BSA Benefits & You
2022

Guide To:

- **Medical Programs**
- **Health Savings Account**
- **Health Care Reimbursement Account**

Brookhaven National Laboratory

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Here's What You'll Find In This Booklet

OVERVIEW

Brookhaven Science Associates, LLC (BSA) is pleased to offer you the following programs for your health care needs:

- Medical Programs
- Health Savings Account
- Health Care Reimbursement Account

Once you've reviewed the information in this booklet, we encourage you to use the modelling tool, ALEX, our online benefits tool to make informed decisions and determine which programs will best meet your health care 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, vision care, life, AD&D, and long term disability plans — as well as reimbursement accounts and retirement plans. ALEX estimates the total yearly out-of-pocket costs (a combination of your premiums 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.

ALEX is available at www.bnl.gov/hr/Benefits/.

Refer to your BSA Employee Benefits booklet and the Benefits website located at www.bnl.gov/hr/Benefits/ for additional information on the programs, including eligibility, enrollment, and coverage.

The information in this booklet is intended to provide only a summary of the programs. Nothing contained in this booklet should be construed as a promise of employment or continued employment, or to constitute contractual obligations. If questions arise, official plan documents and insurance agreements are controlling and govern final determination of benefits consistent with applicable laws and regulations. Benefits, including eligibility and plan provisions, for employees covered under a collective bargaining agreement are specified in the union contract. **BSA reserves the right to amend or terminate the benefit programs at any time and for any reason.**

MEDICAL PROGRAM

You can choose from four programs:

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

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

When you use a provider or healthcare services, you pay for part of the cost of those services yourself in the form of copayments, deductibles, and coinsurance. Aetna's POS network includes not just physicians, but many types of healthcare service providers such as hospitals, laboratories, x-ray facilities, physical therapists, medical equipment providers, outpatient surgery centers, etc. The POS 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.

Plans 1 – 3 vary based on copayments, deductibles, coinsurance and employee contributions.

See page 9 for additional information on copayments, deductibles and coinsurance.

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

A High Deductible Health Plan has a higher deductible than most health plans.

An "employee-only" HDHP covers just you. For the purpose of the HDHP, the term "family" plan means a plan that covers you and at least one other person – so both 2-person coverage and coverage for 3 or more people are "family" coverage for the purpose of this plan.

With the HDHP, you first pay a deductible. Your deductible is based on your coverage level ("employee-only" or "family"). Once you pay the deductible for the calendar year, then the medical plan provides coverage for medical care based on the terms of the plan. (The deductible under the HDHP works differently than how the it works under Plan 1 – 3 where in those plans you can have coverage for 2 or more people but the individual deductible still applies to each person separately. In the HDHP, if you have coverage for 2 or more people, only the "Family" deductible applies – and there is no individual deductible in this example.)

In the HDHP, the out-of-pocket maximum works the same as under Plans 1 – 3. The "individual" out-of-pocket maximum applies to "employee-only" coverage. The individual out-of-pocket maximum also applies to "family" coverage. If you have "family" coverage under the HDHP, each person can either reach the "individual" out-of-pocket maximum or the "family" can reach the "family" maximum each calendar year. Once the applicable out-of-pocket maximum is reached, the plan pays 100% of covered expenses. The out-of-pocket maximum includes copayments, deductibles and coinsurance.

The HDHP also has a Health Savings Account (HSA). See the Health Savings Account section for more information on the HSA.

See page 9 for additional information on copayments, deductibles and coinsurance.

