

# BSA Benefits & You

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## 2021

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This booklet applies to the following participants who are not eligible for Medicare and:

- were part of a reduction-in-force
- are COBRA participants
- are covered family members

**Enroll in the coverage that's right for you!**



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 2020**

## It's Open Enrollment Time!

It's time to consider your needs, review your benefit coverages, and maybe make some changes for 2021.

Brookhaven's Open Enrollment period for 2021 benefits begins on Monday, November 3, 2020 at 9 a.m. and ends on Friday, November 13, 2020 at 5 p.m.

We highly recommend using ALEX, our online benefits tool, to see if your current choices still meet your needs.



**ALEX will help you select the plans that best fit the needs of you and your family. It includes information on the medical, dental, and vision care plans. ALEX estimates the total yearly out-of-pocket costs (a combination of your contributions and the costs for the services you plan to use) for each plan and recommends the one with the lowest overall cost to you.**

**Once you've reviewed the information in this booklet, we encourage you to use ALEX that's available at [www.bnl.gov/hr/Benefits/](http://www.bnl.gov/hr/Benefits/).**

### **You can also get more information at the annual Benefits Fair.**

Our annual Benefits Fair will not be held on-site this year but, instead, will be held virtually with online videos from our representatives from the Aetna Medical plans, the Delta Dental plans and the EyeMed Vision Care plan where you can learn about the plans during the Open Enrollment period. Additional information is available on the Lab's Benefits Program website at <https://www.bnl.gov/hr/Benefits/>.



If you need additional information on all of the Brookhaven Science Associates, LLC (BSA) benefit programs (including Summary Plan Descriptions), you can go to the Benefits website at [www.bnl.gov/hr/Benefits/](http://www.bnl.gov/hr/Benefits/).

**Remember — last year's choices might not make sense for you in 2021. Take the time to review your choices to find the benefit programs that provide the right level of coverage for your needs.**

## WHAT ARE THE CHANGES IN THE BENEFIT PROGRAMS FOR 2021?

### MEDICAL PLANS

- ⇒ Contributions for the Aetna Medical plans are increasing. More information is provided in this booklet.

### ENROLLING IN YOUR BENEFITS

If you want to make changes to your medical, dental and/or vision care plan coverages, complete the form at the back of this booklet, and return it to the address below by no later than 5 p.m. on Friday, November 13, 2020.

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



**Changes made during the Open Enrollment period will be effective on January 1, 2021.**



**What happens to my benefits on January 1, 2021 if I don't take action during the Open Enrollment period?**

- ⇒ If eligible, you'll automatically remain in the medical, dental and/or vision care plans you have on December 31, 2020, if any. Any dependent children who are on your coverage on December 31, 2020 who are no longer eligible on January 1, 2021 will automatically be dropped from your coverage (For instance, a child who is age 23 and in the Dental Plan will no longer be eligible for dental coverage).

### WHAT BENEFIT ELECTIONS CAN I MAKE DURING THE OPEN ENROLLMENT PERIOD?

**For the medical, dental and vision care plans, you can:**

- Drop the plan(s)
- Change from one plan to another (not applicable to vision care plan)
- Add eligible family members to your plan(s) – and you'll need to provide additional documentation (birth and/or marriage certificate)
- Drop family members from your plan(s)



## IMPORTANT DEADLINES

The Open Enrollment period ends at 5 p.m. on Friday, November 13, 2020. You must make your 2021 benefit elections by this deadline, or you will not be able to make a change during 2021 unless you have a Qualifying Event.



## CHANGING YOUR BENEFITS DURING THE YEAR (OTHER THAN DURING OPEN ENROLLMENT)

You may be eligible to make changes to your medical, dental and/or vision care benefits 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.

For more information, refer to the Qualifying Events section of this booklet.



Did you know that if you are enrolled in the Aetna Medical plan, 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.member.teladoc.com/aetna](http://www.member.teladoc.com/aetna) to create your account and then request a consult, or go to [www.teladoc.com/mobile](http://www.teladoc.com/mobile) to download the app from which you can request a consult.

