It’s Open Enrollment Time!

Open Enrollment is your once-a-year opportunity to review your benefits and make changes for the coming year. Your 2026 choices may not be the best fit for 2027, so take time to consider your health care needs, expected expenses, and the family members you want to cover.

During Open Enrollment, you can enroll or drop coverage, add or remove eligible dependents, and/or choose a different medical or dental plan. BSA offers 4 Aetna medical plan options and 3 Delta Dental plan options.

MARK YOUR CALENDAR IT’S OPEN ENROLLMENT

Monday, November 9 – Friday, November 20, 2026

All approved changes are effective January 1, 2027

TAKE ACTION!

1. Review what is changing for 2027
2. Compare your current coverage with your needs for next year
3. Make your elections in Workday between Monday, November 9 and Friday, November 20, 2026
4. Enroll in Flexible Spending Accounts and Vacation Buy for 2027

For More Information Visit The Benefits Program Website https://www.bnl.gov/hr/benefits/oe

You’ll find:

- Our virtual benefits fair where you can learn about the plans
- Answers to frequently asked questions
- Workday enrollment instructions

Where to Get Help

Contact the Benefits Office at oe@bnl.gov or (631) 344-2881

Brookhaven Science Associates | Human Resources | Building 400B | Upton, NY 11973-5000

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.

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What Is Changing for 2027?

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Medical, Dental and Vision

- Medical plan employee contributions have increased
- Aetna Plan 4 (HDHP) in-network deductible increased to $1,750 for employee-only coverage and $3,500 for family coverage
- The maximum employee HSA contribution for Aetna Plan 4 is $4,000 for employee-only coverage and $8,000 for family coverage (excludes the $500 employee-only/$1,000 family BSA contribution from the 2027 IRS maximum)
- Dental Plan employee contributions remain the same
- Vision Care Plan employee contributions remain the same

2027 Flexible Spending Account Limits

- The IRS increased the FSA maximums for Healthcare, Transit/Commuter and Parking for 2027.

Account	Minimum	2026 Maximum
Health Care FSA	$300/year	$3,400/year
Dependent Day Care FSA	$300/year	$7,500/year if single or married filing jointly; $3,750/year if married filing separately
Transit/Commuter	$25/month	$4,080/year; no more than $340/month
Parking	$25/month	$4,080/year; no more than $340/month

IMPORTANT!

Health Care FSA, Dependent Day Care FSA, Transit/Commuter, Parking, and Vacation Buy elections do not automatically roll forward if you want them for 2027. You must enter your enrollment in Workday between November 9th and November 20th.

PAYROLL CONTRIBUTIONS

Please refer to the included Benefit Plan Premiums brochure or the Open Enrollment website https://www.bnl.gov/hr/benefits/oe

What Can You Change During Open Enrollment?

Medical, Dental, Vision and Supplemental Benefits

- Enroll in or drop coverage
- Add or remove eligible family members
- Choose a different medical or dental plan

If you do not make changes to these elections, your current coverage elections continue into the upcoming year

Dental coverage will automatically end on 12/31 for dependents who attained age 23 during the calendar year

Benefits You Must Elect Each Year

- Health Care Flexible Spending Account
- Dependent Day Care Flexible Spending Account
- Transit/Commuter Reimbursement Account
- Parking Reimbursement Account
- Vacation Buy Plan

IF YOU DO NOT TAKE ACTION ...

Your current medical, dental, vision, identity theft, hospital, accident, and critical illness/group specified disease elections roll forward into the upcoming year. Flexible spending accounts and vacation buy elections end December 31st unless you re-enroll.

After open enrollment, you can change your benefit elections only if you experience a qualifying life event. See page 14 for more information about qualifying events.

Make Your Open Enrollment Elections in Workday

How to Enroll

1. Log in to Workday using your User ID and password. For login help, call the ITD Help Desk at ext. 5522.
2. Open the Open Enrollment benefit event task in your Workday inbox and select “Let’s Get Started.”
3. Review each benefit and select “Manage” or “Enroll” to make changes.
4. When finished entering your benefit elections, select “Review and Sign.”
5. Review your elections, scroll to the bottom, check “I Accept,” and select “Submit.”
6. On the confirmation screen, select “View Benefits Statement,” print or save a copy, and keep it for your records. This is confirmation of your open enrollment elections.

IMPORTANT - DO NOT FORGET TO SUBMIT!

