrued vacation time has been exhausted.
	
	The deadlines for use of 2017 vacation buy time are December 20, 2017 for monthly employees and December 24, 2017 for weekly employees.
	
	Health Care, Dependent Day Care and Transit Commuter Reimbursement Accounts
	• You can elect to participate in the Health Care, Dependent Day Care and/or Transit Commuter Reimbursement Accounts. See pages 16 - 18 for more information.
	
	• If you want to participate each year, you must re-enroll in the reimbursement accounts each year. Your election will not roll forward from one year to the next.

How To Make Your Benefit Elections	You may either make your benefit elections online or complete a paper enrollment form. **Online Enrollment/Changes** • Online enrollment is available for Medical and Dental programs, Reimbursement Accounts, and the Vacation Buy Plan. • Online enrollment requires that you have a password for PeopleSoft HR. If you do not currently have access to PeopleSoft HR (this is the same system that is used for electronic time reporting) or you are experiencing a problem logging in, call the ITD Help Desk at x5522. • To access online enrollment, log into PeopleSoft HR and click on the following links: Employee Self Service, Benefits, Open Enrollment, and then select the coverage(s) you are changing. • Kiosks are available in the lobby of Human Resources, Bldg. 400B, for online enrollment. **Enrollment/Changes by Paper Form** • Enrollment/changes will be accepted by paper form. If you choose to use an enrollment form, they are available from the Benefits Office, Bldg. 400B. You may only make changes to your coverage during the Open Enrollment period or when a Qualifying Event occurs. Qualifying Events allow you to make certain changes to your coverage if you notify the Benefits Office within a limited period of time from the date of the event. Qualifying Events may include changes in: legal marital status, number of dependents, dependent status, employment status, work schedule, place of residence, or worksite. The Qualifying Event must relate to the change in coverage that you request. See page 28 for additional information on Qualifying Events.

Open Enrollment For 2017 Benefits

Enrollment Is Required Each Year For The Following Programs

Vacation Buy Plan	**For all employees:** • If you are enrolled in the Vacation Buy Plan for 2016 and you want to continue in the Plan for 2017, you must enroll for the Vacation Buy Plan during the Open Enrollment period. If you do not enroll during the Open Enrollment period, you will not be enrolled in the Plan for 2017. • Page 15 provides more information on the Vacation Buy Plan.
Health Care, Dependent Day Care and Transit Commuter Reimbursement Accounts	**For all employees:** • If you are enrolled in the Health Care, Dependent Day Care or Transit Commuter Reimbursement Accounts for 2016 and you want to continue in such Account(s) for 2017, you must enroll for the Account(s) during the Open Enrollment period. If you do not enroll for 2017, your Account(s) will end on December 31, 2016. • If you enroll in the Health Care or Transit Commuter Reimbursement Accounts for 2017 and were enrolled in it for 2016, PayFlex will automatically apply your 2017 elected contribution to your current HealthHub/PayFlex debit card. You will not receive a new card each year. • If you are enrolled in Aetna Plan 4 High Deductible Health Plan with Health Savings Account (HSA) and contribute to the HSA, the HSA amount you elected to contribute in 2016 will automatically roll into 2017. If you want to change this amount, you can do this at any time. • Pages 16 - 18 provide more information on these Accounts.

Additional Information

Will I receive a new identification card?	**Medical Plan:** If you make a change from one medical plan to another for January 1, 2017, you will receive a new identification card from Aetna. Also, if you add an eligible dependent to your coverage, the dependent will receive an identification card. For coverage of two or more people, Aetna will issue two cards. Each card will have the employee's name listed on top followed by the name of each dependent. Each card will look the same unless you have more than four dependents. If you have more than four dependents you will receive additional cards that will include the employee's name followed by the name of each additional dependent. **Dental Plan:** If you make a change from one dental plan to another for January 1, 2017, you will receive a new identification card from Delta Dental.
Where can I get more information on the programs?	Additional information is available through the Benefits Office at ext. 5126 or ext. 2877 and at www.bnl.gov/hr/Benefits/ and through the following websites and telephone numbers. Provider directories are only available online at the websites indicated below.

Medical Programs	**Website**	**Telephone #**
Aetna	www.aetna.com	(855) 586-6961
Dental Programs	**Website**	**Telephone #**
Delta Dental DMO	www.deltadentalins.com	(800) 422-4234
Delta Dental PPO and Indemnity	www.deltadentalins.com	(800) 932-0783

Brookhaven Science Associates, LLC
Benefit Programs

Effective January 1, 2017

Medical Programs

We are pleased to offer you Medical Programs through Aetna. You can choose from four programs:

- Three Point of Service programs (Aetna POS Plan 1, Aetna POS Plan 2, Aetna POS Plan 3)
- A High Deductible Health Plan with a Health Savings Account (Plan 4 Aetna HDHP with HSA)

Aetna Plans 1 – 3 are Point of Service (POS) programs where you may use physicians and facilities of your choice worldwide.

- When you use a provider or healthcare services, you pay for part of the cost of those services yourself in the form of copayments, deductibles, and coinsurance. Aetna's POS network includes not just physicians, but many types of healthcare service providers such as hospitals, laboratories, x-ray facilities, physical therapists, medical equipment providers, outpatient surgery centers, etc. The POS programs provide an incentive for you to get your care from its network of providers by charging you lower copays, deductibles and coinsurance compared to when your care is provided out-of-network. You do not need to select a primary care physician, and referrals to specialists are not required.
- Plans 1 – 3 vary based on copayments, deductibles, coinsurance and employee contributions.

Aetna Plan 4 is a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) where you may also use physicians and facilities of your choice worldwide.

- A High Deductible Health Plan has a higher deductible than most health plans.
- An "employee-only" HDHP covers just you. For the purpose of the HDHP, the term "family" plan means a plan that covers you and at least one other person – so both 2-person coverage and coverage for 3 or more people are "family" coverage for the purpose of this plan.
- With the HDHP, you first pay a deductible. Your deductible is based on your coverage level ("employee-only" or "family"). Once you pay the deductible for the calendar year, then the medical plan provides coverage for medical care based on the terms of the plan. (The deductible under the HDHP works differently than how the it works under Plan 1 – 3 where in those plans you can have coverage for 2 or more people but the individual deductible still applies to each person separately. In the HDHP, if you have coverage for 2 or more people, only the "Family" deductible applies – and there is no individual deductible in this example.)
- In the HDHP, the out-of-pocket maximum works the same as under Plans 1 – 3. The "individual" out-of-pocket maximum applies for "employee-only" coverage. The individual out-of-pocket maximum also applies to "family" coverage. If you have "family" coverage under the HDHP, you can either reach the "individual" out-of-pocket maximum or the "family" can reach the "family" maximum each calendar year. Once the applicable out-of-pocket maximum is reached, the plan pays 100% of covered expenses. The out-of-pocket maximum includes copayments, deductibles and coinsurance.
- The HDHP also has a Health Savings Account that is used for qualified medical expenses. (This is similar to how the Health Care Reimbursement Account can be used for qualified medical expenses.) You must be enrolled in the HDHP to participate in the HSA.
- HSAs are portable. This means that you retain the money in your HSA even if you terminate employment. Unlike the Health Care Reimbursement Account, there is no "use-it-or-lose-it" rule with HSAs. If you don't use the HSA funds, they remain in your HSA each year. They also earn tax-free interest.
- You cannot be enrolled in both the Health Care Reimbursement Account and the HSA.
- If you are enrolled in Tricare (through the military) you're not eligible for the HSA.
- If you receive care from the Veterans Administration, that may affect your HSA eligibility.
- You cannot contribute to the HSA if you are enrolled in Medicare.
- If you are enrolled in the HDHP on January 1, BSA will contribute $500 to the HSA on your behalf for the calendar year if you have "employee-only" coverage and $1,000 on your behalf if you have "family" coverage. Such amounts will be prorated if you begin participation in this Account later in the calendar year.
- You may also contribute to the HSA on a pre-tax basis through paycheck deductions throughout the calendar year. The Internal Revenue Service (IRS) sets the contribution limits each year. The contribution limits include the amount contributed by BSA. The limits for 2017 are:

Coverage	Maximum Total 2017 Contribution	BSA 2017 Contribution	Maximum 2017 Employee Contribution
"Employee-only"	$3,400	$ 500	$2,900
"Family"	$6,750	$1,000	$5,750

If you are 55 or older you can contribute an additional $1,000 to your HSA during 2017. This is a "catch-up" contribution. You can do this each year that you are eligible for the HSA. Once you enroll in Medicare you are no longer permitted to make these contributions.

The HSA has many additional features, requirements and restrictions based on IRS rules. Additional information is available at www.bnl.gov/hr/Benefits/ and in the 2017 Guide to Medical Programs, Health Savings Account, and Health Care Reimbursement Account.

Q: Is enrollment in the Medical Program voluntary?
A: Yes.

Q: Am I eligible to participate?
A: You may participate as of your first day of employment if you are a regular employee working at least 20 hours per week. Beginning on January 1, 2014, eligible employees who are employed on a temporary basis, who work an average of 30 or more hours per week and are employed for 90 days or more may be eligible to enroll in a Medical Program on the 90th day of employment. Additional ACA criteria may apply.

Q: What is the benefit?
A: The Medical Programs provide coverage for many services such as hospitalization, office visits for illness, prescription medication, and mental health and substance abuse care. We do not have any pre-existing condition clauses in the programs. See the chart on page 11 for additional information.

Q: Can I also enroll my family for medical coverage?
A: Yes. As long as you enroll yourself for medical coverage, you can also enroll the following dependents:

- Your spouse.
- Your same-sex domestic partner and such partner's eligible dependent children. Restrictions apply.
- Your children up to the end of the month in which they attain age 26 (including adopted or stepchildren).
- Your unmarried children age 26 or older who are mentally or physically incapable of self-support (if within 31 days after their 26th birthday or the date they become incapacitated, whichever occurs first, you submit proof of the incapacity to the Benefits Office and they are approved by the insurance company).

Q: What is the cost of coverage?
A: The current cost of coverage is as follows each pay period. (The Annual Base Salary category for eligible part-time employees is based on their full-time equivalent salary.) Coverage can be paid for on a before-tax or an after-tax basis through your paycheck. These costs also apply to all employees who are on an approved leave of absence.