## WHAT ELSE DO I NEED TO KNOW FOR 2021?

### IDENTIFICATION CARDS

#### Medical Plans

- If you make a change from one medical plan to another, you will receive a new identification card. If you add an eligible dependent to your coverage, you will receive a new identification card that will include the dependent you added. For coverage of two or more people, Aetna will issue two cards. Each card will have the employee's name listed on top followed by the name of each dependent. Each card will look the same unless you have more than four dependents. If you have more than four dependents you will receive additional cards that will include the employee's name followed by the name of each additional dependent.

#### Dental Plans

- Delta Dental does not issue identification cards. If you want one, you can print one from their website at [www.deltadentalins.com](http://www.deltadentalins.com).

#### Vision Care Plan

- EyeMed does not issue identification cards. If you use an in-network provider, provide them your name and birthday. If you go out-of-network, you will need to submit a claim form.



A summary of coverages through the medical, dental, and vision care plans, information on Qualifying Events, and BSA's privacy notice are on the next few pages.

#### **If I have questions regarding my monthly bill for medical, dental and/or vision care coverages, 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 contact the Benefits Office at (631) 344-5126, (631) 344-2877, (631) 344-3724 or (800) 353-5321.

### IMPORTANT BENEFITS CONTACT INFORMATION

Plans	Account/ Plan #	Telephone #	Website/Email
Aetna Medical	869887	(855) 586-6961	<a href="http://www.aetna.com">www.aetna.com</a>
Delta Dental DMO	NY76503	(800) 422-4234	<a href="http://www.deltadentalins.com">www.deltadentalins.com</a>
Delta Dental PPO and Indemnity	NY04970	(800) 932-0783	<a href="http://www.deltadentalins.com">www.deltadentalins.com</a>
EyeMed Vision Care	VCN-1	(866) 800-5457	<a href="http://www.eyemed.com">www.eyemed.com</a>
BSA Benefits Office: Melissa Schuchman		(631) 344-2877	<a href="mailto:schuchman@bnl.gov">schuchman@bnl.gov</a>
BSA Benefits Office: Erin Gettler		(631) 344-5126	<a href="mailto:egettler@bnl.gov">egettler@bnl.gov</a>
BSA Benefits Office: Jennifer Froehlich		(631) 344-3724	<a href="mailto:jfroehlich@bnl.gov">jfroehlich@bnl.gov</a>

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

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

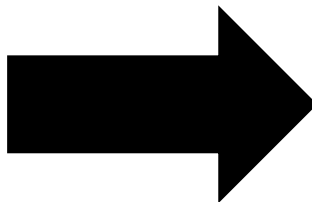
When you use a provider or health care services, you pay for part of the cost of those services yourself in the form of copayments, deductibles, and coinsurance. Aetna's POS II (Open Access) network includes not just physicians, but many types of healthcare service providers such as hospitals, laboratories, 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.



