FLEXIBLE SPENDING ACCOUNTS PLAN 01-01-2016

The Flexible Spending Accounts Plan consists of two accounts, the Health Care Reimbursement Account and the Dependent Day Care Reimbursement Account, which allow you to pay for a variety of health care and dependent day care expenses on a before-tax basis. By paying for expenses on a before-tax basis, you reduce your income for the purpose of state, federal and Social Security taxes. Enrollment in the Flexible Spending Accounts Plan is optional. **Please note that the Employer reserves the right to amend or terminate this Flexible Spending Accounts Plan at any time and for any reason.**

WHO IS ELIGIBLE FOR THE FLEXIBLE SPENDING ACCOUNTS PLAN?

Active Employees

All regular employees of Brookhaven Science Associates, LLC (the "Employer") who work at least 20 hours per week are eligible to participate in the Flexible Spending Accounts Plan on the first day of active employment.

An employee is a "regular employee" if he/she is classified and treated for federal income tax purposes by the Employer as a regular full-time or regular part-time employee of the Employer (as opposed to a temporary, seasonal or casual employee, intern, independent contractor or consultant, agency worker or leased employee), even if the Employer's classification is later determined to be incorrect.

Participation in the Dependent Day Care Reimbursement Account also requires that you are:

- a single parent and require dependent day care so you can work or look for work or,
- married and require day care so you can work and your spouse can work or look for work (if filing jointly) or be a full-time student.

Ineligible Employees

The following employees are not eligible for the Flexible Spending Accounts Plan:

- Employees who are resident undocumented aliens; and
- Employees whose terms of employment are covered by a collective bargaining agreement to which the Employer is a party, unless the collective bargaining agreement provides otherwise.

ENROLLMENT

Eligible employees may enroll in the Health Care and/or Dependent Day Care Reimbursement Accounts within 30 days of their date of hire. Once you enroll, you must continue participation in the Plan until the end of the calendar year or your termination date of employment, if earlier. If you do not enroll for coverage within 30 days of your date of hire, you will be required to wait until the next Open Enrollment Period or until you have a Qualifying Event to elect coverage (see page 2).

If you are enrolled in the Aetna High Deductible Health Plan with the Health Savings Account (in the Brookhaven Science Associates, LLC Medical Plan), you cannot enroll in the Health Care Reimbursement Account.

To enroll, you must complete an enrollment form and indicate the amount you want to contribute to the Health Care and/or Dependent Day Care Reimbursement Accounts. Enrollment forms are available through the BSA Benefits Office. By completing the form, you will authorize an annual salary reduction amount. During the Open Enrollment Period, you may enroll online. Your actual contributions will be made from your paycheck in equal monthly or weekly installments depending on your pay status.

Coverage begins on your date of hire if you complete the enrollment form and submit it to the BSA Benefits Office within 30 days of your date of hire.

Open Enrollment Period

Open enrollment is held once a year. During an Open Enrollment Period, you may elect your contribution amount for the following calendar year. Your election during the Open Enrollment Period will be effective January 1 of the following calendar year. Coverage will not automatically carry forward from year to year. You must elect coverage during the Open Enrollment Period for the following calendar year. Your elections cannot be changed for the remainder of the calendar year unless you notify the BSA Benefits Office of a Qualifying Event within 31 days from the date of the event.

Qualifying Event

A Qualifying Event that allows you to add or drop coverage is a change in your family status or employment status that affects your need for Flexible Spending Accounts Plan coverage. This includes:

(a) Change in legal marital status
    1. marriage
    2. death of spouse
    3. divorce
    4. legal separation
    5. annulment
(b) Change in the 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 termination of the employee for misconduct)
(d) Changes 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 dependent coverage

(f) A change in the place of residence or work site of the employee, spouse or dependent
(g) A significant increase or decrease in the cost of coverage during the Plan Year (Dependent Day Care Reimbursement Account only)
(h) A change in the dependent care provider (Dependent Day Care Reimbursement Account only)

In addition, under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), employees that are eligible but not enrolled in the Health Care Reimbursement Account may enroll for coverage if one the following conditions is met:

- The employee or dependent loses eligibility and is terminated from Medicaid or CHIP* coverage or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP*.