COVERAGE	AETNA POS PLAN 1							
	MONTHLY CONTRIBUTION				WEEKLY CONTRIBUTION (52 PAY PERIODS)			
	ANNUAL BASE SALARY				ANNUAL BASE SALARY			
	$0-$69,999	$70,000-$99,999	$100,000-$174,999	$175,000 +	$0-$69,999	$70,000-$99,999	$100,000-$174,999	$175,000 +
1-PERSON	$ 144.29	$ 192.96	$ 234.69	$ 276.41	$ 33.30	$ 44.53	$ 54.16	$ 63.79
2-PERSON	$ 301.41	$ 400.67	$ 487.30	$ 573.94	$ 69.56	$ 92.46	$ 112.45	$ 132.45
3 OR MORE	$ 395.91	$ 532.68	$ 647.86	$ 763.03	$ 91.36	$ 122.93	$ 149.51	$ 176.08

COVERAGE	AETNA POS PLAN 2							
	MONTHLY CONTRIBUTION				WEEKLY CONTRIBUTION (52 PAY PERIODS)			
	ANNUAL BASE SALARY				ANNUAL BASE SALARY			
	$0-$69,999	$70,000-$99,999	$100,000-$174,999	$175,000 +	$0-$69,999	$70,000-$99,999	$100,000-$174,999	$175,000 +
1-PERSON	$ 121.83	$ 158.54	$ 200.26	$ 241.98	$ 28.11	$ 36.59	$ 46.21	$ 55.84
2-PERSON	$ 252.96	$ 329.19	$ 415.82	$ 502.45	$ 58.38	$ 75.97	$ 95.96	$ 115.95
3 OR MORE	$ 336.30	$ 437.65	$ 552.82	$ 667.99	$ 77.61	$ 101.00	$ 127.57	$ 154.15

COVERAGE	AETNA POS PLAN 3							
	MONTHLY CONTRIBUTION				WEEKLY CONTRIBUTION (52 PAY PERIODS)			
	ANNUAL BASE SALARY				ANNUAL BASE SALARY			
	$0-$69,999	$70,000-$99,999	$100,000-$174,999	$175,000 +	$0-$69,999	$70,000-$99,999	$100,000-$174,999	$175,000 +
1-PERSON	$ 81.43	$ 114.64	$ 156.54	$ 198.44	$ 18.79	$ 26.46	$ 36.12	$ 45.79
2-PERSON	$ 169.08	$ 238.03	$ 325.03	$ 412.04	$ 39.02	$ 54.93	$ 75.01	$ 95.09
3 OR MORE	$ 224.79	$ 316.45	$ 432.12	$ 547.79	$ 51.87	$ 73.03	$ 99.72	$ 126.41

COVERAGE	AETNA PLAN 4 HDHP WITH HSA							
	MONTHLY CONTRIBUTION				WEEKLY CONTRIBUTION (52 PAY PERIODS)			
	ANNUAL BASE SALARY				ANNUAL BASE SALARY			
	$0-$69,999	$70,000-$99,999	$100,000-$174,999	$175,000 +	$0-$69,999	$70,000-$99,999	$100,000-$174,999	$175,000 +
1-PERSON	$ 56.08	$ 92.18	$ 133.66	$ 175.91	$ 12.94	$ 21.27	$ 30.84	$ 40.59
2-PERSON	$ 92.72	$ 168.16	$ 254.59	$ 341.03	$ 21.40	$ 38.81	$ 58.75	$ 78.70
3 OR MORE	$ 123.29	$ 223.59	$ 338.51	$ 453.44	$ 28.45	$ 51.60	$ 78.12	$ 104.64

Q: How do I sign up?
A: New employees sign up for coverage by completing an enrollment form within 30 days from your first day of employment. All other eligible employees may sign up for coverage during the Open Enrollment period. You may also be eligible to sign up for coverage if you have a Qualifying Event. See the Open Enrollment section and the Qualifying Events section for more information.

Q: Can I make changes to my coverage?
A: Yes. If you have a Qualifying Event, you may be eligible to add or drop coverage or dependents at that time. See the Qualifying Events section for more information. You may also change your coverage during the Open Enrollment period, and coverage will be effective January 1 of the following calendar year. See the Open Enrollment section for more information.

Q: Will my election automatically continue into the next calendar year?
A: Yes. The elections you have in place for the medical program will roll forward from one year to the next for you and your eligible family members only if all criteria for eligibility are met. For additional information, refer to the Summary Plan Description available on the Benefits website at www.bnl.gov/hr/Benefits/.

Q: Where can I get more information on the programs?
A: A comparison of the programs is provided on page 11. Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 5126 or ext. 2877.

Additional information is also available through the following website and telephone number. Provider directories are only available online at the website indicated below.

Medical Program	Website	Telephone #
Aetna	www.aetna.com	(855) 586-6961

MEDICAL PROGRAMS

MEDICAL PLAN DESIGN	AETNA POS PLAN 1	AETNA POS PLAN 2	AETNA POS PLAN 3	AETNA PLAN 4 HIGH DEDUCTIBLE HEALTH PLAN WITH HEALTH SAVINGS ACCOUNT
HSA CONTRIBUTION/YR FROM BSA (Individual/Family)	N/A	N/A	N/A	$500 /$1,000
IN-NETWORK				
COPAY (PCP/SPECIALIST) (per visit)	$20/$35	$25/$40	$30/$45	DEDUCTIBLE + COINSURANCE
DEDUCTIBLE/YR (Individual/Family)	$0	$150/$300	$300/$600	$1,300/$2,600
COINSURANCE	0%	10%	20%	20%
OUT-OF-POCKET MAXIMUM/YR MEDICAL (includes deductible, copays, & coinsurance) (Individual/Family)	$5,100/$10,200	$1,000/$2,000	$2,000/$4,000	$3,500/$8,000 MEDICAL & PRESCRIPTION DRUG COMBINED
OUT-OF-POCKET MAXIMUM/YR PRESCRIPTION DRUGS (includes deductible, copays, & coinsurance) (Individual/Family)	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	
EMERGENCY ROOM (per visit)	$100	$150	$200	DEDUCTIBLE + COINSURANCE
INPATIENT HOSPITAL (per admission)	$500	DEDUCTIBLE + COINSURANCE	DEDUCTIBLE + COINSURANCE	DEDUCTIBLE + COINSURANCE
OUTPATIENT SURGERY (per visit)	$100	DEDUCTIBLE + COINSURANCE	DEDUCTIBLE + COINSURANCE	DEDUCTIBLE + COINSURANCE
TELADOC (per telephonic visit)	$20	$25	$30	DEDUCTIBLE + COINSURANCE
WALK-IN CLINIC (per visit)	$20	$25	$30	DEDUCTIBLE + COINSURANCE
URGENT CARE CENTER (per visit)	$50	$50	$50	DEDUCTIBLE + COINSURANCE
X-RAY/LABORATORY	COVERED IN FULL	$20	$20	DEDUCTIBLE + COINSURANCE
COMPLEX IMAGING (MRI, CT SCAN, …)	$50	$50	$50	DEDUCTIBLE + COINSURANCE
HEARING AIDS	COVERED IN FULL	DEDUCTIBLE + COINSURANCE	DEDUCTIBLE + COINSURANCE	DEDUCTIBLE + COINSURANCE
ROUTINE EYE EXAM	COVERED IN FULL (1 EXAM EVERY 24 MONTHS)	COVERED IN FULL (1 EXAM EVERY 24 MONTHS)	COVERED IN FULL (1 EXAM EVERY 24 MONTHS)	COVERED IN FULL (1 EXAM EVERY 24 MONTHS)
ROUTINE PHYSICAL (limits apply)	COVERED IN FULL	COVERED IN FULL	COVERED IN FULL	COVERED IN FULL
OUT-OF-NETWORK				
DEDUCTIBLE (Individual/Family)	$1,000/$3,000	$1,500/$4,500	$2,000/$6,000	$2,600/$5,200
COINSURANCE	30%	30%	30%	40%
OUT-OF-POCKET MAXIMUM (includes deductible & coinsurance) (Individual/Family)	$3,500/$10,500	$5,000/$15,000	$6,000/$18,000	$6,000/$12,000
PRESCRIPTION DRUGS (in-network only)				
DEDUCTIBLE/YR (Individual/Family) (Deductible is combined for retail & mail order)	$100/$300	$100/$300	$100/$300	MEDICAL & PRESCRIPTION DRUG COMBINED
RETAIL: up to 30-day supply				
TIER 1 (generic)	$10	$10	$10	$10 AFTER DEDUCTIBLE
TIER 2 (brand name in Aetna's formulary)	$25	$30	$35	$35 AFTER DEDUCTIBLE
TIER 3 (brand name not in Aetna's formulary)	$40	$50	$60	$60 AFTER DEDUCTIBLE
TIER 4 (specialty drugs)	$50	$60	$70	$80 AFTER DEDUCTIBLE
MAIL ORDER: 31-90-day supply (can also be done through CVS retail pharmacy)				
TIER 1 (generic)	$20	$20	$20	$20 AFTER DEDUCTIBLE
TIER 2 (brand name in Aetna's formulary)	$50	$60	$70	$70 AFTER DEDUCTIBLE
TIER 3 (brand name not in Aetna's formulary)	$80	$100	$120	$120 AFTER DEDUCTIBLE
TIER 4 (specialty drugs)	N/A	N/A	N/A	N/A

This represents only a summary of the coverage through the medical programs. For additional information go to www.bnl.gov/hr/Benefits/.

Dental Programs

We are pleased to offer you Dental Programs through Delta Dental (PPO, DMO and Indemnity). You can choose from:

The **Preferred Provider Organization (PPO)** where you may use dentists of your choice. If services are received from an in-network provider, your out-of-pocket expenses will be lower than if you use a provider who is not in the network. You may use two networks: Delta Dental Premier and Delta Dental PPO. You have an annual deductible and partial reimbursement of expenses. You or your dental provider must submit claims for reimbursement.

The **Dental Maintenance Organization (DMO)** where services are provided through a network of participating dentists. The network is DeltaCare USA. There is a schedule of benefits indicating the cost of services. No claim forms are required. You must select a participating dentist for your general dental care, and referrals to specialists are required.

The **Indemnity Program** where you use dentists of your choice. If services are received from an in-network provider, you will receive a discount on covered services. You may use two networks: Delta Dental Premier and Delta Dental PPO. You have an annual deductible and partial reimbursement of expenses. You or your dental provider must submit claims for reimbursement.

Q: Is enrollment in the Dental Program voluntary?
A: Yes.

Q: Am I eligible to participate?
A: You may participate as of your first day of employment if you are a regular employee working at least 20 hours per week.

Q: What is the benefit?
A: The Dental Programs provide coverage for preventive, basic and restorative dental services and orthodontia (for children). The DMO also has coverage for adult orthodontia. See the chart on page 14 for additional information.

Q: Can I also enroll my family for dental coverage?
A: Yes. As long as you enroll yourself for dental coverage, you can also enroll the following dependents:

- Your spouse.
- Your same-sex domestic partner and such partner's eligible dependent children. Restrictions apply.
- Your unmarried children through the end of the calendar year in which they attain age 23 (including adopted and stepchildren) who reside with you and are dependent on you for at least half of their support. For additional information, refer to the Summary Plan Description available on the Benefits website at www.bnl.gov/hr/Benefits/.
- Your unmarried children age 23 or older who are mentally or physically incapable of self-support (if within 31 days after their 23rd birthday or the date they become incapacitated, whichever occurs first, you submit proof of the incapacity to the Benefits Office and they are approved by the insurance company).

Q: What is the cost of coverage?
A: The current cost of coverage is as follows each pay period. Coverage can be paid for on a before-tax or an after-tax basis through your paycheck. These costs also apply to all employees who are on an approved leave of absence.

