BSA Benefits & You
2024 Open Enrollment

This booklet applies to the following participants who are <u>not eligible for Medicare</u>:

- Retirees
- Former non-IBEW employees who were approved for BSA long term disability (LTD) benefits after 12/31/08 and are receiving such LTD benefits
- Former IBEW employees who were approved for BSA long term disability (LTD) benefits after 12/31/11 and are receiving such LTD benefits
- Covered family members of the above three categories

Enroll in the coverage that's right for you!

Brookhaven National Laboratory

This publication is printed on 100% post-consumer recycled paper.

The information in this booklet is intended to provide only a summary of the benefit programs. If questions arise, official plan documents and insurance agreements are controlling and govern final determination of benefits consistent with applicable laws and regulations. **BSA reserves the right to amend or terminate the benefit programs at any time and for any reason.**

October 2023

It's Open Enrollment Time!

Now is the time to consider your needs, review your benefit coverages, and maybe make some changes to your medical, dental and/or vision care coverages for 2024.

WHAT IS OPEN ENROLLMENT?

Open enrollment is the time of the year when you should review the benefits available to you and make decisions for the coming year. Because there are changes to some of our benefit plans each year — changes that can affect how much you pay for your benefits and the coverage provided by the benefits, it's important to see what best meets your needs each year.

Have you had any changes in your life or expect any changes where a different plan might be a better choice than the plan in which you're currently enrolled? Last year's choices might not make sense for you in 2024.

WHEN IS OPEN ENROLLMENT FOR BENEFITS FOR 2024?

Monday, November 20, 2023 through Tuesday, December 5, 2023

Changes made during the Open Enrollment period will be effective on January 1, 2024.

ANNUAL BENEFITS FAIR

This year we will once again hold a virtual benefits fair for open enrollment including information on the plans available on our Benefits website at https://www.bnl.gov/hr/benefits/oe/ .

WHERE CAN I GET HELP?

More information is available on the Benefits website, including the Summary Plan Descriptions, at https://www.bnl.gov/hr/benefits/oe.

If you have additional questions, send an email to our Benefits Office staff at oe@bnl.gov or call (631) 344-4275, (631) 344-5558, (631) 344-8877.

IMPORTANT INFORMATION

WHAT'S CHANGING FOR 2024?

- The Medical Plan contributions have increased from 2023 to 2024. See page 9 for more information.
- The deductible for Aetna Plan 4 has increased to $1,600 for single-person coverage and $3,200 for family-level coverage.
- Dental contributions have remained the same from 2023 to 2024; for those on COBRA there is an increase. See page 10 for more information.
- The Vison Care Plan contribtuions have increased. See page 13 for more information.

WHAT BENEFIT ELECTIONS CAN I MAKE DURING OPEN ENROLLMENT?

WHAT HAPPENS TO MY BENEFITS IF I DON'T TAKE ACTION DURING OPEN ENROLLMENT?

Open Enrollment is the time during which you can do the following for the plans.

- Drop the plan(s)
- Change from one plan to another
- Add eligible family members to your plan –you'll need to provide additional documentation (birth and/or marriage certificate)
- Drop family members from your plan

If you do not make changes, you'll automatically remain in the plan(s) you have on December 31, 2023, if any. Any dependent children who are on your coverage on December 31, 2023 who are no longer eligible on January 1, 2024 will automatically be dropped from your coverage. (For instance, a child who reaches age 23 in 2023 and is in the dental plan will no longer be eligible for coverage in 2024.)

HOW TO CHANGE BENEFITS DURING OPEN ENROLLMENT

If you want to make a change to your coverage(s), contact the Benefits Office at , (631) 344-4275, (631) 344-5558, (631) 8877 no later than Tuesday, December 5, 2023

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

DEADLINES

The Open Enrollment period ends Tuesday, December 5, 2023. You must make your 2024 benefit elections by this deadline, or you will not be able to make a change during 2024 unless you have a Qualifying Event.

CAN I CHANGE MY BENEFITS DURING THE YEAR (OTHER THAN DURING OPEN ENROLLMENT)?