*CHIP (Children's Health Insurance Program) is a state program designed to provide health care coverage for uninsured children and some adults.

You have 31 days from the date of a Qualifying Event to make changes to your Flexible Spending Accounts Plan coverage for all items indicated above except (a)(3), (a)(4) and (e). You have 60 days from the date of a Qualifying Event to make changes to your Flexible Spending Accounts Plan coverage for items (a)(3), (a)(4), and (e), and for changes related to CHIPRA. The change requested must relate to the change that affects eligibility for Flexible Spending Account coverage. Changes are made by completing an enrollment form available in the BSA Benefits Office. The completed form must be submitted, with proof of the Qualifying Event, to the BSA Benefits Office. Your contributions will then be changed for the remainder of the calendar year. Coverage will become effective as soon as administratively feasible after the Plan Administrator has approved the change in status, except that a new child may be added as of the date of birth, date of adoption or date of placement for adoption.

If a judgment, decree or order, including a Qualified Medical Child Support Order (QMCSO), resulting from a divorce, separation, annulment or custody change requires your dependent child to be covered under this Flexible Spending Accounts Plan, you may change your election to provide coverage for the dependent child. If the order requires that another individual (such as your former spouse) cover the dependent child, you may change your election to revoke coverage for the dependent child.

If you do not make a change to your contributions within the applicable period indicated above, you must wait until the next Open Enrollment Period.

HEALTH CARE REIMBURSEMENT ACCOUNT

Benefits Provided

You can use the Health Care Reimbursement Account to reimburse yourself for eligible health care expenses with before-tax dollars. Estimate the amount you expect to spend in the coming year on health care. Then to cover these costs, you contribute to the Account through automatic salary reduction. Throughout the year, you draw money out of your Account and reimburse yourself for the health care expenses as you and your eligible dependents incur them. Your eligible dependents include:

- Your spouse (which may include your same-sex spouse) to whom you are legally married.
- Your child(ren) up to the end of the month of his or her 26th birthday. Children include your natural child, adopted child and stepchild.
- Your unmarried children who are age 26 or over and who are or become mentally or physically incapable of earning their own living, by submitting proof of the child's incapacity within 31 days from the date of incapacity or 31 days from the child's 26th birthday, whichever occurs first.

What Health Care Expenses are Reimbursed?

Expenses that are reimbursable under the Health Care Reimbursement Account are mainly those goods and services currently allowed by the Internal Revenue Service (IRS) as an income tax deduction, but not all items that qualify for a tax deduction also qualify for the Reimbursement Account. However, this does not include premiums paid for insurance coverages. Eligible expenses include, but are not limited to:

- Deductibles and co-insurance payments that are not reimbursed under the medical or dental insurance plans.
- Out-of-pocket expenses.
- Charges not reimbursed by the Medical or Dental Plans that are above reasonable and customary charges.
- Hearing and vision care expenses such as exams, eyeglasses, and contact lenses.
- Annual physical examinations.
- Approved weight-loss and stop-smoking programs, if prescribed by a physician to treat a specific condition.
- Over-the-counter medications used to alleviate or treat personal illness or injuries that are deemed medically necessary and for which the participant has received a prescription. Dietary supplements to maintain one's health (such as vitamins) do not qualify for reimbursement.

How Much May You Contribute Each Year to the Health Care Reimbursement Account?

You may contribute any amount from a minimum of $300 to a maximum of $2,550 maximum each calendar year. These amounts are subject to change.

It is extremely important that you carefully determine the amount you elect to contribute, if any, since under IRS regulations, all amounts that you do not use toward expenses incurred in the calendar year will be forfeited.