Program	Employee Only		Employee + 1 Dependent		Employee + 2 or More Dependents	
	Weekly (52 pay periods)	Monthly	Weekly (52 pay periods)	Monthly	Weekly (52 pay periods)	Monthly
Delta DMO	$1.15	$ 5.00	$2.31	$10.00	$4.38	$19.00
Delta PPO	$2.33	$10.11	$4.81	$20.86	$7.90	$34.23
Delta Indemnity	$1.15	$ 5.00	$2.31	$10.00	$4.38	$19.00

Q: How do I sign up?
A: New employees sign up for coverage by completing an enrollment form within 30 days from your first day of employment. All other eligible employees may sign up for coverage during the Open Enrollment period. You may also be eligible to sign up for coverage if you have a Qualifying Event. See the Open Enrollment section and the Qualifying Events section for more information.

Q: Can I make changes to my coverage?

A: Yes. If you have a Qualifying Event, you may be eligible to add or drop coverage or dependents at that time. See the Qualifying Events section for more information. You may also change your coverage during the Open Enrollment period, and coverage will be effective January 1 of the following calendar year. See the Open Enrollment section for more information.

Q: Will my election automatically continue into the next calendar year?

A: Yes. The elections you have in place for the dental program will roll forward from one year to the next for you and your eligible family members only if all criteria for eligibility are met. For additional information, refer to the Summary Plan Description available on the Benefits website at www.bnl.gov/hr/Benefits/.

Q: Where can I get more information on the programs?

A: A comparison of the programs is provided on page 14. Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 5126 or ext. 2877.

Additional information is also available through the following websites and telephone numbers. Provider directories are only available online at the websites indicated below.

Dental Programs	**Website**	**Telephone #**
Delta Dental DMO	www.deltadentalins.com	(800) 422-4234
Delta Dental PPO and Indemnity	www.deltadentalins.com	(800) 932-0783

DENTAL PROGRAMS

	DELTA DENTAL			
	DMO	**PPO**		**Indemnity**
Network	DeltaCare	PPO and Premier Networks		PPO and Premier Networks
	In-Network Only	**In-Network**	**Out-of-Network**	**In- and Out-of-Network**
Provider	Participating Provider	Participating Provider	Any Provider	Any Provider
Claim Process	Pay dentist scheduled fee	Dentist will charge you applicable copay	Must submit claim to Delta Dental	Participating dentist will charge you applicable co-pay. Claims must be submitted to Delta Dental for non-participating dentists.
Dependent Children Age Limit	End of year age 23	End of year age 23		End of year age 23
Annual Deductible Per Individual/Family (for basic & major restorative dental services. Does not apply to preventive services.)	N/A	$25/$75 (in- and out-of-network combined)		$25/$75
Calendar Year Maximum Benefit Per Person (for all services other than orthodontia.)	N/A	$1,500 (in- and out-of-network combined)		$1,000
Eligibility for Orthodontia Coverage	Children: To end of year age 23	Children: To age 19		Children: To age 19
	Employee/Spouse: eligible	Employee/Spouse: not eligible		Employee/Spouse: not eligible
Coverage Based On	Fee Schedule	Reduced Contracted Fees	Reasonable & Customary Fees	Reimbursement Schedule
	Amount **participant** pays	Amount **insurance company** pays		Amount **insurance company** pays
Diagnostic & Preventive Services (exams, cleanings, x-rays)	$0	80%	70%	See schedule
Basic Services Fillings: one-surface amalgam (procedure code: 2140)	$0	60%	45%	$26
Fillings: one-surface composite - anterior (procedure code: 2330)	$5	60%	45%	$30
Endodontics				
Root canal therapy - molar (excludes final restoration) (procedure code: 3330)	$350	60%	45%	$282
Periodontics Gingivectomy - per quad (procedure code: 4210)	$145	60%	45%	$150
Major Services Crowns - Porcelain Fused to High Noble Metal (procedure code: 2750)	$380	50%	35%	$250
Implants	Not covered	50%	30%	$1,000
Orthodontic Benefits	See fee schedule	50%	50%	See reimbursement schedule
Orthodontic Lifetime Maximum Benefit Per Person	N/A	$1,000 (in- and out-of-network combined)		$1,000

This represents only a portion of the dental schedule. For additional information go to www.bnl.gov/hr/Benefits/.

Vacation Buy Plan

We are pleased to offer you a Vacation Buy Plan where you can purchase additional vacation time on a pre-tax basis and spread the cost of doing so over the calendar year. For information on time-off for accrued vacation provided by the Laboratory, see the Vacation section in the back of this booklet.

Q: Is enrollment in the Vacation Buy Plan voluntary?
A: Yes.

Q: Am I eligible to participate?
A: You may participate as of your first day of employment if you are a regular employee working at least 20 hours per week.

Q: What is the benefit?
A: You may purchase a minimum of 8 hours (up to a maximum of 40 hours) of vacation time in 1-hour increments each calendar year in addition to the vacation time you are eligible to receive from the Laboratory. Vacation buy benefits for eligible part-time employees will be prorated according to your official work schedule. Additional vacation time is paid for through pre-tax payroll deductions taken equally from your paychecks throughout the year. The hours of vacation you purchase become available to you as of your date of employment. Each year thereafter, if you buy vacation time, the hours of vacation you purchase become available to you as of January 1 of the following year.

Q: How is the cost of purchased vacation time determined?
A: For a full calendar year, divide your full-time Annual Base Salary by 2,080. You can prorate this accordingly for a partial year. Your Base Salary is the amount that will be reflected on your W-2 statement, before exercise of any salary reductions. Overtime payments, shift premiums, termination payments, severance pay, and other forms of compensation are not included in Base Salary. For union employees, Base Salary is based on the terms of their collective bargaining agreements.

Q: Will purchasing vacation time affect any other benefits?
A: When you purchase vacation time, you buy unpaid time off but stretch the cost over the entire year. Since the Retirement Plan and the 401(k) Plan contributions are based on actual base pay, you do not receive and cannot make contributions for the unpaid time.

Q: What happens if I don't use up all of the vacation time I have purchased?
A: It will not be carried over to the next calendar year. That remaining time will be paid back to you in your last paycheck in December based on the rate at which it was purchased. The amount you are reimbursed will be taxable in your paycheck. Any applicable contributions to the Retirement Plan and 401(k) Plan will be made at that time.

Q: How can vacation buy time be used?
A: The use of all vacation time requires the approval of your supervisor and must be in accordance with Laboratory vacation policies. When you record the vacation buy hours on your timecard, you will use a special vacation buy code. Vacation buy time can only be used after your regular accrued vacation time has been exhausted. The deadlines for use of 2017 vacation buy time are December 20, 2017 for monthly employees and December 24, 2017 for weekly employees.

Q: How do I sign up?
A: New employees sign up for coverage by completing an enrollment form within 30 days from your first day of employment. All other eligible employees may sign up for coverage during the Open Enrollment period. See the Open Enrollment section for more information.

Q: Can I make changes to my coverage?
A: You can only make a change in your election if it corresponds to a change in the number of hours you are scheduled to work.

Q: Will my election automatically continue into the next calendar year?
A: No. If you want to participate in the program each year, you must enroll each year during the Open Enrollment period. Your election will not roll forward from one year to the next.

Q: What happens when I terminate employment?
A: The benefits will cease on the earlier of the date your employment terminates or the date you are no longer eligible for coverage. Your final paycheck will be adjusted for:

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

Q: Where can I get more information on the program?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 5126 or ext. 2877.

Health Care Reimbursement Account

We are pleased to offer you a Health Care Reimbursement Account that allows you to pay for a variety of health care expenses on a before-tax basis through a HealthHub account through PayFlex.

Q: Is enrollment in the Health Care Reimbursement Account voluntary?
A: Yes.

Q: Am I eligible to participate?
A: You may participate as of your first day of employment if you are a regular employee working at least 20 hours per week. If, however, you enroll in Aetna Plan 4 High Deductible Health Plan with the Health Savings Account, you cannot participate in the Health Care Reimbursement Account.

Q: What is the benefit?
A: You may reimburse yourself with before-tax dollars for eligible out-of-pocket expenses. By paying for expenses on a before-tax basis, you reduce your income for the purpose of state, federal and Social Security taxes. You estimate how much you expect to spend on unreimbursed health care expenses for the calendar year and have that amount withheld pre-tax from your paychecks throughout the year in equal weekly or monthly amounts.

You may either pay for your qualified purchases using the HealthHub/PayFlex Card at the point of service or you can file a claim (online, by paper, or by fax). Claims are processed daily. You have until March 31 of the following calendar year to submit claims for expenses incurred.

Q: Is there a limit to the amount I can contribute?
A: Yes. You may contribute from a minimum of $300 to a maximum of $2,600 each calendar year. (The limit is subject to change. The 2017 limit is indicated above.)

Q: Will reducing my taxable salary by contributing to this program have an effect on any other benefits?
A: It may. If your annual salary is below the Social Security wage base, your future Social Security benefit may be reduced.

Q: What happens if I don't use up all of the money I have contributed?
A: The IRS requires you to forfeit all amounts that you do not use toward expenses incurred in the calendar year.

Q: What types of expenses are reimbursable?
A: You can be reimbursed for many expenses incurred by you or your eligible dependents that the IRS allows as income tax deductions, but not all items that qualify as a tax deduction also qualify for the reimbursement account. Premiums paid for health care coverage cannot be reimbursed. Eligible expenses include but are not limited to:

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

You can use IRS Publication 502 at http://www.irs.gov/pub/irs-pdf/p502.pdf as a guide, but not all items that qualify for a tax deduction also qualify for the reimbursement account. Contact PayFlex at (800) 284-4885 for additional information.

Q: Who is an eligible dependent?
A: A dependent for the purpose of the Health Care Reimbursement Account includes your spouse and, in general, a dependent you can claim as an exemption on your tax return.

Q: How do I sign up?
A: New employees sign up for coverage by completing an enrollment form within 30 days from your first day of employment. All other eligible employees may sign up for coverage during the Open Enrollment period. You may also be eligible to sign up for coverage if you have a Qualifying Event. See the Open Enrollment section and the Qualifying Events section for more information.

Q: Can I make changes to my coverage?
A: Yes. If you have a Qualifying Event, you may be eligible to add or drop coverage at that time. See the Qualifying Events section for more information. You may also change your coverage during the Open Enrollment period, and coverage will be effective January 1 of the following calendar year. See the Open Enrollment section for more information.

Q: Will my election automatically continue into the next calendar year?
A: No. If you want to participate in the program each year, you must enroll each year during the Open Enrollment period. Your election will not roll forward from one year to the next.

Q: Where can I get more information on the program?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 5126 or ext. 2877.

Dependent Day Care Reimbursement Account

We are pleased to offer you a Dependent Day Care Reimbursement Account that allows you to pay day care expenses on a before-tax basis through a HealthHub account through PayFlex.

Q: Is enrollment in the Dependent Day Care Reimbursement Account voluntary?
A: Yes.

Q: Am I eligible to participate?
A: You may participate as of your first day of employment if you are a regular employee working at least 20 hours per week and are:

- a single parent who requires dependent day care so you can work, or
- married and require day care so you can work and your spouse can work, seek employment, or be a full-time student.

Q: What is the benefit?
A: You may reimburse yourself with before-tax dollars for eligible out-of-pocket expenses. By paying for expenses on a before-tax basis, you reduce your income for the purpose of state, federal and Social Security taxes. You estimate how much you expect to spend on dependent day care expenses for the calendar year and have that amount withheld pre-tax from your paychecks throughout the year in equal weekly or monthly amounts.