SUMMARY OF COVERAGES THROUGH THE MEDICAL PLANS

MEDICAL PLAN DESIGN	AETNA PLAN 1	AETNA PLAN 2	AETNA PLAN 3	AETNA PLAN 4 HIGH DDEDUCTIBLE HEALTH PLAN
PROVIDER NETWORK	Aetna POS II (Open Access)			
HSA CONTRIBUTION/YR FROM BSA TO EMPLOYEE (Individual/Family)	N/A	N/A	N/A	$500/$1,000
MAXIMUM EMPLOYEE HSA CONTRIBUTION/YR (individual/Family)	N/A	N/A	N/A	$3,150/$6,300
IN-NETWORK				
COPAY (PCP/SPECIALIST) (per visit)	$20/$35	$25/$40	$30/$45	DEDUCTIBLE + COINSURANCE
DEDUCTIBLE/YR (Individual/Family*)	$0	$150/$300	$300/$600	$1,400/$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
OUT-OF-NETWORK				
DEDUCTIBLE (Individual/Family*)	$1,000/$3,000	$1,500/$4,500	$2,000/$6,000	$2,600/$5,200
COINSURANCE	30%	30%	30%	40%
OUT-OF-POCKET MAXIMUM (includes deductible & coinsurance) (Individual/Family)	$3,500/$10,500	$5,000/$15,000	$6,000/$18,000	$6,000/$12,000
PRESCRIPTION DRUGS (in-network only)				
DEDUCTIBLE/YR (Individual/Family*) (Deductible is combined for retail & mail order)	$100/$300	$100/$300	$100/$300	MEDICAL & PRESCRIPTION DRUG COMBINED
RETAIL: up to 30-day supply				
TIER 1 (generic)	$10	$10	$10	$10 AFTER DEDUCTIBLE
TIER 2 (brand name in Aetna's formulary)	$25	$30	$35	$35 AFTER DEDUCTIBLE
TIER 3 (brand name not in Aetna's formulary)	$40	$50	$60	$60 AFTER DEDUCTIBLE
TIER 4 (specialty drugs)	$50	$60	$70	$80 AFTER DEDUCTIBLE
MAIL ORDER: 31-90-day supply (can also be done through CVS retail pharmacy)				
TIER 1 (generic)	$20	$20	$20	$20 AFTER DEDUCTIBLE
TIER 2 (brand name in Aetna's formulary)	$50	$60	$70	$70 AFTER DEDUCTIBLE
TIER 3 (brand name not in Aetna's formulary)	$80	$100	$120	$120 AFTER DEDUCTIBLE
TIER 4 (specialty drugs)	N/A	N/A	N/A	N/A

*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/.

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MEDICAL PROGRAM DEFINITIONS

What is a copayment?
A copayment is a fixed payment for a covered service that you pay when you receive a health care service. A copayment is sometimes referred to as a "copay." It applies to services for which coverage is indicated as a flat dollar amount.

What is a deductible?
The deductible is the amount of money you pay for covered expenses that must be paid out-of-pocket before the medical program will pay any expenses. It applies to services for which coverage is indicated as "DEDUCTIBLE + COINSURANCE" but not those services for which coverage is indicated as a copayment. Aetna Plans 1-3 have separate deductibles for medical expenses and prescription drug expenses. In Aetna Plan 4, the deductible is combined for medical expenses and prescription drug expenses. Once an individual or family has met the calendar year in-network deductible, then no further in-network deductible is required for the remainder of the calendar year. Once an individual or family has met the calendar year out-of-network deductible, then no further out-of-network deductible is required for the remainder of the calendar year. The deductible is different for in- and out-of-network services.

What is coinsurance?
Coinsurance is your share of the costs of a health care service. It is expressed as a percentage of the covered health care expense, so if the coinsurance is 20%, this means that you pay 20% of the cost of the covered healthcare expense. The coinsurance is different for in- and out-of-network services.

What is an out-of-pocket maximum?
The out-of-pocket maximum is the maximum amount of money you will pay for covered medical services in a calendar year. The out-of-pocket maximum includes copayments, deductibles and coinsurance. The out-of-pocket maximum is different for in- and out-of-network services.

MEDICAL PROGRAM: EXAMPLES

EXAMPLE 1

Aetna Plan 2 (coverage for employee only)

Office visit copayment for a primary care physician:	$25/visit
In-network deductible for an individual:	$150/year
In-network coinsurance for an individual:	10%
Cost for an in-network hospitalization:	Deductible + Coinsurance
In-network out-of-pocket maximum for an individual:	$1,000/year

Each time you go to an in-network primary care physician (for non-preventive care) you pay a $25 copayment. Let's say you went to the primary care physician 4 times. That would equal $100 (that's $25 times 4 visits.) These copayments go toward the in-network out-of-pocket maximum.