## SUMMARY OF COVERAGES THROUGH THE MEDICAL PLANS

MEDICAL PLAN DESIGN	AETNA PLAN 1	AETNA PLAN 2	AETNA PLAN 3	AETNA PLAN 4 HIGH DEDUCTIBLE HEALTH PLAN
<b>IN-NETWORK</b>				
COPAY (PCP/SPECIALIST) (per visit)	\$20/\$35	\$25/\$40	\$30/\$45	DEDUCTIBLE + COINSURANCE
DEDUCTIBLE/YR (Individual/Family*)	\$0	\$150/\$300	\$300/\$600	\$1,400/\$2,800
COINSURANCE	0%	10%	20%	20%
OUT-OF-POCKET MAXIMUM/YR MEDICAL (includes deductible, copays, & coinsurance) (Individual/Family)	\$5,100/\$10,200	\$1,000/\$2,000	\$2,000/\$4,000	\$3,500/\$8,000 MEDICAL & PRESCRIPTION DRUG COMBINED
OUT-OF-POCKET MAXIMUM/YR PRESCRIPTION DRUGS (includes deductible, copays, & coinsurance) (Individual/Family)	\$1,500/\$3,000	\$1,500/\$3,000	\$1,500/\$3,000	
EMERGENCY ROOM (per visit)	\$100	\$150	\$200	DEDUCTIBLE + COINSURANCE
INPATIENT HOSPITAL (per admission)	\$500	DEDUCTIBLE + COINSURANCE	DEDUCTIBLE + COINSURANCE	DEDUCTIBLE + COINSURANCE
OUTPATIENT SURGERY (per visit)	\$100	DEDUCTIBLE + COINSURANCE	DEDUCTIBLE + COINSURANCE	DEDUCTIBLE + COINSURANCE
TELADOC (per telephonic visit)	\$20	\$25	\$30	DEDUCTIBLE + COINSURANCE
WALK-IN CLINIC (per visit)	\$20	\$25	\$30	DEDUCTIBLE + COINSURANCE
URGENT CARE CENTER (per visit)	\$50	\$50	\$50	DEDUCTIBLE + COINSURANCE
X-RAY/LABORATORY	COVERED IN FULL	\$20	\$20	DEDUCTIBLE + COINSURANCE
COMPLEX IMAGING (MRI, CT SCAN, ...)	\$50	\$50	\$50	DEDUCTIBLE + COINSURANCE
HEARING AIDS	COVERED IN FULL	DEDUCTIBLE + COINSURANCE	DEDUCTIBLE + COINSURANCE	DEDUCTIBLE + COINSURANCE
ROUTINE EYE EXAM	COVERED IN FULL (1 EXAM EVERY 24 MONTHS)	COVERED IN FULL (1 EXAM EVERY 24 MONTHS)	COVERED IN FULL (1 EXAM EVERY 24 MONTHS)	COVERED IN FULL (1 EXAM EVERY 24 MONTHS)
ROUTINE PHYSICAL (limits apply)	COVERED IN FULL	COVERED IN FULL	COVERED IN FULL	COVERED IN FULL
<b>OUT-OF-NETWORK</b>				
DEDUCTIBLE (Individual/Family*)	\$1,000/\$3,000	\$1,500/\$4,500	\$2,000/\$6,000	\$2,600/\$5,200
COINSURANCE	30%	30%	30%	40%
OUT-OF-POCKET MAXIMUM (includes deductible & coinsurance) (Individual/Family)	\$3,500/\$10,500	\$5,000/\$15,000	\$6,000/\$18,000	\$6,000/\$12,000
<b>PRESCRIPTION DRUGS (in-network only)</b>				
DEDUCTIBLE/YR (Individual/Family*) (Deductible is combined for retail & mail order)	\$100/\$300	\$100/\$300	\$100/\$300	MEDICAL & PRESCRIPTION DRUG COMBINED
<b>RETAIL: up to 30-day supply</b>				
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
<b>MAIL ORDER: 31-90-day supply (can also be done through CVS retail pharmacy)</b>				
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/](http://www.bnl.gov/hr/Benefits/).



## HOW MUCH WILL MY MEDICAL BENEFITS COST ME IN 2021?

### Participants Who Were Part Of A Reduction-In-Force:

- The cost for medical benefits during the first 12 months following the reduction-in-force will be the Active Employee Contribution.
- The next 12 months will be one-half of the cost for COBRA participants.
- After the second year, coverage can be continued by paying the full cost for COBRA participants.

### AETNA MEDICAL PLANS

#### Active Employee Monthly Contribution

Coverage	Plan 1			
	Annual Base Salary			
	\$0-\$69,999	\$70,000-\$99,999	\$100,000-\$174,999	\$175,000 +
1 Person	\$ 171.58	\$ 229.46	\$ 279.08	\$ 328.69
2 People	\$ 358.42	\$ 476.46	\$ 579.48	\$ 682.50
3 or More People	\$ 470.80	\$ 633.45	\$ 770.41	\$ 907.37

Coverage	Plan 2			
	Annual Base Salary			
	\$0-\$69,999	\$70,000-\$99,999	\$100,000-\$174,999	\$175,000 +
1 Person	\$ 144.87	\$ 188.53	\$ 238.14	\$ 287.76
2 People	\$ 300.81	\$ 391.46	\$ 494.47	\$ 597.49
3 or More People	\$ 399.91	\$ 520.43	\$ 657.39	\$ 794.35

Coverage	Plan 3			
	Annual Base Salary			
	\$0-\$69,999	\$70,000-\$99,999	\$100,000-\$174,999	\$175,000 +
1 Person	\$ 96.83	\$ 136.32	\$ 186.15	\$ 235.98
2 People	\$ 201.07	\$ 283.05	\$ 386.52	\$ 489.98
3 or More People	\$ 267.31	\$ 376.31	\$ 513.86	\$ 651.41

Coverage	Plan 4			
	Annual Base Salary			
	\$0-\$69,999	\$70,000-\$99,999	\$100,000-\$174,999	\$175,000 +
1 Person	\$ 66.35	\$ 109.08	\$ 158.16	\$ 208.15
2 People	\$ 109.72	\$ 198.98	\$ 301.26	\$ 403.53
3 or More People	\$ 145.88	\$ 264.57	\$ 400.56	\$ 536.55

Annual Base Salary is based on your full-time equivalent salary on the day immediately preceding your termination of employment.