You may either pay for your qualified purchases using the HealthHub/PayFlex Card or you can file a claim (online, by paper, or by fax). Claims are processed daily. You have until March 31 of the following calendar year to submit claims for expenses incurred.

Q: Is there a limit to the amount I can contribute?
A: Yes. You may contribute from a minimum of $300 to a maximum of $5,000 each calendar year. If you are single or if you are married and file separate income tax returns, the maximum you may contribute is $2,500. (The limit is subject to change. The 2017 limit is indicated above.)

Q: Will reducing my taxable salary by contributing to this program have an effect on any other benefits?
A: It may. If your annual salary is below the Social Security wage base, your future Social Security benefit may be reduced.

Q: What happens if I don't use up all of the money I have contributed?
A: The IRS requires you to forfeit all amounts that you do not use toward expenses incurred in the calendar year.

Q: What types of expenses are reimbursable?
A: You can be reimbursed for many expenses incurred by you or your eligible dependents that the IRS allows as income tax deductions, but not all items that qualify as a tax deduction also qualify for the reimbursement account. Eligible expenses include but are not limited to:

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

You can use IRS Publication 503 at http://www.irs.gov/pub/irs-pdf/p503.pdf as a guide, but not all items that qualify for a tax deduction also qualify for the reimbursement account. Contact PayFlex at (800) 284-4885 for additional information.

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

Q: Who is an eligible dependent?
A: A dependent for the purpose of the Dependent Day Care Reimbursement Account includes:

- A child under age 13 who is claimed as a dependent on your income tax return. Claims incurred on or after a child's 13th birthday will not be covered.
- Any dependent you claim for income tax purposes that requires day care because of physical or mental inability.

Q: How do I sign up?
A: New employees sign up for coverage by completing an enrollment form within 30 days from your first day of employment. All other eligible employees may sign up for coverage during the Open Enrollment period. You may also be eligible to sign up for coverage if you have a Qualifying Event. See the Open Enrollment section and the Qualifying Events section for more information.

Q: Can I make changes to my coverage?
A: Yes. If you have a Qualifying Event, you may be eligible to add or drop coverage at that time. See the Qualifying Events section for more information. You may also change your coverage during the Open Enrollment period, and coverage will be effective January 1 of the following calendar year. See the Open Enrollment section for more information.

Q: Will my election automatically continue into the next calendar year?
A: No. If you want to participate in the program each year, you must enroll each year during the Open Enrollment period. Your election will not roll forward from one year to the next.

Q: Where can I get more information on the program?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 5126 or ext. 2877.

Transit Commuter Reimbursement Account

We are pleased to offer you a Transit Commuter Reimbursement Account that allows you to pay transit expenses to and from work on a before-tax basis through a HealthHub account through PayFlex.

Q: Is enrollment in the Transit Commuter Reimbursement Account voluntary?
A: Yes.

Q: Am I eligible to participate?
A: You may participate as of your first day of employment if you are a regular employee working at least 20 hours per week.

Q: What is the benefit?
A: You may reimburse yourself with before-tax dollars for your eligible out-of-pocket expenses. By paying for expenses on a before-tax basis, you reduce your income for the purpose of state, federal and Social Security taxes. You estimate how much you expect to spend on transit commuter expenses for the calendar year and have that amount withheld pre-tax from your paychecks throughout the year in equal weekly or monthly amounts.

You may either pay for your qualified purchases using the HealthHub/PayFlex Card at the point of service or you can file a claim (online, by paper, or by fax). Claims are processed daily. You have until March 31 of the following calendar year to submit claims for expenses incurred.

Q: Is there a limit to the amount I can contribute?
A: Yes. You may contribute from a minimum of $25 per month to a maximum of $3,060 each calendar year (but no more than $255 per month). (The limit is subject to change. The 2017 limit is indicated above.)

Q: Will reducing my taxable salary by contributing to this program have an effect on any other benefits?
A: It may. If your annual salary is below the Social Security wage base, your future Social Security benefit may be reduced.

Q: What happens if I don't use up all of the money I have contributed?
A: If you re-enroll during the Open Enrollment period, the IRS requires the remaining contributions to stay in the account. They may be used for future transit expenses and will apply to the maximum contribution above. If, however, you do not re-enroll, the IRS requires you to forfeit all amounts that you do not use toward expenses incurred in the calendar year.

Q: What types of expenses are reimbursable?
A: You can be reimbursed for the cost of vanpooling, trains, ferries and buses to and from work. It excludes parking, gasoline and telecommuting expenses. Contact PayFlex at (800) 284-4885 for additional information.

Q: How do I sign up?
A: New employees sign up for coverage by completing an enrollment form within 30 days from your first day of employment. All other eligible employees may sign up for coverage during the Open Enrollment period. See the Open Enrollment section for more information. You may also sign up at any time during the year.

Q: Can I make changes to my coverage?
A: Yes. You may make changes to this coverage at any time including electing, dropping, or changing your contribution by notifying the Benefits Office.

Q: Will my election automatically continue into the next calendar year?
A: No. If you want to participate in the program each year, you must enroll each year during the Open Enrollment period. Your election will not roll forward from one year to the next.

Q: Where can I get more information on the program?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 5126 or ext. 2877.

Long Term Disability Plan

We are pleased to offer you Long Term Disability Plan coverage through Liberty Mutual.

Q: Is enrollment in the Long Term Disability (LTD) Plan voluntary?
A: No. Participation in the LTD Plan is mandatory upon completion of one year of active service for all regular employees who work at least 20 hours per week.

Q: Am I eligible to participate?
A: You will participate if you are a regular employee working at least 20 hours per week and have completed one year or more of active service.

Q: What is the benefit?
A: If you become totally disabled for a continuous period of 180 days as a result of an accident or illness and are approved for the benefit by the insurance company, commencing with the 181st day of disability, the LTD insurance program provides a maximum benefit of 60% of your Base Salary plus a contribution to the BSA Retirement Plan. The duration of LTD benefits depends on several factors including, but not limited to, your age at disablement. LTD benefits are offset by other sources of income such as workers' compensation, government retirement system benefits, Social Security benefits, etc.

Q: What is the cost of coverage?
A: The cost of LTD insurance coverage is shared by you and the Laboratory. LTD coverage is paid for on an after-tax basis through your paycheck and costs $0.431 per $100 of annual Base Salary.

Here's an example of the cost for LTD Insurance coverage.

If your annual Base Salary is $49,000 and you have LTD insurance coverage:

Maximum LTD Coverage Amount:	$2,450 per month	($49,000 x 60% / 12 months)
Cost of Coverage:	$17.60 per month	($49,000 x $0.431 / $100 / 12 months)

Q: How do I sign up?
A: You will be signed up for coverage at your new hire orientation meeting and will be eligible to participate in the plan after meeting the eligibility requirements indicated above.

Q: Where can I get more information on the program?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 7516.

Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance Plan

We are pleased to offer you Life Insurance and AD&D Insurance through Liberty Mutual. The Life Insurance and AD&D Insurance Plan consists of:

Employee Basic Life Insurance	Spouse Supplemental Life Insurance
Employee Supplemental Life Insurance	Spouse Supplemental AD&D Insurance
Employee Basic AD&D Insurance	Dependent Child Supplemental Life Insurance (age 15 days to 19 years old or up to age 25 if the child is a full-time student)
Employee Supplemental AD&D Insurance	

Q: Is enrollment in the Life Insurance and AD&D Plan voluntary?
A: Employee Basic Life Insurance and Employee Basic AD&D Insurance are mandatory. All of the other Insurances indicated above are optional.

Q: Am I eligible to participate?
A: You may participate as of your first day of employment if you are a regular employee working at least 20 hours per week.

Q: What is the benefit and what is the cost of the coverage?
A: The Life Insurance and AD&D Insurance Plan provides life insurance in the case of death and AD&D insurance in the case of certain dismembering injuries or accidental death. See below for additional information.

Type of Coverage	Amount of Coverage	Who Pays for the Coverage	Monthly Cost to Employee per $1,000 of Coverage
Employee Basic Life Insurance	Annual Base Salary rounded to the next higher multiple of $2,500	BSA	
Employee Supplemental Life Insurance	This is in addition to Employee Basic Life Insurance and the options are as follows: ➢ 1 times Annual Base Salary (rounded to the next higher multiple of $2,500) ➢ 2 times Annual Base Salary (rounded to the nearest $500) ➢ 3 times Annual Base Salary* (rounded to the nearest $500) ➢ 4 times Annual Base Salary* (rounded to the nearest $500) The amount of Employee Basic Life Insurance coverage plus Employee Supplemental Life Insurance coverage may not exceed $1 million.	Employee	Cost is based on age of employee: Up to age 29: $0.080 Age 30-44: $0.200 Age 45+: $0.300
Employee Basic AD&D Insurance	$25,000	BSA	
Employee Supplemental AD&D Insurance	This is in addition to Employee Basic AD&D Insurance and the options are as follows: ➢ 1 times Annual Base Salary (rounded to the next higher multiple of $2,500) ➢ 2 times Annual Base Salary (rounded to the nearest $500) ➢ 3 times Annual Base Salary (rounded to the nearest $500) ➢ 4 times Annual Base Salary (rounded to the nearest $500) The amount of Employee Basic AD&D Insurance coverage plus Employee Supplemental AD&D Insurance coverage may not exceed $1 million.	Employee	$0.025
Spouse Supplemental Life Insurance	$50,000 - $500,000 (in $50,000 increments) ** You must elect Employee Supplemental Life Insurance to be eligible to elect Spouse Supplemental Life Insurance. The amount of Spouse Supplemental Life Insurance elected cannot exceed the total amount of Employee Basic Life Insurance plus Employee Supplemental Life Insurance.	Employee	Cost is based on age of spouse: Up to age 29: $0.080 Age 30-44: $0.200 Age 45+: $0.300

Type of Coverage	Amount of Coverage	Who Pays for the Coverage	Monthly Cost to Employee per $1,000 of Coverage
Spouse Supplemental AD&D Insurance	$50,000 - $500,000 (in $50,000 increments) You must elect Employee Supplemental AD&D Insurance to be eligible to elect Spouse Supplemental AD&D Insurance. The amount of Spouse Supplemental AD&D Insurance elected cannot exceed the total amount of Employee Basic AD&D Insurance plus Employee Supplemental AD&D Insurance.	Employee	$0.025
Dependent Child Supplemental Life Insurance (age 15 days to 19 years old or up to age 25 if the child is a full-time student)	$10,000 per child	Employee	$0.200 This is the cost for all eligible children (not the cost per child).

* Election of Employee Supplemental Life Insurance coverage in excess of 2 times Annual Base Salary requires you to submit evidence of insurability to the insurance company. Such change in insurance is only effective if approved by the insurance company.
** Spouse Supplemental Life Insurance coverage in excess of $50,000 requires your spouse to submit evidence of insurability to the insurance company. Such change in insurance is only effective if approved by the insurance company.

Life Insurance amounts are adjusted for eligible part-time employees and their applicable spouse.