If you do not click “Submit,” after entering your elections, your changes will not be accepted. You may reopen and revise your elections until Open Enrollment closes. No elections will be accepted after Friday, November 20, 2026.

Adding a new dependent?

Create the dependent record and attach supporting documentation, such as a marriage certificate, birth certificate, or domestic partnership affidavit, before adding the dependent to your benefit plans.

Eligible Dependents

- Spouse
- Domestic Partner
- Your Children
- Your Stepchildren
- Your Domestic Partner ‘s Children
- Children for whom you have legal custody or Guardianship

Dependent children may be covered under the medical, and vision plans through the end of the month they turn age 26 and for the dental plan to the end of the year they turn age 23.

Dependent children with disabilities may be eligible to continue medical, dental, and vision coverage beyond the usual dependent age limit, subject to plan approval. Contact the Benefits Office before your child reaches the age limit for guidance on continuing coverage.

Your Medical Plan Options

BSA offers several Aetna medical plan options that use the Aetna POS II (Open Access) network. The plans differ in employee contributions and how you share the cost of care through copays, deductibles, and coinsurance.

Aetna Plans 1, 2 and 3

These point-of-service plans let you use physicians and facilities of your choice. You generally pay less when you use Aetna network providers. No primary care physician selection or specialist referral is required. Most in-network services require a copay and have an annual out-of-pocket maximum. Out-of-network services are subject to the out-of-network deductible and coinsurance. Copays, deductibles, coinsurance and employee payroll contributions vary based on the plan you elect. A separate annual deductible and out-of-pocket maximum applies to prescription drugs.

Aetna Plan 4 - High-Deductible Health Plan with HSA

Plan 4 is a High-Deductible Health Plan (HDHP) paired with a Health Savings Account (HSA). If you are not eligible for an HSA, you cannot enroll in Plan 4. See IRS Publication 969 for more information.

A high-Deductible Health Plan has a higher deductible than most health plans. An 'employee-only" HDHP covers just you. For the purposes of this plan, "family" coverage means a plan that covers you and at least one other person – whether that is two people or three or more. In a HDHP, you first pay a deductible before coverage for medical care begins. Your deductible is based on your coverage level "employee only" or "family". The deductible works differently in the HDHP than other plans 1-3, where each person has an individual deductible to fulfill. In the HDHP if you have "family" coverage the family deductible applies. There is no individual deductible in this plan. Once the deductible has been met, the coinsurance percentage will determine the cost of services.

HSA Eligibility

- Available to employees in the Aetna HDHP medical plan
- Available to employees under age 65 and not enrolled in Medicare
- Available to employees who have a valid social security number or tax identification number
- You have no other health coverage except what is permissible under IRS Publication 969 http://www.irs.gov/pub/irs-pdf/p969.pdf
- You cannot be claimed as a dependent on someone else's tax return
- You cannot be enrolled in both the Health Care Flexible Spending 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.

HSA Contributions

- 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. These amounts are prorated for partial year enrollments. If your coverage begins on the first of the month you will receive BSA's contribution that month. If your coverage begins after the first of the month, BSA's contribution begins the first day of the following month and will be available after monthly payroll has been processed.
- HSAs are portable, meaning you retain the money in your account even if you leave employment at the Lab. Unlike the Health Care Reimbursement Account, there is no "use-it-or-lose-it" rule—your HSA funds carry over from year to year, even if you change health care plans. They also earn tax-free interest.
- Maximum contribution amounts are determined by the Internal Revenue Service and are subject to change.

Aetna Plan 5

Plan 5 is mandatory for employees working under a J-1 visa and is not available to other employees.

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All Aetna Medical Plans

- Include prescription drug coverage.
- Cover preventive services and routine physicals at no cost when plan requirements are met.
- Provide coverage for virtual care.
- CVS Virtual care offers 24/7 telehealth for minor illnesses, mental health and medication refills. Members can access services through www.cvs.com.
- In-person options available at CVS Minute Clinic participating locations.

Dependent Child(ren)

Dependent children may be covered under the medical plan through the end of the month they turn age 26.