### COBRA Participants

Coverage	Monthly Contribution			
	Plan 1	Plan 2	Plan 3	Plan 4
1 Person	\$ 1,054.29	\$ 1,012.11	\$ 958.94	\$ 927.14
2 People	\$ 2,189.15	\$ 2,101.52	\$ 1,991.14	\$ 1,896.79
3 or More People	\$ 2,910.43	\$ 2,793.91	\$ 2,647.17	\$ 2,522.03

The COBRA contributions indicated above include a 2% administrative fee.

## 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.

**Dental plans are not available unless elected under COBRA immediately following separation of 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 MY DENTAL BENEFITS COST ME IN 2021?

Contributions for dental coverage have not changed from 2020 to 2021.

### DELTA DENTAL PLANS

#### COBRA Participants

Coverage	Monthly Contribution		
	DMO	PPO	Indemnity
1 Person	\$ 20.26	\$ 36.59	\$ 16.18
2 People	\$ 41.17	\$ 77.71	\$ 34.37
3 or More People	\$ 61.26	\$ 109.01	\$ 48.18

## 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	\$0	60%	45%	\$26
Fillings: one-surface amalgam (procedure code: 2140)				
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/](http://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 EyeMed Vision Care plan is not available unless elected under COBRA immediately following separation from employment and for a maximum period in accordance with COBRA regulations.

### SUMMARY OF COVERAGE THROUGH THE VISION CARE PLAN

	Coverage/Cost	
	In-network	Out-of-network
<b>Routine eye exam (annual)</b>	\$10 copay	Up to \$50 reimbursement
<b>Lenses (annual)</b>		
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
<b>Frames (annual)</b>	Up to \$220 allowance + 20% off amount above allowance	Up to \$160 reimbursement
<b>Contact lens exam (annual)</b>	\$10 copay for exam	Not covered
	Standard fit & follow-up exam \$40	Not covered
	Premium fit & follow-up exam 10% off retail	Not covered
<b>Contact lenses (annual)</b>		
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/](http://www.bnl.gov/hr/Benefits/).

### HOW MUCH WILL THE VISION CARE PLAN COST ME IN 2021?

The annual cost of vision care coverage has not changed from 2020 to 2021.

#### COBRA Participants

Coverage	Monthly Contribution
1 Person	\$ 6.78
2 People	\$ 13.55
3 or More People	\$ 21.81

## 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
- (b) change in number of dependents: (1) birth, (2) adoption, (3) placement for adoption, (4) death of a dependent
- (c) change in employment status: (1) termination or commencement of employment of the employee, spouse or dependent, other than for gross misconduct
- (d) change in work schedule: (1) an increase or decrease in the number of hours of employment by the employee, spouse or dependent, (2) a switch between full-time and part-time status, (3) a strike or lockout, (4) commencement or return from an unpaid leave of absence
- (e) the dependent satisfies or ceases to satisfy the requirements for 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?

For the medical, dental and/or vision care plans, 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 31 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).] If you qualify under CHIPRA, you 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 (for medical and/or dental plan coverages) 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 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, dental, or vision benefit options. If you are enrolled in an HMO or a fully insured medical, dental or vision care benefit option, you will receive a separate notice from your HMO provider or insurance company. This Notice also does not apply to BSA’s On-site Medical Clinic.