The amount of Employee Basic Life Insurance and Employee Supplemental Life Insurance coverage decreases for employees at age 65, 70, 75 and 80. Spouse Supplemental Life Insurance coverage will also decrease at age 65, 70, 75 and 80 based on the employee's age.

Here's an example of the cost for Employee Supplemental Life Insurance coverage for an employee who is age 46.
If your base pay is $49,000 and you purchase Employee Supplemental Life Insurance (1 Times Annual Base Pay):

Supplemental Life Insurance Coverage Amount:	$50,000*	
Cost of Coverage:	$15.00 per month	($50,000 x $0.30 / $1,000)

*$50,000 coverage amount is Annual Base Salary rounded up to the nearest multiple of $2,500 that exceeds your Annual Base Salary.

Q: How do I sign up?
A: You will be signed up for Employee Basic Life Insurance and Employee Basic AD&D Insurance at your new hire orientation meeting. You may also elect Supplemental coverages. You will also designate a beneficiary(ies) for your coverage.

Q: Can I make changes to my coverage?
A: Yes. Although Employee Basic Life Insurance and Employee Basic AD&D Insurance are provided to you at no cost, since you pay for Supplemental coverages, you may decrease or drop such Supplemental coverages at any time.

After your initial eligibility (and approval, if applicable) for Supplemental Life Insurance and AD&D Insurance coverages, all elections to increase Employee Supplemental Life Insurance and/or Spouse Supplemental Life Insurance coverage require you (and/or your spouse, as applicable) to submit evidence of insurability to the insurance company. Such change in insurance is only effective if approved by the insurance company. The initial eligibility period for a new employee is the period that begins on the day you are first eligible for this benefit and ends 89 days after that day.

To begin the process, log into PeopleSoft HR and click the following links: Employee Self Service, Benefits, Benefits Home, Life Insurance, and then select Edit Your Coverage Amount. You need to first make your new elections. Then if the change is related to coverage for you, you must complete and submit evidence of insurability information through the online link in PeopleSoft. If the change is related to coverage for your spouse, you must print out the Evidence of Insurability Form and submit it to the insurance company.

Q: Can I make changes to my beneficiary(ies)?
A: Yes. To change the beneficiary(ies) for Life Insurance at any time, you may either make the change online or complete a form. To make your change online, log into PeopleSoft HR and click on the following links: Employee Self Service, Benefits, Benefits Home, Life Insurance and complete the applicable section(s). If you prefer to complete a form, contact the Benefits Office. You are the beneficiary for Spouse or Dependent Child Insurance.

Q: Where can I get more information on the program?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 7516.

Retirement Plan

We are pleased to offer you the BSA Retirement Plan. You can choose to invest Retirement Plan contributions in approved investment funds.

Q: Is enrollment in the Retirement Plan voluntary?
A: No. Participation is mandatory once you meet the eligibility requirements to participate.

Q: Am I eligible to participate?
A: You must work at least 1,000 hours per year to be eligible to participate in the plan. Employees who were not participating in the plan on December 31, 2006 will be enrolled upon the earlier of (a) attainment of age 21 and the completion of one year of continuous service or (b) the attainment of age 30 and the completion of 6 months of continuous service.

Employees who work on a part-time, temporary or irregular basis must complete 1,000 hours of service each year to be credited with a year of service. Persons with guest or visitor appointments, research associates (including RAs, junior RAs, senior RAs, and research fellows), and student assistants are not eligible to participate in this plan.

Q: What is the benefit?
A: For eligible employees hired or rehired on or after January 1, 2011 who are not members of the IBEW union, the Laboratory contributes an amount equal to 9% of your Base Salary to this plan (10% for employees hired before January 1, 2011 who are not members of the IBEW union). For members of the IBEW union hired on or after August 1, 2015, the Laboratory contributes an amount equal to 9% of your Base Salary to this plan (10% for members of the IBEW union hired before August 1, 2015). You are not required or allowed to contribute to this plan.

You can allocate the contributions between approved investment funds. The list of funds is on page 24.

For employees who were participating in the plan on December 31, 2006, the money that is contributed is vested 100% immediately. For employees who began participating in the plan after December 31, 2006, the money that is contributed is vested as follows: 0% after one year of service, 25% after 2 years of service, 50% after 3 years of service, 75% after 4 years of service and 100% after 5 years of service.

You will receive quarterly statements from TIAA.

Q: Is there a limit to the amount the Laboratory will contribute?
A: Yes. The Internal Revenue Service (IRS) limits the amount of your annual Base Salary that can be used for the purpose of contributions to the Plan, and such limit is subject to change.

Q: How do I sign up?
A: If you become eligible to participate in the plan, you will automatically be enrolled in the plan in our default investment fund, the TIAA-CREF Lifecycle Fund, based on your year of birth, and your estate will be designated as your beneficiary. You will receive information from TIAA on the Lifecycle Fund and how to change your asset allocation and your beneficiary designation.

Q: Can I make changes to my investment allocations?
A: Yes. You can change your allocation of contributions among the various investment options at any time. If you want to change the allocation, you must contact TIAA directly.

Q: Can I make changes to my beneficiary(ies)?
A: Yes. To change the beneficiary(ies) for your Retirement Plan you must complete a Designating Your Beneficiaries form. Contact the Benefits Office or go to www.bnl.gov/hr/Benefits/retirement/default.asp for the form.

Q: Are loans available from the plan?
A: No.

Q: Are withdrawals available from this plan?
A: Employees are not permitted to take withdrawals from this plan. Withdrawals may be available after termination of employment. Restrictions apply.

Q: Does this plan accept rollover contributions from other plans?
A: No.

Q: Where can I get more information on the plan?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/ or www.tiaa-cref.org/bnl or through the Benefits Office at ext. 7516.

401(k) Plan

We are pleased to offer you the BSA 401(k) Plan. You can choose to invest 401(k) contributions in approved investment funds.

Q: Is enrollment in the 401(k) Plan voluntary?
A: Yes.

Q: Am I eligible to participate?
A: If you are a full-time employee, you are eligible to participate in this plan as of your first day of employment. If you work on a part-time, temporary or irregular basis, you may participate as of the earlier of January 1 or July 1 following the completion of 1,000 hours of service during the 12 consecutive calendar month period beginning with your date of employment. Persons with guest or visitor appointments are not eligible to participate in this plan.

Q: What is the benefit?
A: This plan enables you to increase your retirement savings in addition to the contributions, if any, under the Retirement Plan. Contributions to this plan are made through regular pre-tax payroll deductions. This reduces your taxable income, so you pay less tax now. All interest and earnings on the money you invest are tax-deferred until you withdraw them in the future. The money that is contributed is 100% vested immediately.

You may contribute up to 25% of your gross pay to this plan. In addition, participants age 50 or over may make additional catch-up contributions to the plan. The maximum catch-up contribution is limited by the Internal Revenue Service (IRS) and is subject to change.

You can allocate the contributions between approved investment funds. The list of funds is on page 24.

You will receive quarterly statements from TIAA.

Q: Is there a limit to the amount you may contribute?
A: Yes. The IRS limits the amount of your annual Base Salary that can be used for the purpose of contributions to the Plan. In addition, the IRS limits the dollar amount that you may contribute each year, including any contributions you may have made to another employer's retirement plan during the calendar year. These limits are subject to change.

Q: When can I sign up?
A: You may sign up at any time.

Q: How do I sign up?
A: Login to PeopleSoft HR and then go to Employee Self Service, Benefits, and Enroll In or Update my 401(k). Enter the percentage of your salary you want to contribute. This is called your salary reduction percentage. If you are age 50 or over during this calendar year, you will also have the option to do a catch-up contribution. If you do not have access to a computer or are unable to enroll online, contact the Benefits Office at ext. 7516 and a representative will assist you.

Q: Can I make changes to my investment allocations?
A: Yes. You can change your allocation of contributions among the various investment options at any time. You can change the percentage you are contributing to the plan once each calendar month. This includes a change from no contributions to starting contributions and vice versa. You can, however, cease your contributions at any time.

If you want to change the allocation of your investments, you must contact TIAA directly. If you want to change the percentage you are contributing, contact the Benefits Office for additional information, or log into PeopleSoft HR and click the following links: Employee Self-Service, Benefits, and then select Change My 401(k).

Q: Can I make changes to my beneficiary(ies)?
A: Yes. To change the beneficiary(ies) for your 401(k) Plan you must complete a Designating Your Beneficiaries form. Contact the Benefits Office or go to www.bnl.gov/hr/Benefits/retirement/default.asp for the form.

Q: Are loans available from the plan?
A: Yes. Loans are permitted from a participant's TIAA accumulations in this plan.

Q: Are withdrawals available from this plan?
A: Withdrawals are permitted from this plan if:

- The participant retires, dies, or terminates employment or
- The participant attains age 59 ½ or
- The participant incurs a financial hardship. (Restrictions apply.)

Q: Does this plan accept rollover contributions from other plans?
A: Yes. A participant may make rollover contributions to this plan upon providing proof that the contribution is eligible for transfer to this plan. Transfers from the following plan types are eligible: 401(a), 403(a), 401(k), 403(b), 457(b) or conduit IRAs (pre-tax).

Q: Where can I get more information on the plan?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/ or www.tiaa-cref.org/bnl or through the Benefits Office at ext. 7516.

Funds Available For Investment*
(Effective October 14, 2016)

Ticker Code	Fund	Type of Fund
	Annuity/Variable Annuity	
	TIAA Traditional Annuity	Guaranteed Annuity
	CREF Money Market Account R3 (Converted to a government type money market account by 10/14/16)	Government
	CREF Social Choice Account	Balanced
	CREF Stock Account	Equity
	CREF Growth Account	Equity
	TIAA Real Estate Account	Real Estate
	Mutual Funds	
VMFXX	Vanguard Federal Money Market Fund (Available on 7/1/16)	Government
VMRXX	Vanguard Prime Money Market Fund**** (Closed to future investments on 7/19/16)	Money Market
VIPIX	Vanguard Inflation Protected Securities Inst.	Fixed Income
VBTIX	Vanguard Total Bond Market Index Inst.	Fixed Income
PTTRX	PIMCO Total Return	Fixed Income
VWIAX	Vanguard Wellesley Income	Balanced
VWENX	Vanguard Wellington	Balanced
TIGRX	TIAA-CREF Growth & Income Institutional	Equity
BSFIX	Baron Small Cap	Equity
VTSNX	Vanguard Total Intl Stock Index Institutional	Equity
RERGX	American Funds EuroPacific Growth	Equity
CDDYX	Columbia Dividend Income Y	Equity
FLMVX	JPMorgan Mid Cap Value	Equity
WFDSX	Wells Fargo Advantage Discovery	Equity
GSSIX	Goldman Sachs Small Cap Value	Equity
VITSX	Vanguard Total Stock Market Index Inst.	Equity
TIREX	TIAA-CREF Real Estate Securities Institutional	Real Estate
	Lifecycle Funds	
TCTIX	TIAA-CREF Lifecycle 2010 Fund Institutional**	Multi-Asset
TCNIX	TIAA-CREF Lifecycle 2015 Fund Institutional**	Multi-Asset
TCWIX	TIAA-CREF Lifecycle 2020 Fund Institutional**	Multi-Asset
TCYIX	TIAA-CREF Lifecycle 2025 Fund Institutional**	Multi-Asset
TCRIX	TIAA-CREF Lifecycle 2030 Fund Institutional**	Multi-Asset
TCIIX	TIAA-CREF Lifecycle 2035 Fund Institutional**	Multi-Asset
TCOIX	TIAA-CREF Lifecycle 2040 Fund Institutional**	Multi-Asset
TTFIX	TIAA-CREF Lifecycle 2045 Fund Institutional**	Multi-Asset
TFTIX	TIAA-CREF Lifecycle 2050 Fund Institutional**	Multi-Asset
TTRIX	TIAA-CREF Lifecycle 2055 Fund Institutional**	Multi-Asset
TLXNX	TIAA-CREF Lifecycle 2060 Fund Institutional** (Available on 5/9/16)	Multi-Asset
	Self-Directed Brokerage Account* **	
	Visit TIAA website at www.tiaa-cref.org/bnl or call TIAA at (800) 927-3059.	Mutual Funds Available

***TIAA is the recordkeeper for these investment funds**. Effective 2/29/16, TIAA-CREF changed its name to TIAA. For information on each fund's performance, refer to the fund's prospectus. For information on the fees and expenses assessed on your account by each fund, refer to the Plan's fee disclosure materials available at www.tiaa-cref.org/bnl.