Let's assume that after the 4 primary care visits indicated above you are then hospitalized at an in-network hospital. Let's assume that you have not already paid out-of-pocket covered expenses that equal the $1,000 out-of-pocket maximum. You pay the $150 deductible. Then coinsurance would be 10% of the covered hospital expense. Both the deductible and coinsurance that you pay for the hospital go toward the in-network out-of-pocket maximum.

If this hospital expense is $12,000, then 10% of this is $1,200 in coinsurance but that's not what you'll pay under this plan.

You already paid $100 in copayments for the primary care physician and a $150 in-hospital deductible ($100 + $150 = $250).

If we total all of the expenses: $100 in copayments + $150 deductible + $1,200 coinsurance = $1,300. This exceeds the $1,000 in-network out-of-pocket maximum.

The most you can pay in total for these expenses for the calendar year is $1,000 which is the out-of-pocket maximum.

Your payment to the hospital for coinsurance is $750 ($1,000 out-of-pocket maximum - $250 copayments and deductibles), and all other covered in-network expenses are covered at 100% for the remainder of the calendar year.

Let's look at how this works:

4 Visits to primary care physician at $25 per visit: (4 x $25)	=	$ 100
Hospital deductible	=	$ 150
		$ 250
Hospital coinsurance before applying individual out-of-pocket maximum (10% x $12,000)	=	$1,200
Hospital coinsurance after applying individual out-of-pocket maximum ($1,000 - $250)	=	$ 750
Maximum amount you pay in total for all of these expenses ($250 + $750)	=	$1,000

EXAMPLE 2

Aetna Plan 3 (coverage for a family of 5 people)

Office visit copayment for a specialist:	$45/visit
In-network deductible for an individual:	$300year
In-network deductible for a family:	$600/year
In-network coinsurance for an individual or a family:	20%
Cost for an in-network hospitalization:	Deductible + Coinsurance
In-network out-of-pocket maximum for an individual:	$2,000/year
In-network out-of-pocket maximum for a family:	$4,000/year

Each time you and your family go to an in-network specialist you pay a $45 copayment. Let's say your family members went to the specialist 35 times in total. That would equal $1,575 (that's $45 times 35 visits). These copayments go toward both the individual and family in-network out-of-pocket maximums.

Let's assume that after the 35 specialist visits indicated above, four members of your family go to the emergency room. [Let's assume that you have not already paid out-of-pocket covered expenses that equal the $2,000 for an individual out-of-pocket maximum (or $4,000 for the family).] You pay a $200 copayment per person for the emergency room for a total of $800 ($200 x 4). This copayment for the emergency room goes toward the in-network out-of-pocket maximum.

So far you and your family have paid $2,375 in expenses ($1,575 + $800).

Let's assume that after the specialist and emergency room visits indicated above you are then hospitalized at an in-network hospital. You pay the $300 deductible. The coinsurance would be 20% of the covered hospital expense. Both the hospital deductible and coinsurance that you pay go toward the in-network out-of-pocket maximum. If this hospital expense is $8,000, then 20% of this is $1,600 in coinsurance but that's not what you'll pay under this plan.

The total bill for your hospitalization is $1,900 in total ($300 deductible + $1,600 coinsurance). These were the first expenses you had for your health care this year, and they did not exceed the individual out-of-pocket maximum of $2,000……but let's look at the family out-of-pocket maximum.

You and your family already paid $2,675 for the specialist visits, the emergency room, and the hospital deductible ($1,575 + $800 + $300).

If we total all of the expenses: $2,675 + $1,600 coinsurance = $4,275. The most you can pay in total for expenses for the family for the calendar year is $4,000 which is the family out-of-pocket maximum.

Your payment to the hospital for coinsurance is $1,325 ($4,000 out-of-pocket maximum - $2,675 copayments and deductibles for you and the family), and all other covered in-network expenses for you and your family are covered at 100% for the remainder of the calendar year.

