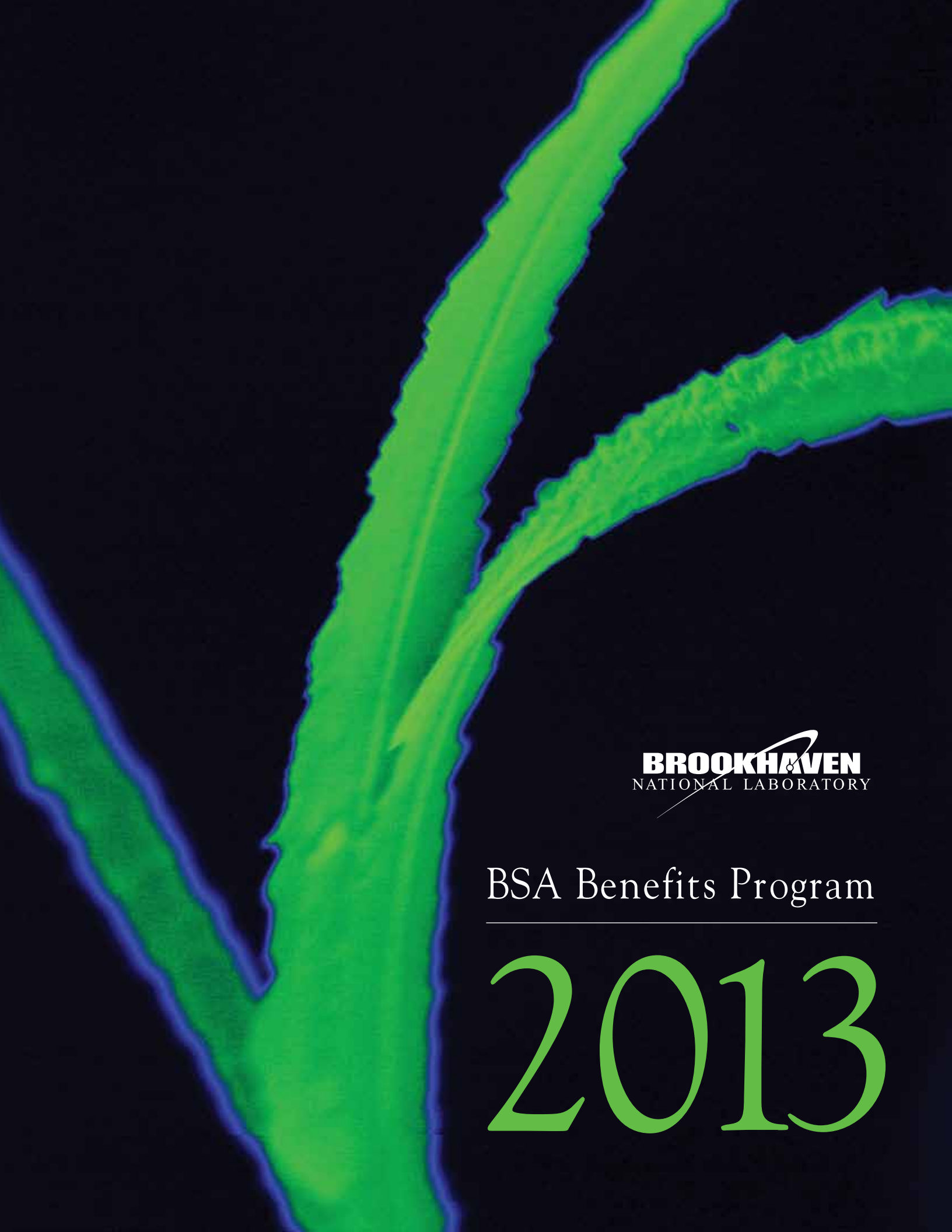

BROOKHAVEN
NATIONAL LABORATORY

BSA Benefits Program

2013

BSA Benefits Program

Brookhaven Science Associates (BSA) believes that employee benefits are an important and meaningful part of the compensation received by employees.

This booklet provides you with an overview of your BSA benefits. Eligible employees can choose from a wide variety of programs designed to offer you the benefits that make the most sense for you and your family. Please review this booklet carefully before making your benefit choices.

Additional information on the benefit programs, including Summary Plan Descriptions, is available on the Benefits Office website at http://www.bnl.gov/hr/Benefits/.

New Employees

New employees may elect benefits during their "new employee" orientation. Information on the benefits program for new employees begins on page 6.

All Employees

All eligible employees may make changes to their benefits during the Open Enrollment period. You may also be eligible to make changes to your benefits if you have a Qualifying Event.

Information on Open Enrollment for 2013 benefits and benefit plan changes, effective January 1, 2013, is on pages 4 through 5.

Information on Qualifying Events is on page 26.

This booklet describes the benefits that are currently in effect and is subject to change. **BSA reserves the right to amend or terminate the benefit programs at any time and for any reason.**

This publication is printed on 100% post consumer recycled paper

Here's What You'll Find In This Booklet

Plan Changes Effective January 1, 2013

Medical Program

For all employees:

- Your premiums for medical coverage are based on the Medical Program you elect, the number of people you enroll, and your annual base salary. The premiums may change from year to year so it is important that you review the 2013 medical premiums in the Medical section of this booklet.

Health Care Reimbursement Account

For all employees:

- Based on the terms of the Affordable Care Act (also known as National Health Care Reform), the maximum amount you may contribute to the Health Care Reimbursement Account has been reduced from $4,000 per year to $2,500 per year.

Transit Commuter Reimbursement Account

For all employees:

- Based on current Internal Revenue Service limits, you may contribute from a minimum of $25 to a maximum of $1,500 each calendar year (but no more than $125 per month).

Important Notice

Long Term Care Plan

Prudential is discontinuing the sale of group long term care insurance effective June 30, 2013. They have indicated that they will continue coverage for participants who have such coverage prior to that date but will not accept new applications or enrollments as of that date. For additional information, contact Prudential at (800) 732-0416.

Open Enrollment For 2013 Benefits

Open Enrollment Dates

The Open Enrollment period will be held from **Monday, November 5, 2012 through Friday, November 16, 2012**.

Open Enrollment Deadline

The deadline for enrollments/changes is **Friday, November 16, 2012**. Online elections and paper forms must be received by the Benefits Office, Bldg. 400B by this date to be eligible for the Open Enrollment period.

Effective Date For Open Enrollment Elections

Changes made during the Open Enrollment period will be effective on **January 1, 2013**.

Representatives and Literature

Representatives from the Benefits Office and the CIGNA and Vytra medical plans, the Delta Dental plan and PayFlex (for the reimbursement accounts) will be available in the lobby of Bldg. 400 on **Thursday, November 8, 2012** from 11:00 a.m. to 2:00 p.m. to answer any questions you may have. Literature will be available.

Open Enrollment For 2013 Benefits

Changes You Can Make to Your Benefits During Open Enrollment

Medical and Dental Programs

- During the Open Enrollment period you may make the following changes to your medical and/or dental coverage:
  - Join the Medical and/or Dental Programs
  - Drop medical and/or dental coverage
  - Change from one Medical and/or Dental Program to another
  - Add eligible family members to your coverage
  - Drop family members from your coverage.
- The elections you have in place for the medical and dental programs will roll forward from one year to the next for you and your eligible family members only if all criteria for eligibility are met, including, for the dental program, timely submission of proof of full-time student status. For additional information, please refer to the Summary Plan Descriptions available on the Benefits Office website at http://www.bnl.gov/hr/Benefits/.

Health Care, Dependent Day Care and Transit Commuter Reimbursement Accounts

- You must re-elect the reimbursement accounts each year. Your election will not roll forward from one year to the next.

Vacation Buy Plan

- You must re-elect vacation buy time each year. Your election will not roll forward from one year to the next.
- Vacation buy time can only be used after your regular accrued vacation time has been exhausted.
- The deadlines for use of 2013 vacation buy time are December 20, 2013 for monthly employees and December 22, 2013 for weekly employees.

How to Make Your Benefit Elections

- You may either make your 2013 benefit elections online or complete a paper enrollment form.

Online Enrollment/Changes

- Online enrollment is available for medical and dental benefits, reimbursement accounts, and the Vacation Buy Plan.
- Online enrollment requires that you have a password for PeopleSoft HR. If you do not currently have access to PeopleSoft HR (this is the same system that is used for electronic time reporting) or you are experiencing a problem logging in, call the ITD Help Desk at x5522.
- To access online enrollment, log into PeopleSoft HR and click on the following links: Employee Self Service, Benefits, Open Enrollment, and then select the coverage(s) you are changing.
- Kiosks are available in the lobby of Human Resources, Bldg. 400B, for online enrollment.

Enrollment/Changes by Paper Form

- Enrollment/changes will be accepted by paper form. If you choose to use an enrollment form, they are available from the Benefits Office, Bldg. 400B.

Additional Information

Additional information is available through the Benefits Office and through the following websites and telephone numbers. Provider directories are only available online at the websites indicated below.

Medical Program	Website	Telephone #
CIGNA	www.cigna.com	(800) 244-6224
Vytra (non-prescription drug assistance)	www.vytra.com	(631) 694-6565
Vytra (use CIGNA for prescription drug assistance)	Use CIGNA website	(800) 244-6224

Dental Program	Website	Telephone #
Delta Dental DMO	www.deltadentalins.com	(800) 422-4234
Delta Dental PPO and Indemnity	www.deltadentalins.com	(800) 932-0783

Reimbursement Accounts	Website	Telephone #
PayFlex	www.bnl.healthhub.com	(800) 284-4885

Medical Programs

We are pleased to offer you Medical Programs through CIGNA (PPO) and Vytra (EPO). You can choose from:

The **CIGNA Preferred Provider Organization (PPO)** where you may use physicians and facilities of your choice. If services are received from an in-network provider, there are co-payments and no claim filing. The network is the Open Access Plus (OAP) network. If services are received from a provider who is not in the network, you have an annual deductible and partial reimbursement of expenses. You or your medical provider must submit claim forms. You do not need to select a primary care physician, and referrals to specialists are not required.

The **Vytra Exclusive Provider Organization (EPO)** where services are provided through a network of participating physicians and facilities. There are co-payments and no claim filing. The EPO does not provide coverage for providers and facilities that are not in Vytra's EPO network except in limited emergency situations. You do not need to select a primary care physician, and referrals to specialists are not required.