You may be eligible to make changes to your plans and who you cover during the year only if you have a **Qualifying Event**, such as a marriage, birth or adoption of your child, divorce or legal separation, death of a covered family member, a spouse's loss of coverage from his/her employer, etc.

To make changes to your benefits, you must contact the Benefits Office within a certain period of time (which differs based on the Qualifying Event). If you don't take action within the required timeframe, then you'll have to wait until the next Open Enrollment period to make changes. See page 15 for more information.

IF I HAVE QUESTIONS REGARDING MY MONTHLY BILL FOR MEDICAL, DENTAL, AND/OR VISION CARE COVERAGE, WHO SHOULD I CONTACT?

You should contact P&A Group, who issues the monthly bills. They can be reached at (800) 688-2611. If, after contacting P&A Group, you require further assistance, you may send an email to our Benefits Office staff at oe@bnl.gov or call (631) 344-4275, (631) 344-5558, (631) 344-8877.

CONTACT INFORMATION

Plans	Account/ Plan #	Telephone #	Website/Email
Aetna Medical	869887	(855) 586-6964	www.aetna.com
Delta Dental DMO	NY76503	(800) 422-4234	www.deltadentalins.com
Delta Dental PPO and Indemnity	NY04970	(800) 932-0783	www.deltadentalins.com
EyeMed Vision Care	VCN-1	(866) 800-5457	www.eyemed.com

IDENTIFICATION CARDS

Medical Plans

- If you enroll for the first time, Aetna will issue a new 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. If you change plans or add dependents, you will be able to download an updated digital identification card at www.aetna.com.

Dental Plans

- Delta Dental does not issue identification cards. If you want one, you can print one from their website at www.deltadentalins.com.

Vision Care Plan

- EyeMed does not issue identification cards. If you want one you can print one from their website at www.eyemed.com.

ADDITIONAL INFORMATION

- If you are an eligible family member of:
  - a current Medicare-eligible retiree who has been receiving coverage through the BSA medical plan

    or

  - a current Medicare-eligible participant who is receiving BSA Long Term Disability (LTD) Plan benefits who has been receiving coverage through the BSA medical plan,

  the retiree/LTD participant must elect and maintain medical coverage through BSA's healthcare insurance program through SelectQuote in order for you to be eligible to continue coverage under BSA's medical plan. If the retiree/LTD participant does not elect and maintain such coverage without a gap in coverage, you are no longer eligible for coverage in BSA's healthcare insurance program and cannot reenroll.

WHICH MEDICAL PLANS ARE AVAILABLE & WHAT'S THE DIFFERENCE BETWEEN THEM?

There are four Point of Service (POS) medical plans through Aetna available to you where you may use physicians and facilities of your choice worldwide.

When you use a provider or health care services, you pay for part of the cost of those services yourself in the form of copayments, deductibles, and coinsurance. Aetna's POS II (Open Access) 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 plans 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.

You can choose from the following medical plans:

- Aetna POS Plan 1
- Aetna POS Plan 2
- Aetna POS Plan 3
- Aetna POS Plan 4

Prescription drug coverage is provided through the Aetna medical plans. There are four tiers of prescription drugs: generic, brand name in Aetna's formulary, brand name not in Aetna's formulary and specialty.

See the next page for a comparison of the medical plans.

If you or a covered dependent attain age 65 or become eligible for Medicare in 2024, you must sign up for Medicare Parts A and B through the Social Security Administration. Any person who is eligible for Medicare will no longer be eligible for the Aetna Medical Plan and must elect healthcare coverage through SelectQuote Senior's healthcare exchange. Contact the Benefits Office for additional information.

If you are enrolled in one of the Aetna Medical Plans, you have access to medical care through phone or video consults 24 hours a day, 365 days a year. To request a consult, call Teladoc at 855-TELADOC, or go to www.teladoc.com/aetna/ to create your account and then request a consult, or go to www.teladoc.com/mobile/ to download the app from which you can request a consult.