Let's look at how this works:

35 Visits to the specialist at $45 per visit: (35 x $45)	=	$1,575
Emergency room copayments at $200 per visit (4 x $200)	=	$ 800
Hospital deductible	=	$ 300
		$2,675
Hospital coinsurance before applying family out-of-pocket maximum (20% x $8,000)	=	$1,600
Hospital coinsurance after applying family out-of-pocket maximum ($4,000 - $2,675)	=	$1,325
Maximum amount you and your family pay in total for all of these expenses ($2,675 + $1,325)	=	$4,000

HEALTH SAVINGS ACCOUNT

The Health Savings Account (HSA) is used to pay qualified medical expenses. You must be enrolled in the Aetna Plan 4 High Deductible Health Plan (HDHP) to participate in the HSA.

An "employee-only" HDHP covers just you. For the purpose of the HDHP, the term "family" plan means a plan that covers you and at least one other person – so both 2-person coverage and coverage for 3 or more people are "family" coverage for the purpose of this plan.

To be eligible to enroll in Aetna Plan 4 you must go through a verification process with Aetna. Aetna must verify your name, date of birth, Social Security number, and address. If you do not have a Social Security Number (or Tax Identification Number) or if you use a post office box for your mailing address, you may not be eligible for the HSA. If you are not eligible for the HSA, you will not be eligible to enroll in Aetna Plan 4 – you'll need to choose from one of the other three Aetna Plans. If Aetna determines that you are eligible to participate in the HSA, your HSA account will then be established.

Contributions to the HSA

If you are enrolled in the HDHP on January 1, BSA will contribute $500 to the HSA on your behalf for the calendar year if you have "employee-only" coverage and $1,000 on your behalf if you have "family" coverage. Such amounts will be prorated if you begin participation in this HSA later in the calendar year.

You may also contribute to the HSA on a pre-tax basis through paycheck deductions throughout the calendar year or on an after-tax basis. The minimum annual contribution is $300. You can deposit money into the HSA at any time and in any amount up to the annual limit as long as you are eligible for the HSA. If you are no longer enrolled in the HDHP, then you no longer can contribute to the HSA.

The Internal Revenue Service (IRS) sets the contribution limits each year. The contribution limits include the amount contributed by BSA. The annual limits for 2022 are:

Coverage	Maximum Total 2022 Contribution	BSA 2022 Contribution	Maximum 2022 Employee Contribution
"Employee-only"	$3,650	$ 500	$3,150
"Family"	$7,300	$1,000	$6,300

If you are 55 or older you can contribute an additional $1,000 to your HSA during 2022. This is a "catch-up" contribution. You can do this each year that you are eligible for the HSA. Once you enroll in Medicare you are no longer permitted to make these contributions.

If you participate in the HSA for less than a full calendar year, the IRS has rules regarding the amount you can contribute to the HSA and potential taxes on such contributions.

The IRS also has rules that apply if you contribute more than the allowable amount to the HSA.

If you are enrolled in Aetna Plan 4 on January 1, BSA contributions and your contributions to the HSA, if any, begin on January 1. For all other enrollments, both BSA contributions and your contributions to the HSA, if any, begin on the first of the month following enrollment in Aetna Plan 4.

If you attain age 65 or become eligible for Medicare in 2022 and are enrolled in Aetna Medical Plan 4 (the high deductible health plan with the health savings account), you will no longer be eligible to participate in that Plan 4 and must elect a different plan. Your choices will be Aetna Plans 1 – 3. Contact the Benefits Office for more information.

HEALTH SAVINGS ACCOUNT

Additional Eligibility Rules

- You cannot be enrolled in both the Health Care Reimbursement Account and the HSA.
- If you are enrolled in Tricare (through the military) you're not eligible for the HSA.
- If you receive care from the Veterans Administration, that may affect your HSA eligibility.
- You cannot contribute to the HSA if you are enrolled in Medicare.

Using The Money In Your HSA

You may use the money that is in the HSA to reimburse yourself for out-of-pocket qualified medical expenses (incurred after the date your HSA is established) that are not paid by the medical and dental programs. Items such as copayments, deductibles, coinsurance and other out-of-pocket costs are the types of items for which you can be reimbursed. Qualified medical expenses can also include vision care costs, prescription drugs, and more. Such expenses can be for you, your spouse and, in general, a dependent you can claim as an exemption on your tax return. You may use the HSA for qualified medical expenses for your spouse and other eligible dependents even if they are not enrolled in the Aetna Plan 4 with you.