**These are the Qualified Default Investment Alternative (QDIA) funds.

***BSA will not monitor the performance of the funds in your personal Brokerage Account and TIAA does not offer investment advice for the Brokerage assets.

****Vanguard Prime Money Market Fund – Closed to future investments on 7/19/16. Any existing assets in this fund as of that date will be transferred to the replacement investment option: Vanguard Federal Money Market Fund.

Other Programs and Benefits

Employee Assistance Program (EAP)

The EAP is a free, voluntary, confidential service, providing employees with assessments, consultations, and referrals. It is designed to assist employees and household members in dealing with a variety of personal concerns such as depression, marital difficulties, concerns with children, alcoholism, and financial issues and provides 1-5 free visits per calendar year, per family member per identified problem. Assistance with geriatric case management is also available. You can contact Magellan at (800) 327-2182. They are available 24 hours a day, 365 days a year.

The EAP counselor will listen to your concerns and identify key issues of your particular situation. The EAP counselor will then assist you in devising a plan of action. Your problem may be resolved through consultation, support, or information. However, if you need further assistance, you may be referred to a counselor, social service, consumer credit, or self-help groups. If an employee has used the EAP for one type of problem and a new problem is identified, an additional 5 visits are available. Although the EAP does not perform long term treatment, after the initial diagnostic or crisis visits are exhausted, if the person needs more counseling in order to resolve the problem, every effort will be made to link the employee to providers who are part of their medical insurance program. Through the EAP, you can find productive solutions to personal problems and improve your health and well-being.

You can also access Magellan's website at www.magellanassist.com. Sign in as an "Existing User" or as a "New or Unregistered User". The toll-free number is (800) 327-2182.

Adoption Assistance Program

All regular employees who work at least 20 hours per week are eligible to participate in this program.

The Adoption Assistance Program provides eligible employees financial assistance up to a maximum of $5,000 per adopted child for certain expenses related to the adoption of an unrelated minor child under the age of eighteen (18). The adoptive child may not be a relative or stepchild. A $10,000 maximum applies if both spouses/same-sex domestic partners work for BNL.

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

The following expenses are reimbursable:

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

In order to be eligible for this program, you must notify the Benefits Office, ext. 2881, in writing within 30 days of the time an adoption proceeding has commenced.

Additional information is available through the Benefits Office at ext. 2881.

Child Development Center (CDC)

All employees, guests or contractors are eligible to enroll their children in the Child Development Center. Space permitting, aunts, uncles and grandparents with affiliations to the Laboratory are also eligible to enroll their nieces, nephews and grandchildren. Full-time and part-time enrollment options are available.

The CDC offers a day care program for children between the ages of six weeks to five years. The Center is open on weekdays from 7:30 a.m. to 6:00 p.m. throughout the year except for Laboratory holidays. The emphasis is on each individual child's process of learning. The Center is managed by Bright Horizons Family Solutions and is licensed by the New York State Department of Social Services and accredited by the National Association for the Education of Young Children (NAEYC). NAEYC accreditation identifies the Center as accomplishing the highest standards possible for early childhood education and establishes compliance, through professional review, to meet NAEYC's highest quality early childhood criteria.

In addition the drop-in care program allows families to access high-quality childcare on an as-needed basis for children between the ages of six weeks to five years.

Additional information is available on the web at www.bnl.gov/HR/CDC/ChildDevCntr.asp, or at ext. 7416.

Other Programs and Benefits

Tuition Assistance Program

All regular employees who work at least 20 hours per week are eligible to participate in this program as of your first day of employment.

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

Additional information is available on the web at https://sbms.bnl.gov/sbmsearch/subjarea/137/137_SA.cfm, or through the Tuition Office at ext. 7631.

Flexible Work Schedule

The Laboratory believes that flexible schedules can help our staff accomplish more while simultaneously addressing their personal needs such as attending college, raising children, caring for elderly parents and volunteering in the community. We have three flexible work arrangements: FlexMonth, CoreHours and TeleWork. Additional information is available at https://sbms.bnl.gov/sbmsearch/subjarea/198/198_SA.cfm.

Travel Accident Insurance Plan

All regular, temporary and part-time employees, visiting scientists, guests, and members of the Board of Directors are eligible for this plan. You do not need to enroll, and the cost is paid for by the Laboratory.

The Travel Accident Insurance Plan provides 24-hour benefits for accidental death and dismemberment and permanent and total disability while on authorized Laboratory business travel. Coverage begins at the actual starting point of an anticipated trip, whether this is your place of employment, your home, or some other location, whichever occurs last. Coverage terminates upon your return to home or place of employment, whichever occurs first.

Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 7516 or ext. 2881.

Sick Leave

All employees who work at least 20 hours per week are eligible for this benefit. Sick leave accrual is prorated for part-time regular employees and employees on part-time term appointments based on their official work schedules. Part-time temporary employees are not eligible for this benefit.

Sick leave is granted to provide continuity of income during absences due to illness or injury. Sick leave accrues at the rate of 1 ¼ days for each full month of service up to a maximum of 108 days.

Additional information is available on the web at https://sbms.bnl.gov/SBMSearch/ld/ld13/ld13d141.htm.

Vacation

All employees who work at least 20 hours per week are eligible for this benefit. Vacation accrual is prorated for eligible part-time employees based on their official work schedules. Temporary employees are not eligible for this benefit.

Vacation credit accrues regularly during the course of your employment to allow you a scheduled period for rest and relaxation.

If you are on a weekly payroll, vacation credit accrues monthly according to the following schedule:

Less than 5 years of service:	1 day for each full month of continuous service
At least 5 years of service, but less than 10 years:	1 ¼ days for each full month of continuous service
At least 10 years of service, but less than 15 years:	1 ½ days for each full month of continuous service
15 or more years of service:	2 days for each full month of continuous service

If you are on a monthly payroll, vacation credit accrues monthly according to the following schedule:

Less than 5 years of service:	1 ½ days for each full month of continuous service
At least 5 years of service, but less than 10 years:	1 ¾ days for each full month of continuous service
10 or more years of service:	2 days for each full month of continuous service

Additional information is available on the web at https://sbms.bnl.gov/SBMSearch/ld/ld13/ld13d131.htm.

Other Programs and Benefits

Holidays

All employees who work at least 20 hours per week (except those employees who are in an ineligible part-time or temporary part-time employment category) are eligible for this benefit.

The following nine regularly scheduled holidays are observed by the Laboratory.

New Year's Day	Independence Day	Thanksgiving Day
Presidents' Day	Labor Day	Friday after Thanksgiving Day
Memorial Day	Veterans Day	Christmas Day

Two additional holidays observed during the year are announced each January. In addition, a half-day holiday will be observed usually consisting of the last four hours of your regularly scheduled day preceding Christmas.

Employee Discounts

All employees are eligible for the following discount programs.

Brookhaven Employees Recreation Association (BERA) Employee Discount Program
The BERA Discount Program provides discounts to events, trips, stores, services, etc. Additional information is available on the web at www.bnl.gov/bera/recreation/discounts.asp.

National Vision, Inc.
National Vision Inc. helps participants enjoy good vision health and save money on vision care needs. The program is easy to use. You pay National Vision, Inc. directly for all professional services and receive instant savings from the program's reduced fees. National Vision, Inc. is located in the Wal-Mart store in Middle Island at 750 Middle Country Road and can be reached at (631) 345-0065.

Recreation

The Laboratory provides and maintains on-site recreation facilities and encourages employees, visitors, guests and facility users to participate in a broad program of social, cultural and athletic events. Recreation facilities located on the Laboratory site include an indoor swimming pool with locker and shower rooms, a gymnasium with exercise and weight rooms, tennis courts, a recreation park with softball, football and soccer fields, and a recreation building for meetings and parties.

Additional information is available on the web at www.bnl.gov/bera/.

Qualifying Events

Q: What is a Qualifying Event?
A: 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 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 gross misconduct
(d) change in work schedule: (1) an increase or decrease in the number of hours of employment by the employee, spouse or dependent, (2) a switch between full-time and part-time status, (3) a strike or lockout, (4) commencement or return from an unpaid leave of absence
(e) the dependent satisfies or ceases to satisfy the requirements for unmarried dependents: (1) due to attainment of age, (2) student status
(f) change in the place of residence or work site of the employee, spouse or dependent

Q: What coverages can I change if I have a Qualifying Event?
A: For the Medical and/or Dental Programs, you may be eligible to add or delete dependents, or add or drop coverage. For the Reimbursement Accounts, you may be eligible to make changes to your contributions for the remainder of the calendar year. The change(s) in coverage that you request must relate to the change that affects eligibility for coverage.

Q: Are there any other circumstances under which I can enroll myself or a dependent?
A: Yes. Based on the provisions of the Children's Health Insurance Program 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.

Q: How do I change my coverage(s)?
A: To change your coverage(s) when a Qualifying Event has occurred, you must notify the Benefits Office and complete an enrollment form within 31 days of the date of the Qualifying Event for all items indicated above, except (a)(3), (a)(4), (e)(1) and (e)(2). [60 days applies for items (a)(3), (a)(4), (e)(1) and (e)(2).] Employees who qualify under CHIPRA have 60 days from the date of the termination of such coverage or eligibility for a premium assistance subsidy to notify the Benefits Office. The completed form must be submitted, with proof of the Qualifying Event, to the Benefits Office. Your employee premiums (for Medical and/or Dental Program coverages) and/or your contributions (to the Reimbursement Accounts) will then be changed for the remainder of the calendar year.

Q: When are coverage changes effective?
A: If you notify the Benefits Office of the Qualifying Event and provide the completed enrollment form within the applicable period, the change in coverage will become effective as of the date of the Qualifying Event.

If a dependent is no longer eligible for coverage and you do not remove that dependent from your coverage within the applicable Qualifying Event period, his/her coverage will end as of the date he/she is no longer eligible.