Q: Is enrollment in the Medical Program voluntary?
A: Yes.

Q: Am I eligible to participate?
A: You may participate as of your first day of employment if you are a regular employee working at least 20 hours per week.

Q: What is the benefit?
A: The Medical Programs provide coverage for many services such as hospitalization, office visits for illness, prescription medication, and mental health and substance abuse care. We do not have any pre-existing condition clauses in the programs.

Q: Can I also enroll my family for medical coverage?
A: Yes. As long as you enroll yourself for medical coverage, you can also enroll the following dependents:

- Your spouse.
- Your same-sex domestic partner and such partner's eligible dependent children. Restrictions apply.
- Your unmarried children up to 26 years of age (including adopted or stepchildren).
- Your unmarried children age 26 or older who are mentally or physically incapable of self-support (if within 31 days after their 26th birthday you submit proof of the incapacity to the Benefits Office and are they approved by the insurance company).

Q: What is the cost of coverage?
A: The current cost of coverage is as follows each pay period. (The Annual Base Salary category for eligible part-time employees is based on their full-time equivalent salary.) Coverage can be paid for on a before-tax or an after-tax basis through your paycheck. These costs also apply to all employees who are on an approved leave of absence.

Annual Base Salary	Medical Program	Employee Only		Employee + 1 Dependent		Employee + 2 or More Dependents	
		Weekly	Monthly	Weekly	Monthly	Weekly	Monthly
$0 - $39,999.99	CIGNA	$18.00	$78.00	$37.97	$164.54	$52.14	$225.93
	Vytra	$12.04	$52.17	$24.47	$106.06	$34.80	$150.80
$40,000 - $69,999.99	CIGNA	$27.00	$117.00	$56.96	$246.81	$78.21	$338.89
	Vytra	$18.06	$78.26	$36.71	$159.09	$52.20	$226.20
$70,000 - $99,999.99	CIGNA	$34.20	$148.19	$72.15	$312.63	$99.06	$429.26
	Vytra	$22.87	$99.12	$46.50	$201.51	$66.12	$286.52
$100,000 and over	CIGNA	$43.20	$187.19	$91.13	$394.90	$125.13	$542.23
	Vytra	$28.89	$125.21	$58.74	$254.54	$83.52	$361.92

Q: How do I sign up?

A: New employees sign up for coverage by completing an enrollment form within 30 days from your first day of employment. All other eligible employees may sign up for coverage during the Open Enrollment period. You may also be eligible to sign up for coverage if you have a Qualifying Event. See the Open Enrollment section and the Qualifying Events section for more information.

Q: Can I make changes to my coverage?

A: Yes. If you have a Qualifying Event, you may be eligible to add or drop coverage at that time. See the Qualifying Events section for more information. You may also change your coverage during the Open Enrollment period, and coverage will be effective January 1 of the following calendar year. See the Open Enrollment section for more information.

Q: Will my election automatically continue into the next calendar year?

A: Yes. The elections you have in place for the medical program will roll forward from one year to the next for you and your eligible family members only if all criteria for eligibility are met. For additional information, please refer to the Summary Plan Description available on the Benefits Office website at http://www.bnl.gov/hr/Benefits/.

Q: Where can I get more information on the programs?

A: A comparison of the programs is provided in the back of this booklet. Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 2877 or ext. 5126.

Dental Programs

We are pleased to offer you Dental Programs through Delta Dental (PPO, DMO and Indemnity). You can choose from:

The **Preferred Provider Organization (PPO)** where you may use dentists of your choice. If services are received from an in-network provider, your out-of-pocket expenses will be lower than if you use a provider who is not in the network. You may use two networks: Delta Dental Premier and Delta Dental PPO. You have an annual deductible and partial reimbursement of expenses. You or your dental provider must submit claim forms.

The **Dental Maintenance Organization (DMO)** that provide 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 **Indemnity Plan** where you use dentists of your choice. If you use a dentist in the network, 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 dentist must submit claims for reimbursement.

Q: Is enrollment in the Dental Program voluntary?
A: Yes.

Q: Am I eligible to participate?
A: You may participate as of your first day of employment if you are a regular employee working at least 20 hours per week.

Q: What is the benefit?
A: The Dental Programs provide coverage for preventive, basic and restorative dental services and orthodontia (for children). The DMO also has coverage for adult orthodontia.

Q: Can I also enroll my family for dental coverage?
A: Yes. As long as you enroll yourself for dental coverage, you can also enroll the following dependents:

- Your spouse.
- Your same-sex domestic partner and such partner's eligible dependent children. Restrictions apply.
- Your unmarried children up to the 19th birthday (including adopted or stepchildren) who are dependent upon you for support. Stepchildren must reside with you to be eligible for coverage.
- Your unmarried children through the end of the calendar year in which they attain age 23 (including adopted and stepchildren) who reside with you and are dependent on you for at least half of their support, and who attend an accredited college or university on a full-time basis. You must submit proof of such attendance to the Benefits Office each school semester. For additional information, including timing of the submission, please refer to the Summary Plan Description available on the Benefits Office website at http://www.bnl.gov/hr/Benefits/.
- Your unmarried children age 19 or older who are mentally or physically incapable of self-support (if within 31 days after their 19th birthday, you submit proof of the incapacity). Coverage may be continued for a covered child who is over age 19 and who becomes mentally or physically incapable of self-support (if within 31 days after the incapacity, you submit proof of the incapacity). You must submit proof of the incapacity to the Benefits Office and be approved by the insurance company.

Q: Are there any circumstances under which a child over age 19 who was covered by the program (based on the requirements above) can continue to be covered if they take a medically necessary leave of absence from school?
A: Yes. Based on the provisions of Michelle's Law, a dependent child who is covered under a group health insurance plan who (1) is enrolled in a post-secondary educational institution and (2) needs to take a medically necessary leave of absence on account of a serious illness or injury from which the child is suffering may be eligible to retain his/her health care coverage while on the medically necessary leave of absence.

To qualify for the extension of coverage:

- the child must be enrolled as an eligible dependent under a BSA health care plan,
- the child must be a full-time student at an accredited college or university immediately before the first day of the medically necessary leave of absence,
- proof of the leave from the educational institution must be provided to the Benefits Office, and
- the child's treating physician must provide certification that the child is suffering from a serious illness or injury that necessitates the leave of absence.

Such coverage can continue until the earlier of:

- one year from the start of the medically necessary leave of absence or
- the date on which such coverage would otherwise be terminated under the terms of the health plan.

In order to be eligible for such benefits, provide proof of the leave from the educational institution and proof of the serious illness from the child's physician to the Benefits Office, Bldg. 400B, within 31 days of the beginning of the medically necessary leave.

Q: What is the cost of coverage?

A: The current cost of coverage is as follows each pay period. Coverage can be paid for on a before-tax or an after-tax basis through your paycheck. These costs also apply to all employees who are on an approved leave of absence.

Program	Employee Only		Employee + 1 Dependent		Employee + 2 or More Dependents	
	Weekly	Monthly	Weekly	Monthly	Weekly	Monthly
Delta DMO	$1.15	$ 5.00	$2.31	$10.00	$4.38	$19.00
Delta PPO	$2.33	$10.11	$4.81	$20.86	$7.90	$34.23
Delta Indemnity	$1.15	$ 5.00	$2.31	$10.00	$4.38	$19.00

Q: How do I sign up?

A: New employees sign up for coverage by completing an enrollment form within 30 days from your first day of employment. All other eligible employees may sign up for coverage during the Open Enrollment period. You may also be eligible to sign up for coverage if you have a Qualifying Event. See the Open Enrollment section and the Qualifying Events section for more information.

Q: Can I make changes to my coverage?

A: Yes. If you have a Qualifying Event, you may be eligible to add or drop coverage at that time. See the Qualifying Events section for more information. You may also change your coverage during the Open Enrollment period, and coverage will be effective January 1 of the following calendar year. See the Open Enrollment section for more information.

Q: Will my election automatically continue into the next calendar year?

A: Yes. The elections you have in place for the dental program will roll forward from one year to the next for you and your eligible family members only if all criteria for eligibility are met, including timely submission of proof of full-time student status. For additional information, please refer to the Summary Plan Description available on the Benefits Office website at http://www.bnl.gov/hr/Benefits/.

Q: Where can I get more information on the programs?

A: A comparison of the programs is provided in the back of this booklet. Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 2877 or ext. 5126.

Health Care Reimbursement Account

We are pleased to offer you a Health Care Reimbursement Account that allows you to pay for a variety of health care expenses on a before-tax basis through a HealthHub account through PayFlex.

Q: Is enrollment in the Health Care Reimbursement Account voluntary?
A: Yes.

Q: Am I eligible to participate?
A: You may participate as of your first day of employment if you are a regular employee working at least 20 hours per week.

Q: What is the benefit?
A: You may reimburse yourself with before-tax dollars for eligible out-of-pocket expenses. By paying for expenses on a before-tax basis, you reduce your income for the purpose of state, federal and Social Security taxes. You estimate how much you expect to spend on unreimbursed health care expenses for the calendar year and have that amount withheld pre-tax from your paychecks throughout the year in equal weekly or monthly amounts.

You may either pay for your qualified purchases using the HealthHub (PayFlex) Card at the point of service or you can file a claim (online, by paper, or by fax). Claims are processed daily. You have until March 31 of the following calendar year to submit claims for expenses incurred.

Q: Is there a limit to the amount I can contribute?
A: Yes. You may contribute from a minimum of $300 to a maximum of $2,500 each calendar year.

Q: Will reducing my taxable salary by contributing to this program have an effect on any other benefits?
A: It may. If your annual salary is below the Social Security wage base, your future Social Security benefit may be reduced, but only minimally.

Q: What happens if I don't use up all of the money I have contributed?
A: The IRS requires you to forfeit all amounts that you do not use toward expenses incurred in the calendar year.

Q: What types of expenses are reimbursable?
A: You can be reimbursed for many expenses incurred by you or your eligible dependents that the IRS allows as income tax deductions, but not all items that qualify as a tax deduction also qualify for the reimbursement account. Premiums paid for health care coverage cannot be reimbursed. Eligible expenses include but are not limited to:

- Deductibles and co-payments not covered by your medical or dental programs
- Out-of-pocket medical or dental expenses and charges above reasonable and customary levels
- Hearing and vision care expenses such as eye 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 if they are deemed as medically necessary and the participant has received a prescription for these expenses. Dietary supplements to maintain one's health (such as vitamins) do not qualify for reimbursement.

