

BSA's 2025 Benefit Open Enrollment & You



**Open Enrollment Dates and Important Information for Retirees,
LTD, and COBRA Participants and their Dependents**

Enroll in the coverage that's right for you!

It's Open Enrollment Time!

Now is the time to consider your needs, review the coverages that are available to you, and decide if you want to enroll or make changes to those plans you are eligible for in 2025.

WHEN IS OPEN ENROLLMENT FOR BENEFITS FOR 2025?

Monday, November 11, 2024, through Monday, November 25, 2024.

Changes made during the Open Enrollment period will be effective on January 1, 2025.

ANNUAL BENEFITS FAIR

The virtual benefits fair for open enrollment including information on the plans is available on our Benefits website at <https://www.bnl.gov/hr/benefits/oe>

WHAT IS OPEN ENROLLMENT?

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

Have you had any changes in your life or expect any changes where a different plan might be a better choice than the plan in which you're currently enrolled? Last year's choices might not make sense for you in 2025.

WHAT BENEFIT ELECTIONS CAN I MAKE DURING OPEN ENROLLMENT?

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

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

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

If you do not make changes, you'll automatically remain in the plan(s) you have on December 31, 2024, if any. Any dependent children who are on your coverage on December 31, 2024 who are no longer eligible on January 1, 2025 will automatically be dropped from your coverage. For instance, a child who reaches age 23 in 2024 and is in the dental plan will no longer be eligible for coverage in 2025.

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

You may be eligible to join the plan 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.

HOW TO ENROLL OR MAKE CHANGES DURING OPEN ENROLLMENT

If you want to enroll or make changes, contact our Benefits Office staff at oe@bnl.gov or call (631) 344-4275, (631) 344-5558, (631) 344-8877. You must make such elections during Open Enrollment.

WHERE CAN I GET HELP?

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

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

DEADLINES

The Open Enrollment period ends on Monday, November 25, 2024. You must make your 2025 benefit elections by this deadline, or you will not be able to make a change during 2025 unless you have a Qualifying Event.

QUALIFYING EVENTS

What is a Qualifying Event?

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

- (a) change in legal marital status: (1) marriage, (2) death of spouse, (3) divorce, (4) legal separation, (5) annulment, (6) domestic partnership
- (b) change in number of dependents: (1) birth, (2) adoption, (3) placement for adoption, (4) death of a dependent, (5) legal guardianship
- (c) change in employment status: (1) termination or commencement of employment of the employee, spouse or dependent, other than for gross misconduct
- (d) change in work schedule: (1) an increase or decrease in the number of hours of employment by the employee, spouse or dependent, (2) a switch between full-time and part-time status, (3) a strike or lockout, (4) commencement or return from an unpaid leave of absence
- (e) the dependent satisfies or ceases to satisfy the requirements for coverage under the plan(s)
- (f) change in the place of residence or work site of the employee, spouse or dependent

QUALIFYING EVENTS

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

For the medical plan and/or vision, you may be eligible to add or delete dependents or add or drop coverage. The change(s) in coverage that you request must relate to the change that affects eligibility for coverage.

How do I change my coverage(s)?

To change your coverage(s) when a Qualifying Event has occurred, you must notify the BSA Benefits Office and complete an enrollment form within 30 days of the date of the Qualifying Event for all Qualifying Events indicated above, except (a)(3), (a)(4) and (e). [60 days applies for items (a)(3), (a)(4) and (e).] 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 vision plan coverage) 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 medical and/or 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
(Applicable to Aetna Medical 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
(Applicable to Aetna Medical Plan)**

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

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

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

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

What is Protected?

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

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

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

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

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

Uses and Disclosures of Your PHI

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

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

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

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

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

Other Uses and Disclosures of Your PHI

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

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

Uses and Disclosures Requiring You to have an Opportunity to Object

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

Your Rights

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

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

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

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

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

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

Brookhaven Science Associates
Brookhaven National Laboratory
Benefits Office, Bldg. 400B
Upton, NY 11973-5000
(631) 344-2877

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/

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) 344-2877.

Notice Date: October 2024

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.

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

| PLAN & BENEFIT: AETNA PRESCRIPTION DRUG BENEFIT | AETNA PLAN 1 | AETNA PLAN 2 | AETNA PLAN 3 | AETNA PLAN 4 |
|---|--------------|--------------|--------------|--------------------------------------|
| PRESCRIPTION DRUGS (in-network only) | | | | Not creditable coverage |
| 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: 631-344-4275, 631-344-5558, or 631-344-8877

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 (TTY 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: October 2024

BSA's 2025 Open Enrollment

Details of Open Enrollment for Participants Not Eligible for Medicare

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

What's New for 2025?