You must notify the Benefits Office within the applicable period for addition of an eligible dependent. If you only notify the Medical and/or Dental Insurance Company directly, we may be unable to make the change until the next Open Enrollment period.

Q: When is the Open Enrollment period and what changes can I make?
A: Refer to the Open Enrollment section.

Q: Where can I get more information on the programs?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 5126, or ext. 2877.

Required Notices

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
- Treatment of physical complications in all stages of mastectomy, including lymphedema
- Mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs

The Medical 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, coinsurance and copayment amounts that are consistent with those that apply to other benefits under the Medical Plan.

Comprehensive Welfare Benefits Plan Notice Of Privacy Practices

Brookhaven Science Associates, LLC ("BSA") continues its commitment to maintaining the confidentiality of your private medical information. This Notice describes our efforts to safeguard your health information from improper or unnecessary use or disclosure. This Notice applies only to health-related information received by or on behalf of the Medical and Dental Benefit Options and the Health Care Reimbursement Account Benefit Option under the Brookhaven Science Associates, LLC Comprehensive Welfare Benefits Plan (the "Health Plan"). A federal law requires us to provide you with a summary of the Health Plan's privacy practices and related legal duties, and your rights in connection with the use and disclosure of your Health Plan information.

This Notice applies to BSA employees, former employees, and dependents who participate in the Health Plan.

In this Notice, the terms "we," "us," and "our" refer to the BSA Health Plan, all BSA employees involved in the administration of the BSA Health Plan, and all third parties who perform services for the BSA Health Plan. Actions by or obligations of the Health Plan include these BSA employees and third parties. However, BSA employees perform only limited Health Plan functions – most Health Plan administrative functions are performed by third party service providers.

Please note: This Notice does not apply to HMO or fully insured medical, dental, or vision benefit options. If you are enrolled in an HMO or a fully insured medical or dental benefit option, you will receive a separate notice from your HMO provider or insurance company. This Notice also does not apply to BSA's On-site Medical Clinic.

What is Protected?

Federal law requires the Health Plan to have a special policy for safeguarding a category of medical information called "protected health information," or "PHI," received or created in the course of administering the BSA Health Plan. PHI is information about your past, present or future health or condition that can be used to identify you and that relates to:

- your physical or mental health condition,
- the provision of health care to you, or
- payment for your health care.

Your medical and dental records, your claims for medical and dental benefits, and the explanation of benefits sent in connection with payment of your claims are all examples of PHI. Employment records maintained by BSA in its capacity as employer are not PHI.

If BSA obtains your health information in another way (for example, if you are hurt in a work accident or if you provide medical records with your request for Family and Medical Leave Act absence), then BSA will safeguard that information in accordance with the employee manual and applicable laws. Similarly, health information obtained by a non-health-related benefits program, such as the long-term disability program, is not protected under this Notice. This Notice does not apply in those types of situations because the health information is not received or created in connection with the BSA Health Plan.

The remainder of this Notice generally describes our rules with respect to your PHI received or created by the Health Plan.

Uses and Disclosures of Your PHI

To protect the privacy of your PHI, the Health Plan not only guards the physical security of your PHI, but we also limit the way your PHI is used or disclosed to others. For routine uses and disclosures, your authorization is not required, but for other uses and disclosures, your authorization (or the authorization of your personal representative) may be required. We may use or disclose your PHI in certain permissible ways described below. To the extent required under federal health information privacy law, we use the minimum amount of your PHI necessary to perform these tasks.

- To determine proper payment of your Health Plan benefit claims. The Health Plan uses and discloses your PHI to reimburse you or your health care providers for covered treatments and services. For example, your diagnosis information may be used to determine whether a specific procedure is medically necessary or to reimburse your doctor for your medical care.
- For the administration and operation of the Health Plan. We use and disclose your PHI for numerous administrative and quality control functions necessary for the Health Plan's proper operation. For example, we may use your claims information for cost-control or planning-related purposes.
- To inform you or your health care provider about treatment alternatives or other health-related benefits that may be offered under a Health Plan. For example, we may use your claims data to alert you to an available case management program if you become pregnant or are diagnosed with diabetes or liver failure.
- To a health care provider if needed for your treatment. For example, we may disclose your prescription information to a pharmacist regarding a drug interaction concern.
- To a health care provider or to a non-BSA health plan to determine proper payment of your claim under the other plan. For example, we may exchange your PHI with your spouse's health plan for coordination of benefits purposes.
- To a non-BSA health plan for certain administration and operations purposes. We may share your PHI with another health plan or health care provider who has a relationship with you for quality assessment and improvement activities, to review the qualifications of health care professionals who provide care to you, or for fraud and abuse detection and prevention purposes.

- To a family member, friend, or other person involved in your health care if you do not object (or it can be inferred that you do not object) to the sharing of your PHI directly relevant to the person's involvement, and, if you are not present or are unable to object due to incapacity or emergency, the disclosure is in your best interest.
- To comply with an applicable federal, state, or local law, including workers' compensation or similar programs.
- For public health reasons, including (1) to a public health authority for the prevention or control of disease, injury or disability; (2) to a proper government or health authority to report child abuse or neglect; (3) to report reactions to medications or problems with products regulated by the Food and Drug Administration; (4) to notify individuals of recalls of medication or products they may be using; or (5) to notify a person who may have been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition.
- To report a suspected case of abuse, neglect or domestic violence, as permitted or required by applicable law.
- To comply with health oversight activities, such as audits, investigations, inspections, licensure actions, and other government monitoring and activities related to health care provision or public benefits or services.
- To the U.S. Department of Health and Human Services to demonstrate our compliance with federal health information privacy law.
- To respond to an order of a court or administrative tribunal.
- To respond to a subpoena, warrant, summons or other legal request if sufficient safeguards, such as a protective order, are in place to maintain your PHI privacy.
- To a law enforcement official for a law enforcement purpose.
- For purposes of public safety or national security.
- To allow a coroner or medical examiner to identify you or determine your cause of death.
- To allow a funeral director to carry out his or her duties.
- To respond to a request by military command authorities if you are or were a member of the armed forces.
- To business associates. We may enter into agreements with entities or individuals to provide services (for example, claims processing services) to one or more of the Health Plans. These service providers, called "business associates," may create, receive, have access to, use, and/or disclose (including to other business associates) PHI in conjunction with the services they provide to the Health Plan(s), provided that we have obtained satisfactory written assurances that the business associates will comply with all applicable Privacy Rules with respect to such Health Plan(s).
- For research purposes. We may use or disclose a "limited data set" of your PHI for certain research purposes.

In no event will we use or disclose PHI that is genetic information for underwriting purposes. In addition to rating and pricing a group insurance policy, this means the Health Plans may not use genetic information (including that requested or collected in a health risk assessment or wellness program) for setting deductibles or other cost sharing mechanisms, determining premiums or other contribution amounts, or applying preexisting condition exclusions.

Certain BSA employees may access your PHI to perform administrative functions on behalf of the Health Plan. Absent your written permission however, BSA employees will only use or disclose your PHI as described above. BSA employees will not access your PHI for reasons unrelated to Health Plan administration. BSA does not use your PHI for any employment-related reason without your express written authorization.

State law may further limit the permissible ways the Health Plan uses or discloses your PHI. If an applicable state law imposes stricter restrictions on the Health Plan, we will comply with that state law.

Other Uses and Disclosures of Your PHI
Before we use or disclose your PHI for any other purpose, we must obtain your written authorization. This includes disclosures of PHI containing psychotherapy notes (except as necessary for the Health Plans' treatment, payment and healthcare operating purposes), for many marketing purposes and for any sale of your PHI, each as defined under HIPAA regulations.

You may revoke your authorization, in writing, at any time. If you revoke your authorization, the Health Plan will no longer use or disclose your PHI except as described above (or as permitted by any other authorizations that have not been revoked). However, we cannot retrieve any PHI disclosed to a third party in reliance on your prior authorization.

Uses and Disclosures Requiring You to have an Opportunity to Object
The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights
Federal law provides you with certain rights regarding your PHI. Parents of minor children and other individuals with legal authority to make health decisions for a Health Plan participant may exercise these rights on behalf of the participant, consistent with state law.

- Right to request restrictions: You have the right to request a restriction or limitation on the Health Plan's use or disclosure of your PHI. For example, you may ask us to limit the scope of your PHI disclosures to a case manager who is assigned

to you for monitoring a chronic condition. Because we use your PHI only as necessary to pay Health Plan benefits, to administer the Health Plan, and to comply with the law, it may not be possible to agree to your request. *The law does not require the Health Plan to agree to your request for restriction.* However, if we do agree to your requested restriction or limitation, we will honor the restriction until you agree to terminate the restriction or until we notify you that we are terminating the restriction on a going-forward basis.

- You may make a request for restriction on the use and disclosure of your PHI to the Benefits Office. Contact information for the Benefits Office is listed at the end of this Notice. When making such a request, you must specify: (1) the PHI you want to limit; (2) how you want the Health Plan to limit the use, disclosure, or both of that PHI; and (3) to whom you want the restrictions to apply.
- Right to receive confidential communications: You have the right to request that the Health Plan communicate with you about your PHI at an alternative address or by alternative means if you believe that communication through normal business practices could endanger you. For example, you may request that the Health Plan contact you only at work and not at home.
- You may request confidential communication of your PHI by contacting the Benefits Manager. You should send your written request for confidential communication to the Benefits Office at the address listed at the end of this Notice. We will accommodate all reasonable requests if you clearly state that you are requesting the confidential communication because you feel that disclosure in another way could endanger your safety. You must make sure your request specifies how or where you wish to be contacted.
- Right to inspect and copy your PHI: You have the right to inspect and copy your PHI that is contained in records that the Health Plan maintains for enrollment, payment, claims determination, or case or medical management activities, or that we use to make enrollment, coverage, or payment decisions about you.
- However, we will not give you access to PHI records created in anticipation of a civil, criminal, or administrative action or proceeding. We will also deny your request to inspect and copy your PHI if a licensed health care professional hired by the Health Plan has determined that giving you the requested access is reasonably likely to endanger the life or physical safety of you or another individual or to cause substantial harm to you or another individual, or that the record makes references to another person (other than a health care provider), and that the requested access would likely cause substantial harm to the other person. In the unlikely event that your request to inspect or copy your PHI is denied, you may have that decision reviewed. A different licensed health care professional chosen by the Health Plan will review the request and denial, and we will comply with the health care professional's decision. You may make a request to inspect or copy your PHI by contacting the Benefits Manager. You have a right to choose what portions of your information you want copied and to receive. Your written request should be sent to the Benefits Office at the address at the end of this Notice. We may charge you a fee to cover the costs of copying, mailing or other supplies directly associated with your request. You will be notified of any costs before you incur any expenses.
- Right to amend your PHI: You have the right to request an amendment of your PHI if you believe the information the Health Plan has about you is incorrect or incomplete. You have this right as long as your PHI is maintained by the Health Plan. We will correct any mistakes if we created the PHI or if the person or entity that originally created the PHI is no longer available to make the amendment.
- You may request amendments of your PHI by contacting the Benefits Manager. Your written request to amend your PHI should be sent to the Benefits Office at the address listed at the end of this Notice. Be sure to include evidence to support your request because we cannot amend PHI that we believe to be accurate and complete. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI.
- Right to receive an accounting of disclosures of PHI: You have the right to request a list of certain disclosures of your PHI by the Health Plan. The accounting will not include (1) disclosures necessary for treatment, to determine proper payment of benefits or to operate the Health Plan, (2) disclosures we make to you, (3) disclosures permitted by your authorization, (4) disclosures to friends or family members made in your presence or because of an emergency, (5) disclosures for national security purposes or law enforcement, or (6) as part of a limited data set. Your first request for an accounting within a 12-month period will be free. We may charge you for costs associated with providing you additional accountings. We will notify you of the costs involved, and you may choose to withdraw or modify your request before you incur any expenses.
- You may request an accounting of disclosures of your PHI from the Benefits Office. Contact information for the Benefits Office is listed at the end of this Notice. When making such a request, you must specify the time period for the accounting, which may not be longer than six (6) years and may not include dates prior to April 14, 2003, and the form (*e.g.*, electronic, paper) in which you would like the accounting.
- Right to file a complaint: If you believe your rights have been violated, you should let us know immediately. We will take steps to remedy any violations of the Health Plan privacy policy or of this Notice.