You can use IRS Publication 502 at http://www.irs.gov/pub/irs-pdf/p502.pdf as a guide, but not all items that qualify for a tax deduction also qualify for the reimbursement account. Contact PayFlex at (800) 284-4885 for additional information.

Q: Who is an eligible dependent?
A: A dependent for the purpose of the Health Care Reimbursement Account includes:

- Your spouse.
- Your children up to their 26th birthday.
- Your unmarried children who are mentally or physically incapable of earning their own living.

Q: How do I sign up?
A: New employees sign up for coverage by completing an enrollment form within 30 days from your first day of employment. All other eligible employees may sign up for coverage during the Open Enrollment period. You may also be eligible to sign up for coverage if you have a Qualifying Event. See the Open Enrollment section and the Qualifying Events section for more information.

Q: Can I make changes to my coverage?
A: Yes. If you have a Qualifying Event, you may be eligible to add or drop coverage at that time. See the Qualifying Events section for more information. You may also change your coverage during the Open Enrollment period, and coverage will be effective January 1 of the following calendar year. See the Open Enrollment section for more information.

Q: Will my election automatically continue into the next calendar year?
A: No. If you want to participate in the program each year, you must enroll each year during the Open Enrollment period. Your election will not roll forward from one year to the next.

Q: Where can I get more information on the program?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 2877 or ext. 5126.

Dependent Day Care Reimbursement Account

We are pleased to offer you a Dependent Day Care Reimbursement Account that allows you to pay day care expenses on a before-tax basis through a HealthHub account through PayFlex.

Q: Is enrollment in the Dependent Day Care Reimbursement Account voluntary?
A: Yes.

Q: Am I eligible to participate?
A: You may participate as of your first day of employment if you are a regular employee working at least 20 hours per week and are:

- a single parent who requires dependent day care so you can work, or
- married and require day care so you can work and your spouse can work, seek employment, or be a full-time student.

Q: What is the benefit?
A: You may reimburse yourself with before-tax dollars for eligible out-of-pocket expenses. By paying for expenses on a before-tax basis, you reduce your income for the purpose of state, federal and Social Security taxes. You estimate how much you expect to spend on dependent day care expenses for the calendar year and have that amount withheld pre-tax from your paychecks throughout the year in equal weekly or monthly amounts.

You file a claim either online, by paper, or by fax. Claims are processed daily. You have until March 31 of the following calendar year to submit claims for expenses incurred.

Q: Is there a limit to the amount I can contribute?
A: Yes. You may contribute from a minimum of $300 to a maximum of $5,000 each calendar year. If you are single or if you are married and file separate income tax returns, the maximum you may contribute is $2,500.

Q: Will reducing my taxable salary by contributing to this program have an effect on any other benefits?
A: It may. If your annual salary is below the Social Security wage base, your future Social Security benefit may be reduced, but only minimally.

Q: What happens if I don't use up all of the money I have contributed?
A: The IRS requires you to forfeit all amounts that you do not use toward expenses incurred in the calendar year.

Q: What types of expenses are reimbursable?
A: You can be reimbursed for many expenses incurred by you or your eligible dependents that the IRS allows as income tax deductions, but not all items that qualify as a tax deduction also qualify for the reimbursement account. Eligible expenses include but are not limited to:

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

You can use IRS Publication 503 at http://www.irs.gov/pub/irs-pdf/p503.pdf as a guide, but not all items that qualify for a tax deduction also qualify for the reimbursement account. Contact PayFlex at (800) 284-4885 for additional information.

A relative is considered an eligible provider of dependent day care if he/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.

Q: Who is an eligible dependent?
A: A dependent for the purpose of the Dependent Day Care Reimbursement Account includes:

- A child under age 13 who is claimed as a dependent on your income tax return. Claims incurred on or after a child's 13th birthday will not be covered.
- Any dependent you claim for income tax purposes that requires day care because of physical or mental inability.

Q: How do I sign up?
A: New employees sign up for coverage by completing an enrollment form within 30 days from your first day of employment. All other eligible employees may sign up for coverage during the Open Enrollment period. You may also be eligible to sign up for coverage if you have a Qualifying Event. See the Open Enrollment section and the Qualifying Events section for more information.

Q: Can I make changes to my coverage?
A: Yes. If you have a Qualifying Event, you may be eligible to add or drop coverage at that time. See the Qualifying Events section for more information. You may also change your coverage during the Open Enrollment period, and coverage will be effective January 1 of the following calendar year. See the Open Enrollment section for more information.

Q: Will my election automatically continue into the next calendar year?
A: No. If you want to participate in the program each year, you must enroll each year during the Open Enrollment period. Your election will not roll forward from one year to the next.

Q: Where can I get more information on the program?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 2877 or ext. 5126.

Transit Commuter Reimbursement Account

We are pleased to offer you a Transit Commuter Reimbursement Account that allows you to pay transit expenses to and from work on a before-tax basis through a HealthHub account through PayFlex.

Q: Is enrollment in the Transit Commuter Reimbursement Account voluntary?
A: Yes.

Q: Am I eligible to participate?
A: You may participate as of your first day of employment if you are a regular employee working at least 20 hours per week.

Q: What is the benefit?
A: You may reimburse yourself with before-tax dollars for your eligible out-of-pocket expenses. By paying for expenses on a before-tax basis, you reduce your income for the purpose of state, federal and Social Security taxes. You estimate how much you expect to spend on transit commuter expenses for the calendar year and have that amount withheld pre-tax from your paychecks throughout the year in equal weekly or monthly amounts.

You may either pay for your qualified purchases using the HealthHub (PayFlex) Card at the point of service or you can file a claim (online, by paper, or by fax). Vanpooling may only be reimbursed by submitting a claim form. Claims are processed daily. You have until March 31 of the following calendar year to submit claims for expenses incurred.

Q: Is there a limit to the amount I can contribute?
A: Yes. You may contribute from a minimum of $25 to a maximum of $2,940 each calendar year (but no more than $245 per month).

Q: Will reducing my taxable salary by contributing to this program have an effect on any other benefits?
A: It may. If your annual salary is below the Social Security wage base, your future Social Security benefit may be reduced, but only minimally.

Q: What happens if I don't use up all of the money I have contributed?
A: If you re-enroll during Open Enrollment, the IRS requires the remaining contributions to stay in the account. They may be used for future transit expenses and will apply to the maximum contribution above. If, however, you do not re-enroll, the IRS requires you to forfeit all amounts that you do not use toward expenses incurred in the calendar year.

Q: What types of expenses are reimbursable?
A: You can be reimbursed for the cost of vanpooling, trains, ferries and buses to and from work. It excludes parking, gasoline and telecommuting expenses. Contact PayFlex at (800) 284-4885 for additional information.

Q: How do I sign up?
A: New employees sign up for coverage by completing an enrollment form within 30 days from your first day of employment. All other eligible employees may sign up for coverage during the Open Enrollment period. See the Open Enrollment section for more information. You may also sign up at any time during the year.

Q: Can I make changes to my coverage?
A: Yes. You may make changes to this coverage at any time including electing, dropping, or changing your contribution by notifying the Benefits Office.

Q: Will my election automatically continue into the next calendar year?
A: No. If you want to participate in the program each year, you must enroll each year during the Open Enrollment period. Your election will not roll forward from one year to the next.

Q: Where can I get more information on the program?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 2877 or ext. 5126.

Vacation Buy Plan

We are pleased to offer you a Vacation Buy Plan where you can purchase additional vacation time on a pre-tax basis and spread the cost of doing so over the calendar year. For information on time-off for accrued vacation provided by the Laboratory, see the Vacation section in the back of this booklet.

Q: Is enrollment in the Vacation Buy Plan voluntary?
A: Yes.

Q: Am I eligible to participate?
A: You may participate as of your first day of employment if you are a regular employee working at least 20 hours per week.

Q: What is the benefit?
A: You may purchase a minimum of 8 hours (up to a maximum of 40 hours) of vacation time in 1-hour increments each calendar year in addition to the vacation time you are eligible to receive from the Laboratory. Vacation buy benefits for eligible part-time employees will be prorated according to your official work schedule. Additional vacation time is paid for through pre-tax payroll deductions taken equally from your paychecks throughout the year. The hours of vacation you purchase become available to you as of your date of employment. Each year thereafter, if you buy vacation time, the hours of vacation you purchase become available to you as of January 1 of the following year.

Q: How is the cost of purchased vacation time determined?
A: For a full calendar year, divide your full-time Annual Base Salary by 2,080. You can prorate this accordingly for a partial year. Your Base Salary is the amount that will be reflected on your W-2 statement, before exercise of any salary reductions. Overtime payments, shift premiums, termination payments, severance pay, and other forms of compensation are not included in Base Salary. For union employees, Base Salary is based on the terms of their collective bargaining agreements.

Q: Will purchasing vacation time affect any other benefits?
A: When you purchase vacation time, you buy unpaid time off but stretch the cost over the entire year. Since the Retirement Plan and the 401(k) Plan contributions are based on actual base pay, you do not receive and cannot make contributions for the unpaid time.

Q: What happens if I don't use up all of the vacation time I have purchased?
A: It will not be carried over to the next calendar year. That remaining time will be paid back to you in your last paycheck in December based on the rate at which it was purchased. The amount you are reimbursed will be taxable in your paycheck. Any applicable contributions to the Retirement Plan and 401(k) Plan will be made at that time.

Q: How can vacation buy time be used?
A: The use of all vacation time requires the approval of your supervisor and must be in accordance with Laboratory vacation policies. When you record the vacation buy hours on your timecard, you will use a special vacation buy code. Vacation buy time can only be used after your regular accrued vacation time has been exhausted. The deadlines for use of 2013 vacation buy time are December 20, 2013 for monthly employees and December 22, 2013 for weekly employees.

Q: How do I sign up?
A: New employees sign up for coverage by completing an enrollment form within 30 days from your first day of employment. All other eligible employees may sign up for coverage during the Open Enrollment period. See the Open Enrollment section for more information.

Q: Can I make changes to my coverage?
A: You can only make a change in your election if it corresponds to a change in the number of hours you are scheduled to work.