Does the Use of Before-Tax Contributions to the Health Care Reimbursement Account Affect Any Other Benefits?

It may. If your annual salary is below the Social Security wage base, your future Social Security benefit may be reduced, but only minimally.

DEPENDENT DAY CARE REIMBURSEMENT ACCOUNT

Benefits Provided

You can use the Dependent Day Care Reimbursement Account to reimburse yourself for eligible dependent day care expenses with before-tax dollars. Estimate the amount you expect to spend in the coming year on day care. Then, to cover these costs, you contribute to the Account through automatic salary reduction. Throughout the year, you draw money out of your Account and reimburse yourself for dependent day care expenses you have made to your day care provider.

What Dependent Day Care Expenses are Reimbursed?

Expenses that are reimbursable under the Dependent Day Care Reimbursement Account are mainly those currently allowed by the IRS as an income tax credit, but not all items that qualify for a tax credit also qualify for the Reimbursement Account. All day care must be rendered by eligible providers. Eligible expenses include, but are not limited to:

- Care of a dependent in your home by a paid provider.
- Care of a dependent outside of your home by a licensed nursery or day care center.
- Household services, such as a housekeeper, provided some portion of the service is to a dependent.

A relative is considered an eligible provider of dependent day care if he or she is not claimed as your dependent for tax purposes. The provider's name, address and Tax Identification Number or Social Security Number must be supplied to receive reimbursement.

Who are Eligible Dependents?

Expenses may be claimed for:

- A child under age 13 who is claimed as a dependent on your income tax return.
- Any dependent you claim for income tax purposes who requires day care because of physical or mental inability.

How Much May You Contribute Each Year to the Dependent Day Care Reimbursement Account?

You may contribute any amount from a minimum of $300 to a maximum of $5,000. However, there are certain guidelines you must follow. If you are single or if you are married and file separate income tax returns, the maximum amount you may contribute is $2,500 in a calendar year. Your total contribution in any calendar year may not exceed your annual earnings or, if less, your spouse's annual earnings.

It is extremely important that you carefully determine the amount you elect to contribute, if any, since under IRS regulations, all amounts you do not use toward expenses incurred in the calendar year will be forfeited.

Dependent Day Care Reimbursement Account or Tax Credit

Federal law currently permits an individual to take a tax credit against federal income taxes for allowable dependent care expenses. When considering contributions to the Dependent Day Care Reimbursement Account, you may want to consider if it is better to take the tax credit or to pay for your dependent care expenses through the Flexible Spending Account.

With the dependent care tax credit, you pay your dependent day care expenses yourself and claim a credit for them on your federal income tax return.

You may use only one of these methods for any given dollar of dependent care costs. You cannot use the Dependent Day Care Reimbursement Account for a particular expense and also claim a credit for that same expense on your tax return.

You should consult your tax advisor to determine whether it is better for you to reimburse yourself for day care expenses with the Dependent Day Care Reimbursement Account or use the tax credit on your income tax return.

Does the Use of Before-Tax Contributions to Dependent Day Care Reimbursement Account Affect Any Other Benefits?

It may. If your annual salary is below the Social Security wage base, your future Social Security benefit may be reduced, but only minimally.

CLAIMS/PAYMENT OF EXPENSES

How to File a Claim or Pay for Expenses

The amounts credited to Flexible Spending Accounts Plan for you may only be used to pay for your, or an Eligible Dependent's, eligible expenses incurred while you were covered under the Health Care Reimbursement Account. An expense is incurred on the date that the service which gives rise to the expense is rendered. If you are not sure whether an expense qualifies for health care reimbursement, you should contact the Claims Administrator.