Dependent children with disabilities may be eligible to continue medical, dental, and vision coverage beyond the usual dependent age limit, subject to plan approval. Contact the Benefits Office before your child reaches the age limit for guidance on continuing coverage

Aetna Medical Plan Comparison

	AETNA PLAN 1	AETNA PLAN 2	AETNA PLAN 3	AETNA PLAN 4**	AETNA PLAN 5 ***
Provider Network	Aetna POS II (Open Access)				
HSA contribution from BSA (Individual/Family*)	N/A	N/A	N/A	$500/$1,000	N/A
Maximum employee HSA contribution (Individual/Family*)	N/A	N/A	N/A	$4,000/$8,000	N/A
IN-NETWORK					
Copay (PCP/Specialist) (per visit)	$20/$35	$25/$40	$30/$45	Deductible & coinsurance	$30/$45
Deductible/year (Individual/Family*)	$0	$150/$300	$300/$600	$1,750/$3,500	$300/$600
Coinsurance	0%	10%	20%	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	$2,000/$4,000
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		$1,500/$3,000
Emergency room (per visit)	$100	$150	$200	Deductible & coinsurance	$200
Inpatient hospital (per admission)	$500	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
Outpatient surgery (per visit)	$100	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
CVS Virtual (per telephonic visit)	$20	$25	$30	Deductible & coinsurance	$30
CVS Virtual Mental Health (per telephonic visit)	$20	$25	$30	Deductible & coinsurance	$30
Walk-in clinic (per visit)	$20	$25	$30	Deductible & coinsurance	$30
Urgent care center (per visit)	$50	$50	$50	Deductible & coinsurance	$50
X-ray/laboratory	Covered in full	$20	$20	Deductible & coinsurance	$20
Complex imaging (MRI, CT Scan, …)	$50	$50	$50	Deductible & coinsurance	$50
Hearing Aids	Covered in full	Deductible & coinsurance	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)	Covered in full (1 exam every 24 months)
Routine physical (limits apply)	Covered in full	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	$500/$1,000
Coinsurance	30%	30%	30%	40%	30%
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	$6,000/$18,000
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	$100/$300
RETAIL: up to 30-day supply					
Tier 1 (generic)	$10	$10	$10	$10 after deductible	$10
Tier 2 (brand name in Aetna's formulary)	$25	$30	$35	$35 after deductible	$35
Tier 3 (brand name not in Aetna's formulary)	$40	$50	$60	$60 after deductible	$60
Tier 4 (specialty drugs)	$50	$60	$70	$80 after deductible	$70
MAIL ORDER: 31-90-day supply (can also be done through CVS retail pharmacy)					
Tier 1 (generic)	$20	$20	$20	$20 after deductible	$20
Tier 2 (brand name in Aetna's formulary)	$50	$60	$70	$70 after deductible	$70
Tier 3 (brand name not in Aetna's formulary)	$80	$100	$120	$120 after deductible	$120
Tier 4 (specialty drugs)	N/A	N/A	N/A	N/A	N/A

* For Aetna Plan 4: Individual = employee only coverage. Family = 2 or more people. Additional information applies. ** Aetna Plan 4 is not available to employees age 65 or over or those who are eligible for Medicare. *** Enrollment in Aetna Plan 5 is mandatory for employees working under a J-1 Visa. It is not available to any other employees.

Dental Plan Options

Healthy teeth and gums are an important part of overall wellness. BSA offers three Delta Dental options so you can choose the network, cost, and flexibility that best fit your needs.

Delta Dental PPO

Use the dentist of your choice. Care received by providers participating in the Delta Dental PPO or Premier networks lowers your out-of-pocket cost. Coverage is provided as a percentage of charges for covered services. The annual maximum benefit is $1,500 per covered member, combined with in- and out-of-network.

Delta Dental DMO

An in-network-only plan using DeltaCare USA participating dentists. A primary dentist and referrals are required for specialists. Network providers are subject to change. Check for providers in your area before electing. Enrollment in this plan is limited to participants who reside in the following states: CA, CO, CT, DC, FL, IL, IN, ME, MD, MT, NJ, NY, NC, PA, SC, and VA. Coverage is provided based on a schedule of benefits and subject to copays. There is no annual maximum benefit.

Delta Dental Indemnity

Use the dentist of your choice, Care received by providers participating in the Delta Dental PPO or Premier networks lowers your out-of-pocket cost with discounted rates. Coverage is provided based on a fee-for-service schedule. The annual maximum benefit is $1,000 per covered member.

Dependent Child(ren)

Dependent children may be covered under the dental plan through the end of the year they turn age 23.