Q: Will my election automatically continue into the next calendar year?
A: No. If you want to participate in the program each year, you must enroll each year during the Open Enrollment period. Your election will not roll forward from one year to the next.

Q: What happens when I terminate employment?
A: The benefits will cease on the earlier of the date your employment terminates or the date you are no longer eligible for coverage. Your final paycheck will be adjusted for:

- Hours purchased but not used. You will be reimbursed for these in your final paycheck based on the rate at which they were purchased and the applicable tax.
- Hours purchased and used but not yet paid for. These will be deducted from your final paycheck based on the rate at which they were purchased.

Q: Where can I get more information on the program?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/**,** or through the Benefits Office at ext. 2877 or ext. 5126.

Life Insurance Plan

We are pleased to offer you Life Insurance coverage through The Hartford. You can choose from:

- Basic Life Insurance
- Supplemental Life Insurance (Option 1 and Option 2)

Q: Is enrollment in the Life Insurance Plan voluntary?
A: Basic Life Insurance and Accidental Death and Dismemberment (AD&D) coverage are mandatory. Supplemental Life Insurance is voluntary.

Q: Am I eligible to participate?
A: You may participate as of your first day of employment if you are a regular employee working at least 20 hours per week.

Q: What is the benefit?
A: The Life Insurance Plan provides both life insurance coverage in the case of death and AD&D coverage in the case of certain dismembering injuries or accidental death.

Basic Life Insurance is provided in an amount approximately equal to one times your Annual Base Salary. In addition, you may purchase Supplemental Life Insurance (Option 1) coverage in an amount equal to your Basic Life Insurance coverage. Supplemental Life Insurance (Option 2) coverage is available in an amount to make total life insurance coverage equal to approximately three times your Annual Base Salary. Life insurance amounts are adjusted for eligible part-time employees and for employees age 65 or older.

AD&D coverage is in addition to life insurance coverage and provides a maximum benefit of $25,000.

Q: What is the cost of coverage?
A: Basic Life Insurance and AD&D coverage are paid for by the Laboratory. Supplemental Life Insurance coverage is paid for on an after-tax basis through your paycheck, and the monthly cost is as follows:

For under age 30:	$.08 per $1,000 of Supplemental Life Insurance coverage
For ages 30 to 44:	$.20 per $1,000 of Supplemental Life Insurance coverage
For ages 45 and over:	$.30 per $1,000 of Supplemental Life Insurance coverage

Here's an example of the cost for Supplemental Life Insurance coverage for an employee who is age 46.

If your base pay is $49,000 and you purchase Supplemental Life Insurance (Option 1) coverage:

Supplemental Life Insurance (Option 1) Coverage Amount:	$50,000*	
Cost of Coverage:	$15.00 per month	($50,000 x $0.30 / $1,000)

*$50,000 coverage amount is Annual Base Salary rounded up to the nearest multiple of $2,500 that exceeds your Annual Base Salary.

Q: How do I sign up?
A: You will be signed up for Basic Life Insurance coverage and may elect Supplemental Life Insurance coverage at your new hire orientation meeting. You will also designate a beneficiary(ies) for your coverage.

If you do not enroll for Supplemental Life Insurance coverage within 90 days from your first day of employment, you must submit evidence of insurability and be approved by the insurance company before insurance can become effective.

Q: Can I make changes to my coverage?
A: Yes. Although Basic Life Insurance is automatically provided to you at no cost, since you pay for Supplemental Life Insurance coverage, you may decrease or drop that coverage at any time. If you do not already have the maximum amount of life insurance coverage available, you may request an increase in your coverage by logging into PeopleSoft HR and clicking the following links: Employee Self Service, Benefits, Benefits Home, Life Insurance, and then select Edit Your Coverage Amount. If you are requesting an increase in coverage, you will receive an email directly from the insurance company with instructions for submitting evidence of insurability. Such increase in coverage is only effective if approved by the insurance company. If you prefer to complete a form to change your coverage, contact the Benefits Office.

Q: Can I make changes to my beneficiary(ies)?
A: Yes. To change the beneficiary(ies) for your life insurance at any time, you may either make the change online or complete a form. To make your change online, log into PeopleSoft HR and click on the following links: Employee Self Service, Benefits, Benefits Home, Life Insurance and then select Edit Your Beneficiaries. If you prefer to complete a form, contact the Benefits Office.

Q: Where can I get more information on the program?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 2877 or ext. 5126.

Long Term Disability Plan

We are pleased to offer you Long Term Disability Plan coverage through The Hartford.

Q: Is enrollment in the Long Term Disability (LTD) Plan voluntary?
A: The LTD Plan is mandatory upon completion of one year of active service for all regular employees who work at least 20 hours per week.

Q: Am I eligible to participate?
A: You will participate if you are a regular employee working at least 20 hours per week and have completed one year or more of active service.

Q: What is the benefit?
A: If you become totally disabled for a continuous period of 180 days as a result of an accident or illness and are approved for the benefit by the insurance company, commencing with the 181st day of disability, the LTD insurance program provides a maximum benefit of 60% of your Base Salary plus a contribution to the BSA Retirement Plan. The duration of LTD benefits depends on several factors including, but not limited to, your age at disablement. LTD benefits are offset by other sources of income such as workers' compensation, government retirement system benefits, Social Security benefits, etc.

Q: What is the cost of coverage?
A: The cost of LTD insurance coverage is shared by you and the Laboratory. LTD coverage is paid for on an after-tax basis through your paycheck and costs $0.431 per $100 of Annual Base Salary

Here's an example of the cost for LTD Insurance coverage.

If your Annual Base Salary is $49,000 and you have LTD insurance coverage:

Maximum LTD Coverage Amount:	$2,450 per month	($49,000 x 60% / 12 months)
Cost of Coverage:	$17.60 per month	($49,000 x $0.431 / $100 / 12 months)

Q: How do I sign up?
A: You will be signed up for coverage at your new hire orientation meeting and will be eligible to participate in the plan after meeting the eligibility requirements indicated above.

Q: Where can I get more information on the program?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 7516.

Retirement Plan

We are pleased to offer you the BSA Retirement Plan. You can choose to invest Retirement Plan contributions in TIAA-CREF, Fidelity Investment Services, and/or The Vanguard Group funds.

Q: Is enrollment in the Retirement Plan voluntary?
A: No. Participation is mandatory once you meet the eligibility requirements to participate.

Q: Am I eligible to participate?
A: You must work at least 1,000 hours per year to be eligible to participate in the plan. Employees who were not participating in the plan on December 31, 2006 will be enrolled upon the earlier of (a) attainment of age 21 and the completion of one year of continuous service or (b) the attainment of age 30 and the completion of 6 months of continuous service.

Employees who work on a part-time, temporary or irregular basis must complete 1,000 hours of service each year to be credited with a year of service. Persons with guest or visitor appointments, research associates (including RAs, junior RAs, senior RAs, and research fellows), and student assistants are not eligible to participate in this plan.

Q: What is the benefit?
A: For eligible employees hired or rehired on or after January 1, 2011, the Laboratory contributes an amount equal to 9% of your Base Salary to this plan (10% for employees hired before January 1, 2011 and for members of the IBEW union). You are not required or allowed to contribute to this plan.

You can allocate the contributions between approved TIAA-CREF, Fidelity Investment Services and The Vanguard Group funds. The list of funds is in the back of this booklet.

For employees who were participating in the plan on December 31, 2006, the money that is contributed is vested 100% immediately. For employees who began participating in the plan after December 31, 2006, the money that is contributed is vested as follows: 0% after one year of service, 25% after 2 years of service, 50% after 3 years of service, 75% after 4 years of service and 100% after 5 years of service.

You will receive quarterly statements from the investment company(ies).

Q: Is there a limit to the amount the Laboratory will contribute?
A: The Internal Revenue Service (IRS) limits the contributions the Laboratory can make on your behalf to take into account no more than $255,000 of your Annual Base Salary. This limit is subject to change.

Q: How do I sign up?
A: If you become eligible to participate in the plan, you will automatically be enrolled in the plan in our default investment fund, the TIAA-CREF Lifecycle Fund, based on your year of birth, and your estate will be designated as your beneficiary. You will receive information from TIAA-CREF on the Lifecycle Fund and how to change your asset allocation and your beneficiary designation.

Q: Can I make changes to my investment allocations?
A: Yes. You can change your allocation of contributions among the various investment options at any time. If you want to change the allocation within an investment company, you must contact the investment company directly. If you want to change investment companies or the allocation between companies, you must complete an allocation form available in the Benefits Office.

Q: Can I make changes to my beneficiary(ies)?
A: Yes. To change the beneficiary(ies) for your Retirement Plan at any time, a change form is available on the website at http://www.bnl.gov/hr/Benefits/retirement/default.asp, or you may contact the Benefits Office.

Q: Are loans available from the plan?
A: No.

Q: Are withdrawals available from this plan?
A: Withdrawals are not permitted from this plan while a participant is eligible for contributions to be made to his/her account. Withdrawals may be available after termination of employment. Restrictions apply.

Q: Does this plan accept rollover contributions from other plans?
A: No.

Q: Where can I get more information on the plan?
A: Additional information is available on the web at http://www.bnl.gov/hr/Benefits/retirement/default.asp, or through the Benefits Office at ext. 7516.

401(k) Plan

We are pleased to offer you the BSA 401(k) Plan. You can choose to invest 401(k) contributions in TIAA-CREF, Fidelity Investment Services, and/or The Vanguard Group funds.

Q: Is enrollment in the 401(k) Plan voluntary?
A: Yes.

Q: Am I eligible to participate?
A: If you are a full-time employee, you are eligible to participate in this plan as of your first day of employment. If you work on a part-time, temporary or irregular basis, you may participate as of the earlier of January 1 or July 1 following the completion of 1,000 hours of service during the 12 consecutive calendar month period beginning with your date of employment. Persons with guest or visitor appointments are not eligible to participate in this plan.

Q: What is the benefit?
A: This plan enables you to increase your retirement savings in addition to the contributions, if any, under the Retirement Plan. Contributions to this plan are made through regular pre-tax payroll deductions. This reduces your taxable income, so you pay less tax now. All interest and earnings on the money you invest are tax-deferred until you withdraw them in the future.

You may contribute up to 25% of your gross pay to this plan. In addition, participants age 50 or over may make additional catch-up contributions to the plan. The maximum catch-up contribution is $5,500. This limit is subject to change.