SUMMARY OF COVERAGES THROUGH THE MEDICAL PLANS

	AETNA PLAN 1	AETNA PLAN 2	AETNA PLAN 3	AETNA PLAN 4
PROVIDER NETWORK	Aetna POS II (Open Access)			
IN-NETWORK				
Copay (PCP/Specialist) (per visit)	$20/$35	$25/$40	$30/$45	Deductible & coinsurance
Deductible/year (Individual/Family*)	$0	$150/$300	$300/$600	$1,600/$3,200
Coinsurance	0%	10%	20%	20%
Medical out-of-pocket maximum/year (includes deductible, copays, & coinsurance) (Individual/Family*)	$5,100/$10,200	$1,000/$2,000	$2,000/$4,000	$3,500/$8,000 Medical & prescription drugs combined
Prescription drugs out-of-pocket maximum/year (includes deductible, copays, & coinsurance) (Individual/Family*)	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	$3,500/$8,000 Medical & prescription drugs combined
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
Teladoc Dermatology (per telephonic visit)	$35	$40	$45	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/year (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/year (Individual/Family*) (Deductible is combined for retail & mail order)	$100/$300	$100/$300	$100/$300	Medical & prescription drugs 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

* For Aetna Plan 4: Individual = employee only coverage. Family = 2 or more people. Additional information applies.

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

HOW MUCH WILL THE MEDICAL PLAN COST IN 2024?

For participants who are <u>not</u> eligible for Medicare

Category	Contributions as a % of Medical Plan Cost	Coverage	Monthly Contribution			
			Plan 1	Plan 2	Plan 3	Plan 4
• Former non-IBEW employees who retired before 1/1/02 • Former IBEW employees who retired before 1/1/04 • Former IBEW employees who were approved for BSA LTD Plan benefits after 12/31/11 and are receiving such benefits	30%	1 Person	$368.41	$353.66	$335.09	$323.79
		2 People	$764.96	$734.34	$695.77	$662.42
		3 or More People	$1,016.99	$976.28	$925.01	$880.77
• Former non-IBEW employees who were hired before 1/1/11 and retired after 12/31/01 • Former IBEW employees who were hired before 1/1/11 and retired after 12/31/03 • Former non-IBEW employees who were approved for BSA LTD Plan benefits after 12/31/08 and are receiving such benefits	40%	1 Person	$491.21	$471.55	$446.78	$431.72
		2 People	$1,019.95	$979.12	$927.70	$883.22
		3 or More People	$1,355.99	$1,301.71	$1,233.34	$1,174.36
• All employees hired on or after 1/1/11 who retire	50%	1 Person	$614.01	$589.44	$558.48	$539.65
		2 People	$1,274.94	$1,223.90	$1,159.62	$1,104.03
		3 or More People	$1,694.99	$1,627.14	$1,541.68	$1,467.95

WHICH DENTAL PLANS ARE AVAILABLE & WHAT'S THE DIFFERENCE BETWEEN THEM?

There are three dental plans available to you.

The **Dental Maintenance Organization (DMO)** is 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 **Preferred Provider Organization (PPO)** is 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 **Indemnity Plan** is where you may 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.

The dental plan is not available to retirees unless elected under COBRA immediately following separation from employment and for a maximum period in accordance with COBRA regulations.

See the next page for a comparison of the dental plans.

HOW MUCH WILL THE DENTAL PLAN COST IN 2024?

Participants Who Are Receiving BSA Long Term Disability Benefits

Coverage	Monthly Contribution		
	DMO	PPO	Indemnity
1 Person	$ 5.00	$ 10.11	$ 5.00
2 People	$ 10.00	$ 20.86	$ 10.00
3 or More People	$ 19.00	$ 34.23	$ 19.00

COBRA Participants

Coverage	Monthly Contribution		
	DMO	PPO	Indemnity
1 Person	$ 20.26	$ 36.32	$ 16.06
2 People	$ 41.17	$ 77.15	$ 34.13
3 or More People	$ 61.26	$ 108.22	$ 47.84

SUMMARY OF COVERAGES THROUGH THE DENTAL PLANS

	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 coinsurance	Must submit claim to Delta Dental	Participating dentist will charge you applicable coinsurance. 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
Orthodontia Benefits	See fee schedule	50%	50%	See reimbursement schedule
Orthodontia Lifetime Maximum Benefit Per Person	N/A	$1,000 (in- and out-of-network combined)		$1,000

This is only a summary of the coverage through the dental plans. For additional information, go to www.bnl.gov/hr/Benefits/.