You must either:

- Use your PayFlex card (which is similar to a debit card) at the point of purchase for your eligible health care expenses where the expenses are debited directly from your Account, or
- Complete a PayFlex Health/Dependent Care Flexible Spending Accounts Claim Form, available in the BSA Benefits Office or through the BSA Benefits Office website at http://www.bnl.gov/hr/Benefits/ReimbursementAccounts.asp , or
- Go online to https://bnl.healthhub.com/EmployeeLogin.aspx and submit your claim electronically.

In general, when submitting a claim for reimbursement, you must submit a receipt along with your claim form including provider name and address, date of service, type of service provided, and dollar amount charged for the service.

For Health Care expense claims, you must first submit your medical and dental claims to the applicable insurance company. You will receive your Explanation of Benefits (EOB) from the

insurance company, which may be submitted to PayFlex as proof of expense. If you are not enrolled in the Medical or Dental Plans or are enrolled in an HMO, you must provide itemized bills.

You can pay for your eligible expenses with the PayFlex card or submit for reimbursement from your Account. If you submit for reimbursement of your claims, you may either set up a direct deposit option with PayFlex or receive a check which is mailed to your home. Please note that if you use your PayFlex card, the Employer reserves the right to request proof that such charges are eligible expenses.

Payments will be issued daily for eligible expenses. For eligible health care expenses, you can be reimbursed for up to the total amount you have elected for the calendar year even though you have not yet contributed that amount into your Account. For eligible dependent care expenses, you can only be reimbursed for up to the total amount that is in your Account at the time of your claims submission or when you use your PayFlex card. You cannot be reimbursed for expenses incurred prior to your participation in the Plan.

How Long Do You Have to Submit Claims for Reimbursement?

You have until March 31 following the calendar year in which you incurred expenses to submit claims for reimbursement. So, for example, if you buy eyeglasses in December, you would still have up to March 31 to claim the expense, provided there is money remaining in your Health Care Reimbursement Account.

If you have any funds in your Account at the time you terminate employment, terminate participation or cease to be eligible to participate, these funds will be forfeited if they are not used for expenses incurred prior to these dates and you do not submit them for reimbursement within the applicable timeframes. Any expenses incurred after these dates are not eligible for reimbursement.

Questions About Claims

If you have a question about your Flexible Spending Account claim, you should contact PayFlex at (800) 284-4885.

How to Appeal a Claim

If your claim is denied, you will receive a written notice of the denial from the Claims Administrator within 30 days after receiving the initial claim. The notice will explain the reason for the denial and indicate the review procedures. This time period may be extended to 45 days if the Claims Administrator needs more information or needs more time for reasons beyond its control, and provides an extension notice during the initial 30-day period. You may request a review of the denied claim. The request must be submitted in writing to the Claims Administrator within 180 days after you receive the denial notice for a claim under the Health Care Reimbursement Account and 60 days after you receive the denial notice for a claim under the Dependent Day Care Reimbursement Account. Submit your request, including your reasons for requesting the review and any additional documents which you believe support your claim. The Claims Administrator will review the claim and ordinarily notify you within 60 days of the date your request for review is received. In special cases requiring a delay, the Claims Administrator will render a decision no later than 60 days after your request for review is received for a claim

under the Health Care Reimbursement Account and 120 days after your request for review is received for a claim under the Dependent Day Care Reimbursement Account.

MISCELLANEOUS

General Information

The Dependent Day Care Reimbursement Account is not covered by ERISA.

Leave of Absence

If you are on an approved Leave of Absence, including for military duty, a serious health condition, or to care for a family member with a serious health condition or a newborn or adopted child, you may continue your Flexible Spending Accounts coverage during the remainder of the calendar year by paying your elected contributions. If you discontinue contributions, only expenses incurred prior to the leave will be eligible for reimbursement. If you discontinued contributions at the time of your leave, upon return to work, you may elect to participate for the remainder of the calendar year by completing an enrollment form. Please note that these rules do not apply to benefits under the Dependent Day Care Reimbursement Account for leaves that extend beyond two weeks.