Dependent children with disabilities may be eligible to continue medical, dental, and vision coverage beyond the usual dependent age limit, subject to plan approval. Contact the Benefits Office before your child reaches the age limit for guidance on continuing coverage

Dental Plan Comparison

	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

Vision Care Plan

EyeMed vision coverage helps you save on eye exams, eyeglasses, contact lenses, and other eligible vision expenses. You may use in-network or out-of-network providers; your cost or reimbursement depends on the service.

Vision	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

Dependent Child(ren)

Dependent children may be covered under the vision plan through the end of the month they turn age 26.

Dependent children with disabilities may be eligible to continue medical, dental, and vision coverage beyond the usual dependent age limit, subject to plan approval. Contact the Benefits Office before your child reaches the age limit for guidance on continuing coverage

Money-Saving Tips

- You can use eligible HSA or FSA funds to pay for qualified out-of-pocket medical, dental, and vision expenses with pre-tax dollars
- Using in-network providers can lower your out-of-pocket expenses
- Using Generic prescription drugs reduces the amount you pay for covered prescriptions
- Aetna's mail order pharmacy benefit for maintenance prescription drugs allows you to obtain a 3-month supply by paying only 2-months copay

Flexible Spending Accounts (FSA)

FSAs let you pay eligible expenses with pre-tax dollars. You choose your annual contribution, subject to plan and Internal Revenue Service (IRS) annual limits, and contributions are deducted from your paychecks on a pre-tax basis in equal amounts over the course of the year.

2027 FSA maximums have not been released as of the printing of this booklet. The 2026 maximums below are subject to change.

Health Care FSA

Use the account for eligible expenses such as copays, deductibles, and certain over-the-counter medications. Minimum contribution is $300; 2026 maximum is $3,400. Employees enrolled in Aetna Plan 4 with an HSA cannot enroll in the Health Care FSA.

Dependent Day Care FSA

Use the account for eligible dependent day care expenses that allow you and your spouse or domestic partner to work, look for work, or attend school. Minimum contribution is $300. The 2026 maximum is $7,500 if single or married filing jointly, or $3,750 if married filing separately.

Transit/Commuter and Parking Accounts

Eligible Transit/Commuter expenses include public transportation (buses, ferries, subway, trains) and vanpool services. Minimum contribution is $25. The 2026 maximum is $340 per month, $4,080 per year.

Eligible Parking Accounts expenses include parking near your workplace or parking at a garage, parking lot, commuter lot, or metered expenses from which you commute. Minimum contribution is $25 The 2026 maximum is $340 per month, $4,080 per year.

Unlike Healthcare and Dependent Daycare, you can enroll, terminate or make changes at any time throughout the year.

RE-ENROLL EACH YEAR

FSA elections do not roll forward each year. Amounts not used are forfeited. If you want to enroll in an FSA for 2027, you must elect it during Open Enrollment. Expenses must be incurred by December 31, 2027, and 2027 claims submitted by March 31, 2028.

Vacation Buy Plan

Purchase up to 40 hours of additional vacation for 2027, prorated for part-time employees based on FTE (Full Time Equivalent). The cost to purchase vacation buy is calculated by multiplying your hourly rate of pay by the number of hours purchased. Contributions are deducted from your paychecks on a pre-tax basis in equal amounts over the course of the year. You must use all accrued vacation time before using vacation buy. Vacation time must be approved by your supervisor in advance and used by the dates listed below. Any vacation time purchased but not used will be refunded in your last paycheck of the year and will be subject to payroll taxes. Vacation Buy must be elected during Open Enrollment and does not roll forward each year.

- Monthly employees: use purchased time by December 31, 2027.
- Weekly employees: use purchased time by December 27, 2027.

Supplemental Insurance Options

Hospital Insurance

Pays a lump-sum admission benefit and daily benefits for a covered hospital stay for an illness, surgery, or to have a baby. Benefits are paid directly to you and may be used for out-of-pocket medical or personal expenses.

Accident Insurance

Pays cash benefits for covered accidental injuries, including certain initial and follow-up care, imaging, fractures, physical therapy, and more. Benefits are paid directly to you and may be used for out-of-pocket medical or personal expenses.

Critical Illness / Group Specified Disease Insurance

Provides a cash payment if you are diagnosed with a covered serious illness such as a heart attack, stroke or cancer and more. Members receive an annual reimbursement of $50 by submitting proof that you received eligible preventive service You can elect coverage in increments of $5000 up to $30,000.