### **What is Protected?**

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

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

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

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

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

### **Uses and Disclosures of Your PHI**

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

- To determine proper payment of your Health Plan benefit claims. The Health Plan uses and discloses your PHI to reimburse you or your health care providers for covered treatments and services. For example, your diagnosis information may be used to determine whether a specific procedure is medically necessary or to reimburse your doctor for your medical care.
- For the administration and operation of the Health Plan. We use and disclose your PHI for numerous administrative and quality control functions necessary for the Health Plan's proper operation. For example, we may use your claims information for cost-control or planning-related purposes.
- To inform you or your health care provider about treatment alternatives or other health-related benefits that may be offered under a Health Plan. For example, we may use your claims data to alert you to an available case management program if you become pregnant or are diagnosed with diabetes or liver failure.
- To a health care provider if needed for your treatment. For example, we may disclose your prescription information to a pharmacist regarding a drug interaction concern.
- To a health care provider or to a non-BSA health plan to determine proper payment of your claim under the other plan. For example, we may exchange your PHI with your spouse's health plan for coordination of benefits purposes.
- To a non-BSA health plan for certain administration and operations purposes. We may share your PHI with another health plan or health care provider who has a relationship with you for quality assessment and improvement activities, to review the qualifications of health care professionals who provide care to you, or for fraud and abuse detection and prevention purposes.
- To a family member, friend, or other person involved in your health care if you do not object (or it can be inferred that you do not object) to the sharing of your PHI directly relevant to the person's involvement, and, if you are not present or are unable to object due to incapacity or emergency, the disclosure is in your best interest.
- To comply with an applicable federal, state, or local law, including workers' compensation or similar programs.
- For public health reasons, including (1) to a public health authority for the prevention or control of disease, injury or disability; (2) to a proper government or health authority to report child abuse or neglect; (3) to report reactions to medications or problems with products regulated by the Food and Drug Administration; (4) to notify individuals of recalls of medication or products they may be using; or (5) to notify a person who may have been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition.
- To report a suspected case of abuse, neglect or domestic violence, as permitted or required by applicable law.
- To comply with health oversight activities, such as audits, investigations, inspections, licensure actions, and other government monitoring and activities related to health care provision or public benefits or services.
- To the U.S. Department of Health and Human Services to demonstrate our compliance with federal health information privacy law.
- To respond to an order of a court or administrative tribunal.
- To respond to a subpoena, warrant, summons or other legal request if sufficient safeguards, such as a protective order, are in place to maintain your PHI privacy.
- To a law enforcement official for a law enforcement purpose.
- For purposes of public safety or national security.
- To allow a coroner or medical examiner to identify you or determine your cause of death.
- To allow a funeral director to carry out his or her duties.
- To respond to a request by military command authorities if you are or were a member of the armed forces.
- To business associates. We may enter into agreements with entities or individuals to provide services (for example, claims processing services) to one or more of the Health Plans. These service providers, called "business associates," may create, receive, have access to, use, and/or disclose (including to other business associates) PHI in conjunction with the services they provide to the Health Plan(s), provided that we have obtained satisfactory written assurances that the business associates will comply with all applicable Privacy Rules with respect to such Health Plan(s).



- For research purposes. We may use or disclose a “limited data set” of your PHI for certain research purposes.

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

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

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

### **Other Uses and Disclosures of Your PHI**

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

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

### **Uses and Disclosures Requiring You to have an Opportunity to Object**

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

### **Your Rights**

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

- Right to request restrictions: You have the right to request a restriction or limitation on the Health Plan’s use or disclosure of your PHI. For example, you may ask us to limit the scope of your PHI disclosures to a case manager who is assigned to you for monitoring a chronic condition. Because we use your PHI only as necessary to pay Health Plan benefits, to administer the Health Plan, and to comply with the law, it may not be possible to agree to your request. *The law does not require the Health Plan to agree to your request for restriction.* However, if we do agree to your requested restriction or limitation, we will honor the restriction until you agree to terminate the restriction or until we notify you that we are terminating the restriction on a going-forward basis.
- You may make a request for restriction on the use and disclosure of your PHI to the Benefits Office. Contact information for the Benefits Office is listed at the end of this Notice. When making such a request, you must specify: (1) the PHI you want to limit; (2) how you want the Health Plan to limit the use, disclosure, or both of that PHI; and (3) to whom you want the restrictions to apply.
- Right to receive confidential communications: You have the right to request that the Health Plan communicate with you about your PHI at an alternative address or by alternative means if you believe

that communication through normal business practices could endanger you. For example, you may request that the Health Plan contact you only at work and not at home.

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

You may request an accounting of disclosures of your PHI from the Benefits Office. Contact information for the Benefits Office is listed at the end of this Notice. When making such a request, you must specify the time period for the accounting, which may not be longer than six (6) years and may not include dates prior to April 14, 2003, and the form (e.g., electronic, paper) in which you would like the accounting.