You can allocate the contributions between approved TIAA-CREF, Fidelity Investment Services and The Vanguard Group funds. The list of funds is in the back of this booklet. The money that is contributed is 100% vested immediately.

You will receive quarterly statements from the investment company(ies).

Q: Is there a limit to the amount you may contribute?
A: The Internal Revenue Service (IRS) limits the contributions you can make to the plan. The 2013 limit is $17,500. This includes any contributions you may have made to another employer's retirement plan during the calendar year. In addition, the IRS limits the contributions to take into account no more than $255,000 of your Annual Base Salary. These limits are subject to change.

Q: When can I sign up?
A: You may sign up at any time.

Q: How do I sign up?
A: Contact the Benefits Office at ext. 7516. You will complete enrollment forms that will authorize the contributions (pre-tax salary reduction) and the funds in which plan contributions will be invested and designate your beneficiary(ies).

Q: Can I make changes to my investment allocations?
A: Yes. You can change your allocation of contributions among the various investment options at any time. You can change the percentage you are contributing to the plan once each calendar month. This includes a change from no contributions to starting contributions and vice versa. You can, however, cease your contributions at any time.

If you want to change the allocation within an investment company, you must contact the investment company directly. If you want to change investment companies, the allocation between companies, or the percentage you are contributing, contact the Benefits Office for additional information, or log into PeopleSoft HR and click the following links: Employee Self-Service, Benefits, and then select Change My 401(k).

Q: Can I make changes to my beneficiary(ies)?
A: Yes. To change the beneficiary(ies) for your 401(k) Plan at any time, a change form is available on the website at http://www.bnl.gov/hr/Benefits/retirement/default.asp, or you may contact the Benefits Office.

Q: Are loans available from the plan?
A: Yes. Loans are permitted from a participant's TIAA-CREF accumulations in this plan.

Q: Are withdrawals available from this plan?
A: Withdrawals are permitted from this plan if:

- The participant retires, dies, or terminates employment or
- The participant attains age 59 ½ or
- The participant incurs a financial hardship. (Restrictions apply.)

Q: Does this plan accept rollover contributions from other plans?
A: Yes. A participant may make rollover contributions to this plan upon providing proof that the contribution is eligible for transfer to this plan. Transfers from the following plan types are eligible: 401(a), 403(a), 401(k), 403(b), 457(b) or conduit IRAs (pre-tax).

Q: Where can I get more information on the plan?
A: Additional information is available on the web at http://www.bnl.gov/hr/Benefits/retirement/default.asp, or through the Benefits Office at ext. 7516.

Long Term Care Plan

We are pleased to offer you Long Term Care Plan that can provide benefits for specific types of medical care and assistance not covered by the medical program. This program is provided through the Prudential Insurance Company of America. Prudential is discontinuing the sale of group long term care insurance. They have indicated that they will continue coverage for participants who have such coverage prior to June 30, 2013 but will not accept new applications or enrollments after that date. For additional information, contact Prudential at (800) 732-0416.

Q: Is enrollment in the Long Term Care Plan voluntary?
A: Yes.

Q: Am I eligible to participate?
A: You may participate as of your first day of employment if you are a regular employee working at least 20 hours per week. Your spouse, your parents and parents-in-law, retirees (and their spouses or surviving spouses), grandparents (including in-laws) and adult children age 18 and older (and their spouse) may also participate subject to satisfactory evidence of insurability.

Q: What is the benefit?
A: Long term care refers to a wide range of personal care, health care and social services for people of all ages who suffer a chronic disease or long-lasting disability. Such care is sometimes referred to as custodial care and also provides help with normal activities of daily living such as walking or dressing. Services can take place in a skilled nursing facility, an adult day care/community center, in your home, or in a hospice.

The Long Term Care Plan can help to pay for the cost of such care if the participant suffers a loss of functional capacity after coverage is effective. The loss must result in the need for continual human assistance in at least two of the following six activities of daily living: eating, transferring, dressing, bathing, continence or toileting. The qualifying loss of functional capacity can be caused in two ways:

- By injury, illness or the effects of aging which make the person physically incapable of performing specific activities of daily living, or
- By a diagnosed, irreversible, organic, mental impairment which makes the person incapable of performing specified activities of daily living.

Alternatively, a participant with a severe cognitive impairment (e.g. Alzheimer disease) may qualify for benefits without meeting two of the six activities indicated above.

If the participant qualifies for the benefit, the program will provide a daily benefit based on the level of coverage elected and the place of confinement. Preexisting conditions limitations, waiting periods, and other restrictions apply.

Q: What is the cost of coverage?
A: The cost is based on your age at the time the coverage is issued and the level of coverage you elect.

Q: How do I sign up?
A: To sign up for coverage, request an enrollment form at your new hire orientation meeting. If you do not enroll for long term care coverage within 31 days from your first day of employment, you must submit evidence of insurability and be approved by the insurance company before coverage can become effective. Eligible dependents may apply at the same time as the employee but must submit evidence of insurability and be approved by the insurance company before coverage can become effective. Prudential will not accept new enrollments after June 30, 2013.

Q: Can I make changes to my coverage?
A: Contact Prudential for additional information.

Q: Where can I get more information on the program?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through Prudential at (800) 732-0416, or at www.prudential.com/gltcweb (Group Name: brookhaven; Access Code: bsaltc). Enrollment forms are available through the Benefits Office at ext. 2877 or ext. 5126.

Other Programs and Benefits

Employee Assistance Program (EAP)

The EAP is a free, voluntary, confidential service, providing employees with assessments, consultations, and referrals. It is designed to assist employees and household members in dealing with a variety of personal concerns such as depression, marital difficulties, concerns with children, alcoholism, and financial issues and provides 1-5 free visits per calendar year, per family member per identified problem. You can contact Magellan at (800) 327-2182. They are available 24 hours a day, 365 days a year.

The EAP counselor will listen to your concerns and identify key issues of your particular situation. The EAP counselor will then assist you in devising a plan of action. Your problem may be resolved through consultation, support, or information. However, if you need further assistance, you may be referred to a counselor, social service, consumer credit, or self-help groups. If an employee has used the EAP for one type of problem and a new problem is identified, an additional 5 visits are available. Although the EAP does not perform long term treatment, after the initial diagnostic or crisis visits are exhausted, if the person needs more counseling in order to resolve the problem, every effort will be made to link the employee to providers who are part of their medical insurance plan. Through the EAP, you can find productive solutions to personal problems and improve your health and well-being.

You can also access Magellan's website at www.magellanhealth.com/member. Click on the "I'm A Member" link and then the "New or Unregistered User" link. Enter the toll-free number (800) 327-2182 and click "Continue."

In addition, EAP services are also available onsite in the Occupational Medicine Clinic. You can schedule an appointment by calling our onsite EAP at ext. 4567 (Monday through Friday; 8:30 a.m. – 5:00 p.m.).

Adoption Assistance Program

All regular employees who work at least 20 hours per week are eligible to participate in this program.

The Adoption Assistance Program provides eligible employees financial assistance up to a maximum of $5,000 per adopted child for individuals for certain expenses related to the adoption of an unrelated minor child under the age of eighteen (18). The adoptive child may not be a relative or stepchild. A $10,000 maximum applies if both spouses/same-sex domestic partners work for BNL.

To request a reimbursement for eligible expenses, you must submit a request for reimbursement form, itemized bills, proof of payment, and a certified copy of the judicial order of adoption to the Benefits Office within 90 days after the adoption is final. Financial assistance reimbursement will be made only after the adoption is final. Reimbursements are made directly to the employee, are considered taxable income, and are subject to withholdings at the time of payment.

The following expenses are reimbursable:

- Licensed adoption agency fees (including fees for placement and parental counseling).
- Legal costs (including attorney's fees and court costs).
- Charges for transportation to obtain physical custody of the adoptive child (including reasonable and customary travel expenses for both the adoptive parents and the adoptive child).

In order to be eligible for this program, you must notify the Benefits Office, ext. 2881, in writing within 30 days of the time an adoption proceeding has commenced.

Additional information is available through the Benefits Office at ext. 2881.

Child Development Center (CDC)

All employees, guests or contractors are eligible to enroll their children in the Child Development Center. Space permitting, grandparents with affiliations to the Laboratory are also eligible. Full-time and part-time enrollment options are available.

The CDC offers a day care program for children between the ages of six weeks to five years. The Center is open on weekdays from 7:30 a.m. to 6:00 p.m. throughout the year except for Laboratory holidays. The emphasis is on each individual child's process of learning. The Center is managed by Bright Horizons Family Solutions. and is licensed by the New York State Department of Social Services and accredited by the National Association for the Education of Young Children (NAEYC). NAEYC accreditation identifies the Center as accomplishing the highest standards possible for early childhood education and establishes compliance, through professional review, to meet NAEYC's highest quality early childhood criteria.

Additional information is available on the web at www.bnl.gov/HR/CDC/ChildDevCntr.asp, or at ext. 7416.

Other Programs and Benefits

Tuition Assistance Program

All regular employees who work at least 20 hours per week are eligible to participate in this program as of your first day of employment.

The Tuition Assistance Program encourages and supports the continuing education and training of employees. The program is designed to encourage attendance at credit courses and degree programs offered by accredited institutions and job-relevant vocational courses. The program provides reimbursement for pre-approved courses that are intended to enhance job-relevant skills and contribute to the employee's career growth at the Laboratory.

Additional information is available on the web at https://sbms.bnl.gov/sbmsearch/subjarea/137/137_SA.cfm, or through the Tuition Office at ext. 7631.

Flexible Work Schedule

The Laboratory believes that flexible schedules can help our staff accomplish more while simultaneously addressing their personal needs such as attending college, raising children, caring for elderly parents and volunteering in the community. We have three flexible work arrangements: FlexMonth, CoreHours and TeleWork. Additional information is available at https://sbms.bnl.gov/sbmsearch/subjarea/198/198_SA.cfm.

Travel Accident Insurance Plan

All regular, temporary and part-time employees, visiting scientists, guests, and members of the Board of Directors are eligible for this plan. You do not need to enroll, and the cost is paid for by the Laboratory.

The Travel Accident Insurance Plan provides 24-hour benefits for accidental death and dismemberment and permanent and total disability while on authorized Laboratory business travel. Coverage begins at the actual starting point of an anticipated trip, whether this is your place of employment, your home, or some other location, whichever occurs last. Coverage terminates upon your return to home or place of employment, whichever occurs first.

Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 7516 or ext. 2881.

Sick Leave

All employees who work at least 20 hours per week (except part-time temporary employees) are eligible for this benefit. Sick leave accrual is prorated for part-time regular employees and employees on part-time term appointments based on their official work schedules.

Sick leave is granted to provide continuity of income during absences due to illness or injury. Sick leave accrues at the rate of 1 ¼ days for each full month of service up to a maximum of 108 days.

Additional information is available on the web at https://sbms.bnl.gov/sbmsearch/Id/ID13/ID13d141.htm.

Vacation

All employees who work at least 20 hours per week (except temporary or part-time employees) are eligible for this benefit. Vacation accrual is prorated for eligible part-time employees based on their official work schedules.

Vacation credit accrues regularly during the course of your employment to allow you a scheduled period for rest and relaxation.

If you are on a weekly payroll, vacation credit accrues monthly according to the following schedule:

Less than 5 years of service:	1 day for each full month of continuous service
At least 5 years of service, but less than 10 years:	1 ¼ days for each full month of continuous service
At least 10 years of service, but less than 15 years:	1 ½ days for each full month of continuous service
15 or more years of service:	2 days for each full month of continuous service

If you are on a monthly payroll, vacation credit accrues monthly according to the following schedule:

Less than 5 years of service:	1 ½ days for each full month of continuous service
At least 5 years of service, but less than 10 years:	1 ¾ days for each full month of continuous service
10 or more years of service:	2 days for each full month of continuous service

Additional information is available on the web at https://sbms.bnl.gov/sbmsearch/Id/Id13/Id13d131.htm.

Other Programs and Benefits

Holidays

All employees who work at least 20 hours per week (except those employees who are in an ineligible part-time or temporary part-time employment category) are eligible for this benefit.

The following nine regularly scheduled holidays are observed by the Laboratory.

New Year's Day	Independence Day	Thanksgiving Day
Presidents' Day	Labor Day	Friday after Thanksgiving Day
Memorial Day	Veterans Day	Christmas Day

Two additional holidays observed during the year are announced each January. In addition, a half-day holiday will be observed usually consisting of the last four hours of your regularly scheduled day preceding Christmas.

Employee Discounts

All employees are eligible for the following discount programs.

Brookhaven Employees Recreation Association (BERA) Employee Discount Program
The BERA Discount Program provides discounts to events, trips, stores, services, etc. Additional information is available on the web at www.bnl.gov/bera/recreation/discounts.asp.

National Vision, Inc.
National Vision Inc. helps participants enjoy good vision health and save money on vision care needs. The program is easy to use. You pay National Vision, Inc. directly for all professional services and receive instant savings from the program's reduced fees. National Vision, Inc. is located in the Wal-Mart store in Middle Island at 750 Middle Country Road and can be reached at (631) 345-0065.

Recreation

The Laboratory provides and maintains on-site recreation facilities and encourages employees, visitors, guests and facility users to participate in a broad program of social, cultural and athletic events. Recreation facilities located on the Laboratory site include an indoor swimming pool with locker and shower rooms, a gymnasium with exercise and weight rooms, six tennis courts, a recreation park with softball, football and soccer fields, an 18-station parcourse fitness circuit, and a recreation building for meetings and parties.

Additional information is available on the web at www.bnl.gov/bera/.

Domestic Partner Information for Health Care Programs

Summary of Benefits and Tax Implications
Brookhaven Science Associates (BSA) offers medical and dental coverage to the same-sex domestic partners of eligible employees, participants receiving long-term disability benefits, and retirees. This means that a same-sex domestic partner and that person's child(ren) will be eligible for the medical and dental benefits for which a spouse and child(ren) are currently eligible. Due to Internal Revenue Service regulations, expenses for domestic partners and their dependents are not eligible for reimbursement from either the health care or dependent care reimbursement accounts. (Domestic partner coverage is not available to persons with guest or visitor appointments, or research collaborators.)

This summary contains additional information on the definition of a domestic partner, and on the tax impact of enrolling a domestic partner for medical and/or dental coverage.

If, after reading this material, you want to enroll your same-sex domestic partner for benefits, please contact the Benefits Office at ext. 2877 or ext. 5126. You will need to complete enrollment and payroll authorization forms and either provide (a) a copy of your marriage certificate or (b) an Affidavit of Domestic Partnership form and proof of domestic partnership to the Benefits Office, Building 400B. You may enroll a same-sex domestic partner and such domestic partner's eligible child(ren) during the annual Open Enrollment period or when you have a Qualifying Event.

Once enrolled for the calendar year, you cannot change or cancel your medical or dental elections for the remainder of the calendar year. You may only make changes to your coverage during the annual Open Enrollment period, effective as of January 1 of the following year, or when a Qualifying Event occurs. See the Qualifying Events section for more information.

Definition of Domestic Partner for the Purpose of the BSA Medical and Dental Programs
For the purpose of benefit eligibility, BSA defines "Domestic Partners" as an eligible BSA employee, participant receiving BSA long-term disability benefits, or a BSA retiree and one other person of the same sex sharing a committed and exclusive relationship that meets all of the following criteria:

- You are legally married (if you reside in a state that recognizes same-sex marriage) OR

- If you are live in a state that does not recognize same-sex marriage:
    - Both the enrollee and the domestic partner are eighteen years of age or older and unmarried, and
    - Are of the same sex as each other, and
    - Are not related by blood in any manner that would prohibit legal marriage, and
    - Have assumed mutual obligations for the welfare and support of each other, and
    - Have been sharing a common residence and living together as a couple in the same household, and
    - Are each other's sole domestic partner.

Domestic partners do not include roommates, siblings, parents or other blood relationships. BSA is extending medical and dental benefits to eligible domestic partners and their eligible dependents for all eligible regular employees who are scheduled to work 20 or more hours a week, participants receiving BSA long-term disability benefits, and BSA retirees who are otherwise eligible for medical benefits.

Medical and Dental Program Provisions
The program provisions for domestic partners are generally the same as for married couples. For example, the same employee contribution amounts, enrollment procedures, and coverage limitations apply to everyone**.** However, there are some important procedural and federal income tax differences, so be sure to carefully review this entire summary as you and your domestic partner make your benefits decisions.

Enrolling for Benefits
Before you can enroll your domestic partner in the program, you must first either supply (a) a copy of your marriage certificate or (b) an Affidavit of Domestic Partnership form and proof of domestic partnership (a copy of your domestic partner registry or proof of financial interdependence). By signing the form, you affirm that your relationship with your domestic partner meets BSA's definition. If this relationship ends or changes so that it no longer meets BSA's definition, you are required to notify the Benefits Office immediately by submitting an Affidavit of Termination of Domestic Partnership form. These forms are available in the Benefits Office.

Falsification of information on the certification form or failure to notify BSA of any relevant change in the relationship will subject you to disciplinary action up to and including termination of employment and possible charges of fraud.

You must sign up your domestic partner and any eligible domestic partner's children during the annual Open Enrollment period or within 31 days of either:

- Becoming eligible for the benefit or
- The date that the relationship becomes one that meets BSA's criteria for such benefit.

Federal Tax Consequences
You should read this section carefully, since the tax treatment of domestic partner health care benefits under federal law is different than the tax treatment of health care benefits provided to a spouse.

Federal tax law generally provides that the provision of health care benefits by an employer to its employees does not create any additional income for an employee. The same is true of employer-provided health care benefits for the spouses and dependent children of employees. Furthermore, federal tax law provides that employees can make pre-tax contributions to pay for benefits for themselves, their dependent children and spouses.

However, there is no such treatment for domestic partners. In general, the provision of health care benefits to your domestic partner (or that person's child) will result in additional taxable income to you. There is an exception to this general statement. If your domestic partner (or that person's child(ren)) qualifies as your dependent under federal tax law, such tax treatment can be avoided. While you will have to make your own informed decision about the status of your domestic partner and/or that person's child(ren), in general, either will qualify as your dependent if all of the following are true:

- The person is a citizen or national of the United States or a resident of the U.S., Canada or Mexico,
- The person is not your spouse,
- The person is a member of your household during the entire calendar year,
- The person has his or her principal place of abode throughout the year in your home,
- The person receives more than half of his or her annual financial support from you, and
- He or she does not violate local law by virtue of his or her relationship with you.

If this is the case, to avoid such taxation, you will need to complete a Dependent Tax Affidavit form.

Assuming that your domestic partner and/or that person's child is not your dependent, then enrolling either of them in the program will result in additional taxable income to you. The amount of additional taxable income will be equal to the excess of the value of the benefits provided over the amounts you contribute under the program for the benefits. Your contributions for such dependent's coverage must be made on an after-tax basis. Reimbursements received or payments made to providers under the program will not be taxable to you.

Any tax consequences of the domestic partnership and the coverage offered under the program are the responsibility of the employee and not of BSA. You should also be aware that some courts have recognized non-marriage relationships as the equivalent of marriage for the purpose of establishing and dividing community property. Any legal consequences of domestic partnership are the responsibility of the employee and not of BSA.

Contributions for Coverage
Your contributions for providing health care coverage to your domestic partner (or that person's child) will be the same as that charged for a spouse (or child), if any. However, current IRS rules require:

- Any contribution for your domestic partner and that person's child(ren) must be made on a post-tax basis.
- You pay taxes on the additional amount BSA contributes toward coverage for your domestic partner; this is called "imputed income." Taxes on the imputed income will be deducted from your paycheck automatically just like your regular pay.

Example
This example assumes that Suzy is an active BSA employee, and has Employee Only coverage under the CIGNA program. Suzy wants to add a non-dependent domestic partner. This example is merely for illustrative purposes.
Suzy's Cost
Let's say the cost to BSA per month for Employee Only coverage is $500, toward which Suzy contributes $70. When she adds one additional person, BSA's cost is $1,100, and Suzy would generally contribute $150 on a pre-tax basis towards that amount. However, in the domestic partner context, the employee contribution has to be split out differently. Part of the employee contribution amount is contributed on a pre-tax basis (for Suzy's coverage) and part is on an after-tax basis (for her partner's coverage). Therefore, in this example, Suzy would pay $80 on an after-tax basis for her partner's coverage ($150-$70=$80), and $70 on a pre-tax basis for her own coverage. Both these amounts will be deducted from Suzy's paycheck.
Suzy's Imputed Income
The other part of the equation is the amount of imputed income that Suzy will have included in her gross income due to BSA's added cost for the coverage for Suzy's partner. That amount is calculated by subtracting from BSA's total cost for the coverage for Suzy and her partner ($1,100) the total amount that is paid for Suzy's coverage alone ($500). The result is $600. The amount of Suzy's additional contribution for her partner's coverage is subtracted from this amount to determine Suzy's imputed income of $520 ($600-$80=$520). This amount will be added as income to Suzy's paycheck each month, and federal taxes on the imputed income will be deducted automatically. State and local income and employment taxes may also be due (you should consult your tax advisor as to how this imputed income will affect you, given your personal circumstances).