- ⇒ The deductible for Aetna Plan 4 has increased to \$1,650 for single-person coverage and \$3,300 for family-level coverage.
- ⇒ Dental contributions for the PPO and Indemnity Plans have increased slightly for COBRA participants.

ADDITIONAL IMPORTANT INFORMATION

- If you are an eligible family member of:
 - a current Medicare-eligible retiree who has been receiving coverage through the BSA medical plan
- or
- a current Medicare-eligible participant who is receiving BSA LTD Plan benefits who has been receiving coverage through the BSA medical plan,

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

When a participant who is currently not eligible for Medicare is approaching eligibility for Medicare, the participant will receive information from BSA on how to transition to the medical coverage available to Medicare-eligible participants. If the spouse or dependent child of a retiree (or participant who is approved for LTD benefits) becomes eligible for Medicare due to a disability, please contact the Benefits Office at (631) 344-4275, (631) 344-5558 or (631) 344-8877 to notify us of this change.

If you or a covered dependent attain age 65 or become eligible for Medicare in 2025, you must sign up for Medicare Parts A and B through the Social Security Administration. Any person who is eligible for Medicare will no longer be eligible for the Aetna Medical Plan and must elect healthcare coverage through SelectQuote Senior's healthcare exchange. Contact the Benefits Office for additional information.

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

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

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

You can choose from the following medical plans:

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

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



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

SUMMARY OF COVERAGES THROUGH THE MEDICAL PLANS

| | AETNA PLAN 1 | AETNA PLAN 2 | AETNA PLAN 3 | AETNA PLAN 4 |
|---|--|--|--|---|
| PROVIDER NETWORK | Aetna POS II (Open Access) | | | |
| IN-NETWORK | | | | |
| Copay (PCP/Specialist) (per visit) | \$20/\$35 | \$25/\$40 | \$30/\$45 | Deductible & coinsurance |
| Deductible/year (Individual/Family*) | \$0 | \$150/\$300 | \$300/\$600 | \$1,650/\$3,300 |
| Coinsurance | 0% | 10% | 20% | 20% |
| Medical out-of-pocket maximum/year (includes deductible, copays, & coinsurance) (Individual/Family*) | \$5,100/\$10,200 | \$1,000/\$2,000 | \$2,000/\$4,000 | \$3,500/\$8,000 Medical & prescription drugs combined |
| Prescription drugs out-of-pocket maximum/year (includes deductible, copays, & coinsurance) (Individual/Family*) | \$1,500/\$3,000 | \$1,500/\$3,000 | \$1,500/\$3,000 | \$3,500/\$8,000 Medical & prescription drugs combined |
| Emergency room (per visit) | \$100 | \$150 | \$200 | Deductible & coinsurance |
| Inpatient hospital (per admission) | \$500 | Deductible & coinsurance | Deductible & coinsurance | Deductible & coinsurance |
| Outpatient surgery (per visit) | \$100 | Deductible & coinsurance | Deductible & coinsurance | Deductible & coinsurance |
| Teladoc (per telephonic visit) | \$20 | \$25 | \$30 | Deductible & coinsurance |
| Teladoc Dermatology (per telephonic visit) | \$35 | \$40 | \$45 | Deductible & coinsurance |
| Walk-in clinic (per visit) | \$20 | \$25 | \$30 | Deductible & coinsurance |
| Urgent care center (per visit) | \$50 | \$50 | \$50 | Deductible & coinsurance |
| X-ray/laboratory | Covered in full | \$20 | \$20 | Deductible & coinsurance |
| Complex imaging (MRI, CT Scan, ...) | \$50 | \$50 | \$50 | Deductible & coinsurance |
| Hearing Aids | Covered in full | Deductible & coinsurance | Deductible & coinsurance | Deductible & coinsurance |
| Routine eye exam | Covered in full (1 exam every 24 months) | Covered in full (1 exam every 24 months) | Covered in full (1 exam every 24 months) | Covered in full (1 exam every 24 months) |
| Routine physical (limits apply) | Covered in full | Covered in full | Covered in full | Covered in full |
| OUT-OF-NETWORK | | | | |
| Deductible (Individual/Family*) | \$1,000/\$3,000 | \$1,500/\$4,500 | \$2,000/\$6,000 | \$2,600/\$5,200 |
| Coinsurance | 30% | 30% | 30% | 40% |
| Out-of-pocket maximum/year (includes deductible & coinsurance) (Individual/Family) | \$3,500/\$10,500 | \$5,000/\$15,000 | \$6,000/\$18,000 | \$6,000/\$12,000 |
| PRESCRIPTION DRUGS (in-network only) | | | | |
| Deductible/year (Individual/Family*) (Deductible is combined for retail & mail order) | \$100/\$300 | \$100/\$300 | \$100/\$300 | Medical & prescription drugs combined |
| RETAIL: up to 30-day supply | | | | |
| Tier 1 (generic) | \$10 | \$10 | \$10 | \$10 after deductible |
| Tier 2 (brand name in Aetna's formulary) | \$25 | \$30 | \$35 | \$35 after deductible |
| Tier 3 (brand name not in Aetna's formulary) | \$40 | \$50 | \$60 | \$60 after deductible |
| Tier 4 (specialty drugs) | \$50 | \$60 | \$70 | \$80 after deductible |
| MAIL ORDER: 31-90-day supply (can also be done through CVS retail pharmacy) | | | | |
| Tier 1 (generic) | \$20 | \$20 | \$20 | \$20 after deductible |
| Tier 2 (brand name in Aetna's formulary) | \$50 | \$60 | \$70 | \$70 after deductible |
| Tier 3 (brand name not in Aetna's formulary) | \$80 | \$100 | \$120 | \$120 after deductible |
| Tier 4 (specialty drugs) | N/A | N/A | N/A | N/A |