Restrictions

Flexible Spending Accounts are allowable under Section 125 of the Internal Revenue Code, and certain restrictions apply to them.

- Determination of your annual contributions to your Flexible Spending Account(s) must be made prior to the start of the Plan Year.
- To be eligible for reimbursement, expenses must be incurred in the same year that your salary reductions are credited to the Plan.
- Health care expenses cannot be reimbursed from a Dependent Day Care Reimbursement Account, nor dependent day care expenses from a Health Care Reimbursement Account.
- The amount of pre-tax dollars you elect to contribute to your Health Care or Dependent Day Care Reimbursement Account is irrevocable and thus, will remain in effect for the entire calendar year. You may be eligible to change your contribution only if you have a Qualifying Event.
- All unused Account balances remaining at the end of a Plan Year are forfeited on March 31 following the end of the Plan Year.
- Expenses reimbursed from your Account(s) cannot be claimed as deductions or credits on your federal income tax return.
- Re-enrollment is required each year to have your before-tax contributions made to the Flexible Spending Accounts Plan.
- The IRS considers the two Flexible Spending Accounts totally separate and thus, does not allow you to transfer money from one account to the other.

TERMINATION OF COVERAGE

Flexible Spending Accounts Plan benefits will cease on the earlier of the date your employment terminates or the date you are no longer eligible for coverage. You may not

continue your Dependent Day Care Reimbursement Account but you may continue your Health Care Reimbursement Account. Health Care Reimbursement Account coverage for terminated employees, who continue benefits under COBRA, will cease on the earlier of the date you elect to drop such coverage, the date you are no longer eligible for coverage, when you fail to pay contributions or if the Employer terminates the Flexible Spending Accounts Plan.

Coverage for terminated employees, who continue benefits under COBRA, will cease on the earlier of the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay contributions.

Please note that your coverage will terminate immediately if you commit an intentional misrepresentation or fraud on the Flexible Spending Accounts Plan.

Your coverage will also end on the date the Employer discontinues the Flexible Spending Accounts Plan.

COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your Health Care Reimbursement Account coverage. It can also become available to other members of your family who are covered under the Health Care Reimbursement Account when they would otherwise lose their Health Care Reimbursement Account coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Flexible Spending Accounts Plan Health Care Reimbursement Account coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Flexible Spending Accounts Plan Health Care Reimbursement Account, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Flexible Spending Accounts Plan Health Care Reimbursement Account because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Flexible Spending Accounts Plan Health Care Reimbursement Account because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Flexible Spending Accounts Plan Health Care Reimbursement Account because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Flexible Spending Accounts Plan as a "dependent child."

When is COBRA Coverage Available?

The Flexible Spending Accounts Plan will offer COBRA continuation coverage to qualified beneficiaries of your Health Care Reimbursement Account only after the BSA Benefits Office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the BSA Benefits Office of the qualifying event.

Please note that the Employer does not have to offer you COBRA continuation coverage for the Health Care Reimbursement Account if, at the time of the qualifying event, the premium you must pay for this coverage exceeds the remaining coverage available to you for the Plan Year under your Health Care Reimbursement Account. For example, if you end employment in March after electing to contribute $1,800 to the Health Care Reimbursement Account and you have already submitted claims totaling $1,000, then your remaining coverage would be $800, but your cost to keep this coverage would be $1,377 ($1,800 X 102% = $1,836/12 = $153/month times the nine months remaining in Plan Year). In this case, you would not be entitled to continuation coverage under the Health Care Reimbursement Account. Before electing continuation coverage under the Health Care Reimbursement Account, you should contact the BSA Benefits Office and evaluate your alternatives.

Notification Requirements

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the BSA Benefits Office in writing within 60 days after the qualifying event occurs and provide documentation of the event.

When the BSA Benefits Office has been notified that one of these events has occurred, they will in turn notify you and your dependents of the right to elect continuation coverage.