Tables indicating the additional after-tax contribution and the imputed income amount due can be found in the Domestic Partner Coverage and Imputed Income section.

Continuation Coverage
A Federal law known as COBRA requires that continuation coverage be offered for certain periods of time to employees (as well as their spouses and dependents) upon the occurrence of specified events that would otherwise lead to a loss of health care coverage. Federal law does not require that the same protection be afforded to domestic partners (or their children) who are not dependents of employees. BSA does, however, provide COBRA continuation coverage for domestic partners and/or their dependents.

Continuation Coverage Rights Under COBRA

Introduction
This notice applies to you if you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan 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 Plan, 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 Plan 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 Plan 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 Plan 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 plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Brookhaven Science Associates, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator 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 Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
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 Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Benefits Office.

How is COBRA Coverage Provided?
Once the Plan Administrator 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), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage
If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information
If you have any questions, please contact the Benefits Office at (631) 344-2877 or (631) 344-5126, or write to: Brookhaven Science Associates, Brookhaven National Laboratory, Attention: Benefits Office, Bldg. 400B, Upton, N.Y. 11973.

Qualifying Events

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

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

Q: What coverages can I change if I have a Qualifying Event?
A: For the Medical and/or Dental Programs, you may be eligible to add or delete dependents, or add or drop coverage. For the Reimbursement Accounts, you may be eligible to make changes to your contributions for the remainder of the calendar year. The change(s) in coverage that you request must relate to the change in your family status.

Q: Are there any other circumstances under which I can enroll myself or a dependent?
A: Yes. Based on the provisions of the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA), employees and dependents that are eligible but not enrolled for BSA health insurance plan coverage 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.

Q: How do I change my coverage(s)?
A: To change your coverage(s) when a Qualifying Event has occurred, you must notify the Benefits Office and complete an enrollment form within 31 days of the date of the Qualifying Event for all items indicated above, except (a)(3), (a)(4), (e)(1) and (e)(2). [60 days applies for items (a)(3), (a)(4), (e)(1) and (e)(2).] Employees who qualify under CHIPRA 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 employee premiums (for Medical and/or Dental Program coverages) and/or your contributions (to the Reimbursement Accounts) will then be changed for the remainder of the calendar year.

Q: When are coverage changes effective?
A: 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 you don't notify the Benefits Office and make a change in your coverage(s) for a dependent within the applicable period, your dependent will be removed from your coverage as of the date the Benefits Office is notified.

You must notify the Benefits Office within the applicable period. If you only notify the Medical and/or Dental Insurance Company directly, we may be unable to make the change until the next Open Enrollment period.

Q: When is the Open Enrollment period and what changes can I make?
A: Refer to the Open Enrollment section.

Q: Where can I get more information on the programs?
A: Additional information is available on the web at www.bnl.gov/hr/Benefits/, or through the Benefits Office at ext. 2877, or ext. 5126.

Comprehensive Welfare Benefits Plan Notice of Privacy Practices

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

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

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

Please note: This Notice does not apply to HMO or fully insured medical, dental, or vision benefit options. If you are enrolled in an HMO or a fully insured medical or dental 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 health information that can be used to identify you and that relates to:

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

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

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

Uses and Disclosures of Your PHI
To protect the privacy of your PHI, the Health Plan not only guards the physical security of your PHI, but we also limit the way your PHI is used or disclosed to others. 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.

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. 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.

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. 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.

- 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 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, or (5) disclosures for national security purposes. Your first request for an accounting within a 12-month period will be free. We may charge you for costs associated with providing you additional accountings. We will notify you of the costs involved, and you may choose to withdraw or modify your request before you incur any expenses.

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

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

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

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

Attn: Privacy Officer

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

Additional Information About This Notice

- Changes to this Notice: We reserve the right to change the Health Plan's privacy practices as described in this Notice. Any change may affect the use and disclosure of your PHI already maintained by the BSA Health Plan, as well as any of your PHI that the Health Plan may receive or create in the future. If there is a material change to the terms of this Notice, you will receive a revised Notice.

- How to obtain a copy of this Notice: You can obtain a copy of the current Notice on the BSA Intranet or by writing to the Benefits Office at the address listed above.

- No guarantee of employment: This Notice does not create any right to employment for any individual, nor does it change BSA's right to discharge any of its employees at any time, with or without cause.

- No change to Health Plan benefits: This Notice explains your privacy rights as a current or former participant in the BSA Health Plan. The Health Plan is bound by the terms of this Notice as 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.

Contact Information

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

REQUIRED NOTICES

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, co-insurance and co-payment amounts that are consistent with those that apply to other benefits under the Medical Plan.

MEDICAL PROGRAMS

For Employees and Non-Medicare eligible: retirees, participants on long term disability, COBRA participants, and their eligible family members

	CIGNA		Vytra
	In-Network	**Out-of-Network**	**In-Network**
Plan Type	Preferred Provider Organization (PPO)		Exclusive Provider Organization (EPO)
Network	Open Access Plus (OAP)	N/A	HIP Premium
Medical Care Provider	Participating physician/facility	Any physician/facility	Participating physician/facility
Payment of Benefits	No claim forms	Submit claim forms	No claim forms
Age Limit for Dependent Children	Up to 26th birthday		Up to 26th birthday
Annual Deductible (Individual/Family)	N/A	$1,000/$3,000	N/A
Annual Out-of-Pocket Maximum (Indiv/Family) (Excl. Deductible)	N/A	$3,500/$10,500	N/A
Lifetime Maximum Benefit	Unlimited		Unlimited
Pre-Existing Condition Limitation	N/A		N/A
Office Visits	Covered in full after $20 co-pay PCP $30 co-pay Specialist	70% of R&C after deductible	Covered in full after $25 co-pay PCP $40 co-pay Specialist
Emergency Room (Accident/Illness)	Covered in full	Emergency: Covered in full Non-emergency: 70% of R&C after deductible	Emergency: Covered in full after $100 co-pay see Inpatient Hospital co-pay if admitted Non-emergency: not covered
Inpatient Hospital (Semi-Private Room, Board, Services, Supplies)	Covered in full Pre-admission Certification required or $250 penalty plus 50% reduction in benefits on any days not approved.		Covered in full after $500 co-pay per admission Pre-admission Certification required or $250 penalty plus 50% reduction in benefits on any days not approved.
(Physician/Surgeon)	Covered in full	70% of R&C after deductible	Covered in full
Second Surgical Opinion (Office Visit)	Covered in full	100% of R&C	Covered in full
Laboratory/X-Ray	Covered in full	70% of R&C after deductible	Covered in full
Maternity (Initial Visit To Determine Pregnancy)	Covered in full after $20 co-pay	70% of R&C after deductible	Covered in full after $25 co-pay
(Subsequent Visits/Delivery)	Covered in full	70% of R&C after deductible	Covered in full
Prescription Medication (Retail)	$10 generic $25 brand name formulary $40 brand name non-formulary (up to 30-day supply) after Rx deductible*	Use in-network benefit	**Administered by CIGNA** (see CIGNA column for prescription drug benefits coverage)
(Mail Order)	$20 generic $50 brand name formulary $80 brand name non-formulary (up to 90-day supply) after Rx deductible*	Use in-network benefit	**Administered by CIGNA** (see CIGNA column for prescription drug benefits coverage)

* After meeting a separate $100 per person/$300 per family annual drug (Rx) deductible

MEDICAL PROGRAMS

For Employees and Non-Medicare eligible: retirees, participants on long term disability, COBRA participants, and their eligible family members

	CIGNA		Vytra
	In-Network	**Out-of-Network**	**In-Network**
Preventive Care	The Patient Protection and Affordable Care Act requires that certain, but not all, preventive care services be covered at 100% with no deductible, coinsurance or co-pay. Such preventive services will be defined by agencies and committees identified by the government and may be subject to change. Not all preventive care services are included in this mandate.		
Mental Health Care			
(Inpatient)	Same as Inpatient Hospital		Same as Inpatient Hospital
(Outpatient)	Covered in full after $20 co-pay	70% of R&C after deductible	Covered in full after $40 co-pay
Substance Abuse Treatment			
(Inpatient Detox)	Same as Inpatient Hospital		Same as Inpatient Hospital
(Outpatient Rehab)	Covered in full after $20 co-pay	70% of R&C after deductible	Covered in full after $40 co-pay
Alternate Care			
(Home Health Care)	Covered in full	70% of R&C after deductible	Covered in full
	(Max: 40 visits/year combined in and out of network)		(Max: 40 visits/year)
(Skilled Nursing Facility Non-Custodial)	Same as Inpatient Hospital		Same as Inpatient Hospital
	(Max: 60 days/year combined in and out of network)		(Max: 45 days/year)
(Outpatient Short-Term Rehab: Physical Therapy)	Covered in full after $30 co-pay	70% of R&C after deductible	Covered in full after $40 co-pay (Max: 60 consecutive days/injury/ lifetime)
Durable Medical Equipment	Covered in full	70% of R&C after deductible	Covered in full
External Prosthetic Devices	Covered in full	70% of R&C after deductible	Covered in full
Vision Care**			
(Routine Eye Exam)	Not covered		Covered in full after $40 co-pay (1 exam per year)
(Hardware)	1 pair of glasses following cataract surgery		Coverage available. Based on fee schedule.
Hearing Aids	Covered in full	70% of R&C after deductible	Not covered
	(Max: $2,000/ 1095 days)		

** Also available to all employees is a vision discount program through National Vision, Inc. located at the Walmart in Middle Island, NY. Additional information is available through the Benefits Office.