You may file a formal complaint with our Privacy Officer and/or with the United States Department of Health and Human Services at the addresses at the end of this Notice. You should attach any documents or evidence that supports your belief that your privacy rights have been violated. We take your complaints very seriously. BSA prohibits retaliation against any person for filing such a complaint. Complaints should be sent to:

Brookhaven Science Associates, LLC
Brookhaven National Laboratory
Attention: Benefits Office
P.O. Box 5000, Bldg. 400B
Upton, NY 11973-5000

Attn: Privacy Officer
(631) 344-2881

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
www.hhs.gov/ocr/hipaa/

Additional Information About This Notice

Changes to this Notice: We reserve the right to change the Health Plan's privacy practices as described in this Notice. Any change may affect the use and disclosure of your PHI already maintained by the BSA Health Plan, as well as any of your PHI that the Health Plan may receive or create in the future. If there is a material change to the terms of this Notice, you will receive a revised Notice.

How to obtain a copy of this Notice: You can obtain a copy of the current Notice on the BSA Intranet or by writing to the Benefits Office at the address listed above.

No guarantee of employment: This Notice does not create any right to employment for any individual, nor does it change BSA's right to discharge any of its employees at any time, with or without cause.

No change to Health Plan benefits: This Notice explains your privacy rights as a current or former participant in the BSA Health Plan. The Health Plan is bound by the terms of this Notice as they relate to the privacy of your protected health information. However, this Notice does not change any other rights or obligations you may have under the Health Plan. You should refer to the Health Plan documents for additional information regarding your Health Plan benefits.

Notification of a Privacy Breach

The Plan must notify you within 60 days of discovery of a breach. A breach occurs if unsecured PHI is acquired, used or disclosed in a manner that is impermissible under the Privacy Rules, unless there is a low probability that the PHI has been compromised.

Contact Information

If you have any questions regarding this Notice, please contact the Benefits Office at (631) 344-2881.

Continuation Coverage Rights Under COBRA

Introduction

This notice applies to you if you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this 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."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Brookhaven Science Associates, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, 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 Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

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 Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Benefits Office.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA

continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

Disability Extension of 18-month Period of Continuation Coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

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

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

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

Plan Contact Information
If you have any questions, please contact the Benefits Office at (631) 344-5126 or (631) 344-2877, or write to: Brookhaven Science Associates, LLC, Brookhaven National Laboratory, Attention: Benefits Office, P.O. Box 5000, Bldg. 400B, Upton, N.Y. 11973.

This Notice is current based on the Department of Labor's website and is required to be distributed by law.

New Health Insurance Marketplace Coverage Options And Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Brookhaven Science Associates, LLC,, Brookhaven National Laboratory, Benefits Office, P.O. Box 5000, Bldg. 400B, Upton, NY 11973.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs

PART B: Information About Health Coverage Offered By Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Brookhaven Science Associates, LLC	4. Employer Identification Number (EIN) 11-3403915	
5. Employer Address Brookhaven National Laboratory, P.O. Box 5000	6. Employer phone number 631-344-2877	
7. City Upton	8. State NY	9. ZIP code 11973
10. Who can we contact about employee health coverage at this job? Benefits Office at number listed above		
11. Phone number (if different from above)	12. E-mail address schuchman@bnl.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees.

☑ Some employees. Eligible employees are:

All regular employees of Brookhaven Science Associates, LLC (the "Employer") who work at least 20 hours per week are eligible to participate in the group Medical Plan on the first day of active employment.

An employee is a "regular employee" if he/she is classified and treated for federal income tax purposes by the Employer as a regular full-time or regular part-time employee of the Employer (as opposed to a temporary, seasonal or casual employee, intern, independent contractor or consultant, agency worker or leased employee), even if the Employer's classification is later determined to be incorrect.

Employees who work an average of 30 or more hours per week and are employed for 90 days or more may be eligible to enroll in the Medical Plan on the 90th day of employment. Additional Affordable Care Act criteria may apply.

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

- Your spouse to whom you are legally married.
- Your child(ren) up to the end of the month of his or her 26th birthday, including adopted children and stepchildren. Children include your natural child, adopted child, and stepchild.
- Coverage may be continued for your eligible dependents who are age 26 or over 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 from the date of incapacity or 31 days from the child's 26th birthday, whichever occurs first.

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The employer-sponsored health plan meets the "minimum value standard." The plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

Creditable Coverage Notice

Important Notice from BSA About Your Prescription Drug Coverage and Medicare
(For Medicare-eligible Participants in the BSA Medical Plan through Aetna)

If you and/or your covered dependents are not Medicare eligible, this document is for information purposes only. However, if any of your covered benefit eligible dependents are Medicare eligible, please read this information carefully so that you and your dependents can make an informed decision regarding their prescription drugs.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with BSA and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. BSA has determined that the prescription drug coverage offered to participants in the Aetna medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug coverage.

When can you join a Medicare Drug Plan?
You can join a Medicare drug plan when they first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current BSA coverage will not be affected. You and your dependents can enroll in a Part D plan as a supplement to, or in lieu of, the group health plan coverage.

Under your coverage with BSA, you are currently offered a prescription drug program that covers the following depending on the medical plan to which you are enrolled:

PLAN & BENEFIT: AETNA PRESCRIPTION DRUG BENEFIT	**AETNA POS PLAN 1**	**AETNA POS PLAN 2**	**AETNA POS PLAN 3**
PRESCRIPTION DRUGS (in-network only)			
DEDUCTIBLE/YR (Individual/Family) (Deductible is combined for retail & mail order)	$100/$300	$100/$300	$100/$300
RETAIL: up to 30-day supply*			
TIER 1 (generic)	$10	$10	$10
TIER 2 (brand name in Aetna's formulary)	$25	$30	$35
TIER 3 (brand name not in Aetna's formulary)	$40	$50	$60
TIER 4 (specialty drugs)	$50	$60	$70
PLAN & BENEFIT: AETNA PRESCRIPTION DRUG BENEFIT	**AETNA POS PLAN 1**	**AETNA POS PLAN 2**	**AETNA POS PLAN 3**
MAIL ORDER: 31-90-day supply *,**			
TIER 1 (generic)	$20	$20	$20
TIER 2 (brand name in Aetna's formulary)	$50	$60	$70
TIER 3 (brand name not in Aetna's formulary)	$80	$100	$120
TIER 4 (specialty drugs)	N/A	N/A	N/A

* After meeting a $100 per person / $300 per family annual drug deductible.
** Mail order can also be done through CVS retail pharmacy.

See the CMS Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and suspend your current BSA coverage, be aware that you and your dependents will be able to get this coverage back by re-enrolling in the BSA plan during an Open Enrollment period.

When will you pay a higher premium (penalty) to join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with BSA and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 days or longer without creditable drug coverage, your monthly premium will go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage contact:
Name of Entity/Sender: Brookhaven Science Associates, LLC
Contact: Benefits Office
Address: Brookhaven National Laboratory, Bldg. 400B
Upton, NY 11973
Phone Number: 631-344-2877, 631-344-5126 or 800-353-3521

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through BSA changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage**:**
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TYY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are not required to pay a higher premium (a penalty).

October 2016

Contact Information

Plan	Account/Plan #	Telephone #	Website/Email
Medical Insurance			
Aetna	869887	(855) 586-6961	www.aetna.com
Health Savings Account	139814	(888) 678-8242	www.aetna.com
Benefits Office	N/A	(631) 344-2877	schuchman@bnl.gov
		(631) 344-5126	egettler@bnl.gov
Dental Insurance			
Delta Dental DMO	NY76503	(800) 422-4234	www.deltadentalins.com
Delta Dental PPO and Indemnity	NY04970	(800) 932-0783	www.deltadentalins.com
Benefits Office	N/A	(631) 344-2877	schuchman@bnl.gov
		(631) 344-5126	egettler@bnl.gov
Reimbursement Accounts			
PayFlex	116036	(800) 284-4885	https://bnl.healthhub.com
Benefits Office	N/A	(631) 344-2877	schuchman@bnl.gov
		(631) 344-5126	egettler@bnl.gov
Life and AD&D Insurance			
Benefits Office	N/A	(631) 344-7516	bsoeyadi@bnl.gov
Long Term Disability Insurance			
Benefits Office	N/A	(631) 344-7516	bsoeyadi@bnl.gov
Retirement and 401(k) Plans	Retirement / 401(k)		
TIAA	100945 / 100946	(800) 842-2776	www.tiaa-cref.org/bnl
One-on-One Financial Counseling	N/A	(800) 732-8353 M - F 8 a.m.-8 p.m.	www.tiaa-cref.org/schedulenow
Benefits Office	N/A	(631) 344-7516	bsoeyadi@bnl.gov
Adoption Assistance	N/A	(631) 344-2881	dimeglio@bnl.gov
Employee Assistance Program (EAP)	N/A	Available 24 hours 7 days/week 365 days/year (800) 327-2182	www.magellanhealth.com/member
Tuition Assistance	N/A	(631) 344-7631	munson@bnl.gov
Child Development Center	N/A	(631) 344-7416	www.bnl.gov/HR/CDC/ChildDevCntr.asp
Payroll	N/A	(631) 344-2470	http://intranet.bnl.gov/fsd/payroll.asp
Vacation	N/A	(631) 344-2470	N/A
Sick Leave	N/A	(631) 344-7516	bsoeyadi@bnl.gov
Family & Medical Leave Act (FMLA)		Initial call reporting FML: 24 hours 7 days per week 365 days/year (888) 408-7300 Follow-up calls with a leave specialist:: M - F 8 a.m.-8 p.m. (877) 353-7188	www.mylibertyconnection.com Company Code: BROOKHAVEN
Occupational Medicine Clinic	N/A	(631) 344-3670	http://intranet.bnl.gov/hr/occmed/
Brookhaven Employees Recreation Association (BERA)	N/A	(631) 344-2873	www.bnl.gov/bera/