VISION CARE PLAN

Through the EyeMed Vision Care plan, you can defray the cost of routine eye exams and the purchase of eyeglasses and contact lenses. If you are enrolled in this program, you can use in- or out-of-network providers and will pay a copay or receive reimbursements for many services and purchases. EyeMed is a national provider of eyecare services whose in-network providers include Walmart, Target Optical, LensCrafters, Pearle Vision, and a large network of independent providers. EyeMed also has many online, in-network options such as ray-ban.com, contactsdirect.com, lenscrafters.com, targetoptical.com, and glasses.com.

The vision plan is not available to retirees unless elected immediately following separation from employment or during 2023 open enrollment.

See the below for a summary of the vision care plan coverage.

SUMMARY OF COVERAGE THROUGH THE VISION CARE PLAN

	Coverage/Cost	
	In-network	**Out-of-network**
Routine eye exam (annual)	$10 copay	Up to $50 reimbursement
Lenses (annual)		
Single	$25 copay	Up to $50 reimbursement
Bifocal	$25 copay	Up to $75 reimbursement
Trifocal	$25 copay	Up to $100 reimbursement
Standard progressive	$25 copay	Up to $75 reimbursement
Premium progressive	$110-$200 copay depending on brand/type	Up to $75 reimbursement
Frames (annual)	Up to $220 allowance + 20% off amount above allowance	Up to $160 reimbursement
Contact lens exam (annual)	$10 copay for exam	Not covered
	Standard fit & follow-up exam $40	Not covered
	Premium fit & follow-up exam 10% off retail	Not covered
Contact lenses (annual)		
Disposable	Up to $200 allowance	Up to $160 reimbursement
Medically necessary	$0 copay	Up to $210 reimbursement
Conventional	Up to $220 allowance + 15% off amount above allowance	Up to $160 reimbursement

This is only a summary of the coverage through the plan. For additional information, go to www.bnl.gov/hr/Benefits/.

HOW MUCH WILL THE VISION CARE PLAN COST IN 2024?

Coverage	Monthly Contribution
1 Person	$ 7.15
2 People	$ 14.28
3 or More People	$ 22.99

QUALIFYING EVENTS

What is a Qualifying Event?

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

(a) change in legal marital status: (1) marriage, (2) death of spouse, (3) divorce, (4) legal separation, (5) annulment (6) domestic partnership
(b) change in number of dependents: (1) birth, (2) adoption, (3) placement for adoption, (4) death of a dependent (5) legal guardianship
(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 coverage under the plan(s)
(f) change in the place of residence or work site of the employee, spouse or dependent

What coverages can I change if I have a Qualifying Event?

You may be eligible to add or delete dependents or drop coverage. The change(s) in coverage that you request must relate to the change that affects eligibility for coverage.

How do I change my coverage(s)?

To change your coverage(s) when a Qualifying Event has occurred, you must notify the BSA Benefits Office and complete an enrollment form within 30 days of the date of the Qualifying Event for all Qualifying Events indicated above, except (a)(3), (a)(4) and (e). [60 days applies for items (a)(3), (a)(4, and (e).] 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 premiums will then be changed for the remainder of the calendar year.

When are coverage changes effective?

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 dental insurance company directly, we may be unable to make the change until the next Open Enrollment period.

THE FOLLOWING SECTION PROVIDES THE REQUIRED NOTICES APPLICABLE TO THE BSA COMPREHENSIVE WELFARE BENEFITS PLAN

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.

THE FOLLOWING SECTION PROVIDES THE BSA COMPREHENSIVE WELFARE BENEFITS PLAN NOTICE OF PRIVACY PRACTICES

Brookhaven Science Associates, LLC ("BSA") continues its commitment to maintaining the confidentiality of your private healthcare 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 benefit options. If you are enrolled in an HMO or a fully insured medical 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 records, your claims for medical 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
Brookhaven National Laboratory
Benefits Office, Bldg. 400B
Upton, NY 11973-5000
(631) 344-2877

Attn: Privacy Officer

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) 344-2877.

Notice Date: October 2023