PCP = Primary Care Physician

R&C = Reasonable & Customary

DENTAL PROGRAMS

	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 co-pay	Must submit claim to Delta Dental	Participating dentist will charge you applicable co-pay. Claims must be submitted to Delta Dental for non-participating dentists.
Dependent Children Age Limit	To age 19. End of year age 23 if full-time student.	To age 19. End of year age 23 if full-time student.		To age 19. End of year age 23 if full-time student.
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	$1,000 (in- and out-of-network combined)		$1,000
Eligibility for Orthodontia Coverage	Children: To age 19. End of year age 23 if full-time student. Employee/Spouse: eligible.	Children: To age 19. Employee/Spouse: not eligible.		Children: To age 19. 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 Filings: one-surface amalgam (procedure code: 2140)	$0	60%	45%	$26
Filings: 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
Orthodontic Benefits	See fee schedule	50%	50%	See reimbursement schedule
Orthodontic Lifetime Maximum Benefit Per Person	N/A	$1,000 (in- and out-of-network combined)		$1,000

This represents only a portion of the dental schedule. For additional information, refer to the schedule of benefits for each plan.

Funds Available For Investment*

Investment Company	Ticker Code	Fund	Type of Fund	Average Annual Return as of 12/31/12 (%)		
		Annuity/Variable Annuity		**1-Year**	**5-Year**	**10-Year**
TIAA-CREF		TIAA Traditional Annuity	Guaranteed Annuity	3.00	4.79	4.46
		CREF Money Market Account	Money Market	0.00	0.51	1.67
		CREF Bond Market Account	Fixed Income	5.29	5.42	4.79
		CREF Inflation-Linked Bond Account	Fixed Income	6.40	6.54	6.15
		CREF Social Choice Account	Fixed Income & Equity	10.98	3.46	6.47
		TIAA Real Estate Account	Real Estate	10.06	-2.63	4.60
		CREF Stock Account	Equity	17.26	0.54	7.63
		CREF Equity Index Account	Equity	15.98	1.67	7.25
		CREF Growth Account	Equity	15.87	2.08	6.93
		CREF Global Equities Account	Equity	18.45	-1.21	7.44
		Mutual Funds				
	TIREX	TIAA-CREF Real Estate Securities Institutional	Real Estate	19.55	5.12	11.24
	TISCX	TIAA-CREF Social Choice Equity Institutional	Equity	14.05	2.24	7.60
	TISPX	TIAA-CREF S&P 500 Index Institutional	Equity	15.94	1.63	7.01
	TIGRX	TIAA-CREF Growth & Income Institutional	Equity	16.41	2.30	8.70
	TRLIX	TIAA-CREF Large-Cap Value Institutional	Equity	19.68	0.98	8.03
	TIMVX	TIAA-CREF Mid-Cap Value Institutional	Equity	16.60	2.45	11.19
	TRPWX	TIAA-CREF Mid-Cap Growth Institutional	Equity	17.96	2.56	10.40
	TISEX	TIAA-CREF Small-Cap Equity Institutional	Equity	14.07	3.60	9.28
	TIIEX	TIAA-CREF International Equity Institutional	Equity	31.29	-4.32	8.93
		Lifecycle Funds				
	TCTIX	Lifecycle 2010 Fund Institutional**	Multi-Asset	12.67	3.26	N/A
	TCNIX	Lifecycle 2015 Fund Institutional**	Multi-Asset	13.47	2.77	N/A
	TCWIX	Lifecycle 2020 Fund Institutional**	Multi-Asset	14.62	2.26	N/A
	TCYIX	Lifecycle 2025 Fund Institutional**	Multi-Asset	15.60	1.70	N/A
	TCRIX	Lifecycle 2030 Fund Institutional**	Multi-Asset	16.53	1.08	N/A
	TCIIX	Lifecycle 2035 Fund Institutional**	Multi-Asset	17.32	0.82	N/A
	TCOIX	Lifecycle 2040 Fund Institutional**	Multi-Asset	17.52	0.88	N/A
	TTFIX	Lifecycle 2045 Fund Institutional**	Multi-Asset	17.56	0.58	N/A
	TFTIX	Lifecycle 2050 Fund Institutional**	Multi-Asset	17.53	0.54	N/A
	TTRIX	Lifecycle 2055 Fund Institutional**	Multi-Asset	17.65	N/A	N/A
Fidelity Investment Services	FRTXX	Retirement Money Market Portfolio	Money Market	0.01	0.71	1.83
	FGMXX	Retirement Gov't Money Market Portfolio	Money Market	0.01	0.54	1.69
	FTHRX	Intermediate Bond Fund	Income	4.93	5.74	4.67
	FPUKX	Puritan Fund – Class K	Growth & Income	13.94	3.36	7.23
	FEIKX	Equity-Income Fund – Class K	Growth & Income	17.41	-0.40	6.18
	FMGKX	Magellan Fund – Class K	Growth	18.13	-3.35	4.37
	FDIKX	Diversified International Fund – Class K	International	19.61	-3.83	8.85
	FOSKX	Overseas Fund – Class K	International	25.30	-5.70	7.90
	FFKAX	Freedom K Income Fund**	Blend	6.36	N/A	N/A
	FFKBX	Freedom K 2000 Fund**	Blend	6.44	N/A	N/A
	FFKVX	Freedom K 2005 Fund**	Blend	8.77	N/A	N/A
	FFKCX	Freedom K 2010 Fund**	Blend	10.53	N/A	N/A
	FKVFX	Freedom K 2015 Fund**	Blend	10.81	N/A	N/A
	FFKDX	Freedom K 2020 Fund**	Blend	11.86	N/A	N/A
	FKTWX	Freedom K 2025 Fund**	Blend	13.26	N/A	N/A
	FFKEX	Freedom K 2030 Fund**	Blend	13.65	N/A	N/A
	FKTHX	Freedom K 2035 Fund**	Blend	14.60	N/A	N/A
	FFKFX	Freedom K 2040 Fund**	Blend	14.61	N/A	N/A
	FFKGX	Freedom K 2045 Fund**	Blend	14.97	N/A	N/A
	FFKHX	Freedom K 2050 Fund**	Blend	15.23	N/A	N/A
The Vanguard Group	VMRXX	Prime Money Market Fund Institutional	Money Market	0.11	0.80	1.99
	VMFXX	Federal Money Market Fund Investor***	Money Market	0.01	0.59	1.76
	VWENX	Wellington Fund Admiral	Balanced	12.67	4.35	8.32
	VWIAX	Wellesley Income Fund Admiral	Balanced	10.10	6.98	7.29
	VIFSX	500 Index Fund Signal	Growth & Income Stock	15.97	1.68	N/A
	VWNEX	Windsor Fund Admiral	Growth & Income Stock	20.94	1.20	7.23
	VEXRX	Explorer Fund Admiral	Aggressive Growth Stock	15.07	3.30	9.38
	VTSGX	Total International Stock Index Fund Signal	International Stock	18.21	N/A	N/A
	VWILX	International Growth Fund Admiral	International Stock	20.18	-1.20	9.83

*For information on each fund's performance, refer to the fund's prospectus. For information on the fees and expenses assessed on your account by each fund, refer to the Plan's fee disclosure materials provided separately.

**These are the Qualified Default Investment Alternative (QDIA). The Fidelity K share fund classes are available effective November 7, 2012.

***Vanguard Federal Money Market – closed to new contributions as of August 1, 2009.

Contact Information

Plan	Account/Plan #	Telephone #	Website/Email
Medical Insurance			
CIGNA	3210488	(800) 244-6224	www.cigna.com
Vytra (non-prescription drug assistance)	4770387	(631) 694-6565	www.vytra.com
Vytra (use CIGNA for prescription drug assistance)	3210488	(800) 244-6224	www.cigna.com
Benefits Office	N/A	(631) 344-2877	bittrolff@bnl.gov
		(631) 344-5126	sarmann@bnl.gov
Dental Insurance			
Delta Dental DMO	NY06503	(800) 422-4234	www.deltadentalins.com
Delta Dental PPO and Indemnity	NY04970	(800) 932-0783	www.deltadentalins.com
Benefits Office	N/A	(631) 344-2877	bittrolff@bnl.gov
		(631) 344-5126	sarmann@bnl.gov
Reimbursement Accounts			
PayFlex	N/A	(800) 284-4885	www.bnl.healthhub.com
Benefits Office	N/A	(631) 344-2877	bittrolff@bnl.gov
		(631) 344-5126	sarmann@bnl.gov
Life and AD&D Insurance			
Benefits Office	398456	(631) 344-5126	sarmann@bnl.gov
Long Term Disability Insurance			
Benefits Office	398456	(631) 344-7516	bsoeyadi@bnl.gov
Retirement and 401(k) Plans	Retirement / 401(k)		
TIAA-CREF	100945 / 100946	(800) 842-2776	www.tiaa-cref.org/bnl
Fidelity Investment Services	72002 / 72003	(800) 343-0860	http://netbenefits.nonprofits.com
The Vanguard Group	100945 / 100946	Contact TIAA-CREF	Use TIAA-CREF website
Benefits Office	N/A	(631) 344-7516	bsoeyadi@bnl.gov
Long Term Care Insurance			
Prudential	44185	(800) 732-0416	www.prudential.com/gltcweb Group Name: brookhaven Access Code: bsaltc
Adoption Assistance	N/A	(631) 344-2881	dimeglio@bnl.gov
Employee Assistance Program (EAP)	N/A	Onsite: M - F 8:30 a.m.-5:00 p.m. (631) 344-4567	www.bnl.gov/eap/
		24 hours 7 days (800) 327-2182	www.magellanhealth.com/member Enter the toll free number
Tuition Assistance	N/A	(631) 344-7631	munson@bnl.gov
Child Development Center	N/A	(631) 344-7416	www.bnl.gov/HR/CDC/ChildDevCntr.asp
Payroll	N/A	(631) 344-2470	http://intranet.bnl.gov/fsd/payroll.asp
Vacation	N/A	(631) 344-2470	N/A
Sick Leave	N/A	(631) 344-7516	bsoeyadi@bnl.gov
Family & Medical Leave Act (FMLA)			
The Hartford	402111	(888) 598-7462	N/A
Occupational Medicine Clinic	N/A	(631) 344-3670	N/A
Brookhaven Employees Recreation Association (BERA)	N/A	(631) 344-2873	www.bnl.gov/bera/

The information in this booklet is intended to provide only a summary of the benefit 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 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.**