If you do not elect continuation coverage within 60 days from the date of the notice from the BSA Benefits Office or the date of the qualifying event, whichever is later, your Flexible

Spending Accounts Plan coverage will end retroactively to the date of the event that caused the loss of coverage.

If you elect continuation coverage, you will have the Flexible Spending Accounts Plan coverage you had before the event, although it may be modified if coverage changes for similarly situated participants.

How is COBRA Coverage Provided?

Once the BSA Benefits Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts until the last day of the Plan Year in which the qualifying event occurs.

COBRA Premium Requirements

You, or your eligible dependents, will be required to pay 102% of the full cost of the continuation coverage under the provisions of COBRA. You will be billed for the required premium on a regular basis. Under the Health Care Reimbursement Account, your compensation is reduced, and you pay for medical expenses on a pre-tax basis. However, to continuation coverage under the Health Care Reimbursement Account, required premiums must be paid on an after-tax basis (plus the two percent administrative fee).

Termination of Coverage Under COBRA

Continuation coverage will end when any of the following events occur:

- The BSA Benefits Office is notified by you or your dependent to discontinue coverage.
- The last day of the Plan Year in which the qualifying event occurs.
- The individual becomes eligible for Medicare after the date of the COBRA election.
- An individual becomes covered under another group plan, unless a pre-existing condition prevents you or your dependent from being covered by the other plan.
- For a spouse or dependent child: If the BSA Benefits Office is not notified within 31 days of the date of divorce or legal separation.
- For a dependent child: If the BSA Benefits Office is not notified within 31 days of the date the dependent status ends.
- Payment for continuation coverage is not paid on time.
- The Flexible Spending Accounts Plan is terminated for active employees.

GENERAL INFORMATION

Name of Plan:	Brookhaven Science Associates, LLC Comprehensive Welfare Benefits Plan
Type of Benefit:	This benefit is a welfare plan consisting of an account which allows you to pay for a variety of health care expenses on a before-tax basis.
Effective Date:	January 1, 2016
Name, address, and telephone number of the Plan Sponsor and Plan Administrator: The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. Benefits under the Plan shall be paid only if the Plan Administrator, or it delegate, in its sole discretion determines that a Participant is entitled thereto. The Plan Administrator has delegated the discretionary authority to make benefit determinations to the Third Party Administrator.	Brookhaven Science Associates, LLC Brookhaven National Laboratory PO Box 5000 Upton, NY 11973-5000 (631) 344-8000
Agent for Service of Legal Process:	General Counsel Brookhaven Science Associates, LLC Brookhaven National Laboratory PO Box 5000 Upton, NY 11973-5000
Plan Sponsor's federal tax identification number:	11-3403915
Plan Number:	501
Plan Year:	January - December
Type of Funding:	The benefit is funded from the general assets of the employer.
Source of Funds:	This benefit is paid for by employee contributions.

Type of Administration:	PayFlex Systems USA, Inc. provides claims administration and other services through an administrative contract.
Benefit and Claims Administrator:	PayFlex Systems USA, Inc. PO Box 3039 Omaha, NE 68103-4310 Phone: (800) 284-4885 Fax: (402) 231-4310

PRIVACY OF INFORMATION

Your protected health information will not be disclosed without your written authorization, unless such disclosure is permitted by law. Protected health information is individually identifiable information that is maintained relating to the provision of your health care, such as your health care records, claims payment information, and health care visit and treatment patterns.

YOUR RIGHTS UNDER ERISA

As a participant in the Health Care Reimbursement Account of the Flexible Spending Accounts Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plans and Benefits

- Examine without charge, at the Plan Administrator's office, all documents governing the plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Termination of Coverage and COBRA sections and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

- In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your right under ERISA.

Enforce Your Rights

- If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof, concerning the qualified status of a domestic relations order or medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance With Your Questions

- If you have any questions about your plans, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

This information is intended to provide only a summary of BSA's benefits program. Nothing contained herein 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.