- Right to file a complaint: If you believe your rights have been violated, you should let us know immediately. We will take steps to remedy any violations of the Health Plan privacy policy or of this Notice.

You may file a formal complaint with our Privacy Officer and/or with the United States Department of Health and Human Services at the addresses at the end of this Notice. You should attach any documents or evidence that

supports your belief that your privacy rights have been violated. We take your complaints very seriously. BSA prohibits retaliation against any person for filing such a complaint. Complaints should be sent to:

Brookhaven Science Associates  
Brookhaven National Laboratory  
Benefits Office, Bldg. 400B  
Upton, NY 11973-5000  
(631) 344-2881

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

Attn: Privacy Officer

#### **Additional Information About This Notice**

- **Changes to this Notice:** We reserve the right to change the Health Plan's privacy practices as described in this Notice. Any change may affect the use and disclosure of your PHI already maintained by the BSA Health Plan, as well as any of your PHI that the Health Plan may receive or create in the future. If there is a material change to the terms of this Notice, you will receive a revised Notice.
- **How to obtain a copy of this Notice:** You can obtain a copy of the current Notice on the BSA Intranet or by writing to the Benefits Office at the address listed above.
- **No guarantee of employment:** This Notice does not create any right to employment for any individual, nor does it change BSA's right to discharge any of its employees at any time, with or without cause.
- **No change to Health Plan benefits:** This Notice explains your privacy rights as a current or former participant in the BSA Health Plan. The Health Plan is bound by the terms of this Notice as they relate to the privacy of your protected health information. However, this Notice does not change any other rights or obligations you may have under the Health Plan. You should refer to the Health Plan documents for additional information regarding your Health Plan benefits.

#### **Notification of a Privacy Breach**

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

#### **Contact Information**

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



**MEDICAL, DENTAL AND VISION CARE COVERAGE ELECTION FORM FOR PARTICIPANTS WHO WERE PART OF A REDUCTION-IN-FORCE OR WHO ARE ON COBRA**

Complete this form only if you are electing changes to your medical, dental and/or vision care coverage effective January 1, 2021.

<b>NAME (first and last)</b>	
<b>ADDRESS</b>	
<b>TELEPHONE #</b>	
<b>LIFE #</b>	

**EFFECTIVE DATE:** January 1, 2021

**AETNA MEDICAL PLAN:** (select one)    ☐ **PLAN 1**    ☐ **PLAN 2**    ☐ **PLAN 3**    ☐ **PLAN 4**  
**COVERAGE:** (select one)    ☐ **1 PERSON**    ☐ **2 PEOPLE**    ☐ **3 OR MORE PEOPLE**  
**ARE YOU CANCELLING COVERAGE?**    ☐ **YES**    ☐ **NO**

**DELTA DENTAL PLAN:** (select one)    ☐ **DMO**    ☐ **PPO**    ☐ **INDEMNITY**  
**COVERAGE:** (select one)    ☐ **1 PERSON**    ☐ **2 PEOPLE**    ☐ **3 OR MORE PEOPLE**  
**ARE YOU CANCELLING COVERAGE?**    ☐ **YES**    ☐ **NO**

**VISION CARE PLAN:** **COVERAGE:** (select one)    ☐ **1 PERSON**    ☐ **2 PEOPLE**    ☐ **3 OR MORE PEOPLE**  
**ARE YOU CANCELLING COVERAGE?**    ☐ **YES**    ☐ **NO**

**PROVIDE INFORMATION ON ALL INDIVIDUALS TO BE COVERED:**

NAME (first and last)	MEDICAL	DENTAL	VISION CARE	Check if Eligible for Medicare	RELATIONSHIP	SOCIAL SECURITY #	DATE OF BIRTH (mm/dd/yyyy)	GENDER	
								M	F
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

**AUTHORIZATION:**

I hereby authorize the elections indicated above and agree to pay the required premiums for the coverage I have elected.

\_\_\_\_\_

Signature Date

**Mail this form to:** Brookhaven Science Associates, LLC, Brookhaven National Laboratory, P.O. Box 5000, Bldg.400B, Attn: Benefits Office, Upton, NY 11973. **This form must be received by November 13, 2020.**