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

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

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've added. For coverage of two or more people, Aetna will issue two cards. Each card will have the policyholder'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 policyholder's name followed by the of each additional dependent.

HOW MUCH WILL THE MEDICAL PLAN COST IN 2025?

For participants who are not eligible for Medicare

| Category | Contributions as a % of Medical Plan Cost | Coverage | Monthly Contribution | | | |
|--|---|------------------|----------------------|------------|------------|------------|
| | | | Plan 1 | Plan 2 | Plan 3 | Plan 4 |
| <ul style="list-style-type: none"> Former non-IBEW employees who retired before 1/1/02 Former IBEW employees who retired before 1/1/04 Former IBEW employees who were approved for BSA LTD Plan benefits after 12/31/11 and are receiving such benefits | 30% | 1 Person | \$406.70 | \$390.42 | \$369.92 | \$357.30 |
| | | 2 People | \$844.47 | \$810.67 | \$768.09 | \$730.98 |
| | | 3 or More People | \$1,122.70 | \$1,077.76 | \$1,021.15 | \$971.93 |
| <ul style="list-style-type: none"> Former non-IBEW employees who were hired before 1/1/11 and retired after 12/31/01 Former IBEW employees who were hired before 1/1/11 and retired after 12/31/03 Former non-IBEW employees who were approved for BSA LTD Plan benefits after 12/31/08 and are receiving such benefits | 40% | 1 Person | \$542.26 | \$520.56 | \$493.22 | \$476.40 |
| | | 2 People | \$1,125.96 | \$1,080.89 | \$1,024.12 | \$974.64 |
| | | 3 or More People | \$1,496.94 | \$1,437.02 | \$1,361.54 | \$1,295.91 |
| <ul style="list-style-type: none"> All employees hired on or after 1/1/11 who retire | 50% | 1 Person | \$677.83 | \$650.71 | \$616.53 | \$595.50 |
| | | 2 People | \$1,407.46 | \$1,351.11 | \$1,280.16 | \$1,218.31 |
| | | 3 or More People | \$1,871.17 | \$1,796.27 | \$1,701.92 | \$1,619.89 |

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

There are three dental plans available to you.

The **Dental Maintenance Organization (DMO)** provides services 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)** allows you to 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** also allows you to 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.

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

SUMMARY OF COVERAGES THROUGH THE DENTAL PLANS

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

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

HOW MUCH WILL THE DENTAL PLAN COST IN 2025?

Participants Who Are Receiving BSA Long Term Disability Benefits

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

COBRA Participants

| Coverage | Monthly Contribution | | |
|------------------|----------------------|-----------|-----------|
| | DMO | PPO | Indemnity |
| 1 Person | \$ 20.26 | \$ 37.34 | \$ 16.51 |
| 2 People | \$ 41.17 | \$ 79.31 | \$ 35.08 |
| 3 or More People | \$ 61.26 | \$ 111.25 | \$ 49.18 |

IDENTIFICATION CARDS

Dental Plans

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

VISION CARE PLAN

Through the 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 with in-network providers that 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.

Retirees who aren't currently enrolled in the plan cannot elect the coverage for 2025.

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

SUMMARY OF COVERAGE THROUGH THE VISION CARE PLAN

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

HOW MUCH WILL THE VISION CARE PLAN COST IN 2025?

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

IDENTIFICATION CARDS

Vision Care Plan

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

CONTACT INFORMATION

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