Critical Illness/Group Specified Disease Premiums vary by age and the amount of coverage elected. Refer to the supplement or 2027 Open Enrollment rate tables on the Benefit Program website for the complete monthly and weekly premium schedule or the rate sheet included with this booklet.

Identity Theft Protection - MetLife/Aura

Provides digital security tools and monitoring for suspicious activity involving credit, financial accounts, personal information, online accounts, and more. Coverage includes identity theft insurance for each enrolled member. It includes a $5,000,000 identify theft insurance policy for up to 10 enrolled adults.

Refer to the supplement or 2027 Open Enrollment rate tables on the Benefit Program website for the complete monthly and weekly premium schedule or the rate sheet included with this booklet.

Identification Cards

Medical

If you enroll in an Aetna medical plan for the first time, Aetna will issue an ID card. If you change plans or add dependents, an updated digital ID card will be available at www.aetna.com on or after January 1, 2027.

Dental

Delta Dental does not automatically issue ID cards. You can print one from www.deltadentalins.com.

Vision

If you enroll in EyeMed for the first time, you will receive an ID card. Replacement cards can be printed from www.eyemed.com.

FSA / HSA Debit Card

If you enroll in an eligible Inspira account for the first time, you will receive a debit card. If you already have an Inspira card, your 2027 election will be applied to the current card. A new card is not issued each year.

Paying for Benefits

BSA pays the full cost of some benefits, shares the cost of others with you, and offers certain voluntary benefits that you pay for in full. Your share of benefit costs is deducted from your paychecks each pay period.

Please refer to the Benefit Plan Premiums brochure for 2027 plan costs.

THE BSA BENEFITS OFFICE TEAM IS HERE TO ASSIST YOU!

Visit www.bnl.gov/hr/Benefits/ or call (631) 344-2881.what about adding our benefits inbox email?

Qualifying Events: Making Changes During the Year

Outside Open Enrollment, you may be able to change certain benefits when you experience a Qualifying Event. The benefit change must be consistent with the event and must be submitted in Workday within the applicable deadline.

Examples of Qualifying Events

- Marriage, divorce, legal separation, annulment, or domestic partnership
- Birth, adoption, placement for adoption, or death of a dependent
- Loss or gain of other coverage
- Change in employment status
- A dependent becoming eligible or no longer eligible
- Change in residence or work site

How to Make a Change

Initiate the benefit event in Workday and upload supporting documentation. Most events must be submitted within 30 days. Divorce, legal separation, certain dependent eligibility changes, and CHIPRA events may have a 60-day period. Changes cannot be processed without required supporting documents.

TIMING MATTERS

If you miss the applicable Qualifying Event deadline, your request may be denied, and you may need to wait until the next Open Enrollment period. The event must relate to the change you are requesting.

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 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 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 communication: 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 contacts 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 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 it relates 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: November 2026

THE FOLLOWING SECTION PROVIDES THE CREDITABLE COVERAGE NOTICE

Important Notice from Brookhaven Science Associates, LLC (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.

PLAN & BENEFIT: AETNA PRESCRIPTION DRUG BENEFIT	AETNA PLAN 1	AETNA PLAN 2	AETNA PLAN 3	AETNA PLAN 4
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

PLAN & BENEFIT: AETNA PRESCRIPTION DRUG BENEFIT	AETNA PLAN 1	AETNA PLAN 2	AETNA PLAN 3	AETNA PLAN 4
MAIL ORDER: 31-90-day supply *,**				
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

* 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--Position/Office:	Benefits Office
Address:	Brookhaven National Laboratory, Bldg. 400B Upton, NY 11973
Phone Number:	631-344-2881

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).

Notice Date: November 2026

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1][2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's 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.

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	4. Employer Identification Number (EIN)
Brookhaven Science Associates	11-3403915
5. Employer address	6. Employer phone number
Brookhaven National Laboratory, P.O. Box 5000	631-344-2877
7. City / 8. State / 9. ZIP code	
Upton / NY / 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. Email 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. Eligible employees are:

  ☑ Some employees. Eligible employees are:

  All regular employees of Brookhaven Science Associates, LLC (the "Employer") who work at least 20 employment.

  Employees who work an average of 30 or more 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 are legally married or domestic partner.
  - 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.

Notes