You determine when you want to spend your HSA funds. There is no time limit by which you must spend the money in the HSA.

You may either pay for your qualified purchases using a PayFlex debit card at the point of service or pay online from your HSA. You can also transfer funds from your HSA to your personal bank account online.

You do not need receipts to take withdrawals from your HSA, but withdrawals from your HSA are tax-free only if they pay for qualified medical expenses. It is important that you save your receipts and Explanation of Benefits (EOB) notices so that you have proof of such qualified medical expenses in case you are audited by the IRS. If you use the money in the HSA for non-eligible expenses, you will owe income taxes on that withdrawal – and possibly a penalty.

Investing

The money in your HRA earns tax-free interest. In addition, once you reach a certain balance in your account, you may choose from an Aetna's list of mutual funds and invest your HSA money. There are fees associated with such mutual fund investments.

Portability

HSAs are portable. This means that you retain the money in your HSA even if you terminate employment. There is no "use-it-or-lose-it" rule with HSAs. If you don't use the HSA funds, they remain in your HSA each year.

Additional Information

The HSA has many additional features, requirements and restrictions based on IRS rules. Additional information is available through:

- IRS Publication 969 (HSAs and Other Tax-Favored Health Plans) at www.irs.gov/pub/irs-pdf/p969.pdf
- IRS Publication 502 (Medical and Dental Expenses) at www.irs.gov/pub/irs-pdf/p502.pdf
- Benefits website at www.bnl.gov/hr/Benefits/
- PayFlex at (888) 678-8242

HEALTH CARE REIMBURSEMENT ACCOUNT

The Health Care Reimbursement Account is also used to pay qualified medical expenses. If you are enrolled the High Deductible Health Plan (HDHP), you cannot participate in the Health Care Reimbursement Account.

Contributions to the Health Care Reimbursement Account

You may contribute to the Health Care Reimbursement Account on a pre-tax basis through your paycheck throughout the calendar year. Once you are enrolled in this Account, you can only make a change to the amount you are contributing if you have a Qualifying Event.

The Internal Revenue Service (IRS) sets the contribution limits each year. Go to https://www.bnl.gov/hr/Benefits/ for information on the calendar year limits.

If you participate in this Account for less than a full calendar year, you can still contribute up to the maximum annual limit.

Using The Money In Your Health Care Reimbursement Account

The full amount you will be contributing to this Account for the calendar year is available to you as of January 1 (or such later date when you first begin your participation in this Account).

You may use the money in the Health Care Reimbursement Account to reimburse yourself for out-of-pocket qualified medical expenses that are not paid by the medical and dental programs. Items such as copayments, deductibles, coinsurance and other out-of-pocket costs are the types of items for which you can be reimbursed. Qualified medical expenses can also include vision care costs, prescription drugs, and more. Such expenses can be for you, your spouse and, in general, a dependent you can claim as an exemption on your tax return. You may use the Health Care Reimbursement Account for qualified medical expenses for you, your spouse and other eligible dependents even if none of you are enrolled in the Aetna Medical Plans 1-3.

You may either pay for your qualified purchases using a PayFlex debit card at the point of service or you can file a claim (online, by paper, or by fax). Claims are processed daily.

It is important that you save your receipts and Explanation of Benefits (EOB) notices. You do need receipts for your Health Care Reimbursement Account expenses. Payments and reimbursements from your Account are tax-free only if they pay for qualified medical expenses.

You have until March 31 of the following calendar year to submit claims for expenses incurred during the current calendar year.

HEALTH CARE REIMBURSEMENT ACCOUNT

Use-It-Or-Lose-It

The IRS requires you to forfeit any money that you have not used in this Account for expenses incurred during the current calendar year. You have until March 31 of the following calendar year to submit claims for expenses incurred during the current calendar year.

Additional Information

Additional information is available through:

- IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans) at www.irs.gov/pub/irs-pdf/p969.pdf
- IRS Publication 502 (Medical and Dental Expenses) at www.irs.gov/pub/irs-pdf/p502.pdf
  Not all items identified in this publication qualify for the reimbursement account.
- Benefits website at www.bnl.gov/hr/Benefits/
- PayFlex at (800) 284-4885 or www.payflex.com

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10/01/2021