

DENTAL PLAN

The Dental Plan provides benefits for preventive, diagnostic, restorative, and orthodontic dental services. Enrollment in the Dental Plan is optional.

WHO IS ELIGIBLE FOR THE DENTAL PLAN?

Active Employees

All regular employees who work at least 20 hours per week are eligible to participate in the group Dental Plan on the first day of active employment.

Eligible Dependents

The following members of your family are also eligible for Medical Plan coverage:

- Your spouse, defined as the person of the opposite sex to whom you are legally married.
- Your eligible same-sex domestic partner and that partner's eligible child(ren). To be eligible, you must provide a copy of your marriage certificate, domestic partner registry or proof of financial interdependence. Additional information is available at <http://www.bnl.gov/hr/Benefits/DomesticPartners.asp>

Children of your eligible domestic partner must meet the criteria for children indicated below.

- Your unmarried children up to 19 years of age, including adopted children and stepchildren who are dependent upon you for support. Stepchildren must reside with you to be eligible for coverage. An unmarried child is considered to be eligible for dependent coverage up to his or her 19th birthday.
- Your unmarried children who are mentally or physically incapable of earning their own living may be continued beyond age 19 if, within 31 days after they have reached age 19, you submit proof of the child's incapacity. Coverage may be continued for dependents who are over age 19 and who become mentally or physically incapable of earning their own living while covered as an eligible dependent, by submitting proof of the child's incapacity within 31 days after they become incapacitated.
- Your unmarried children age 19 and over who meet the following criteria:
 - The dependent child must be the taxpayer's child, including adopted child or stepchild.
 - The dependent child must have the same principal residence as the taxpayer for more than one-half of the tax year. Children who are away at school will not be excluded by this criterion as long as when they're not at school, they are living with you. Children of parents who are divorced will not be excluded as long as they are living with one of the parents for at least one-half of the tax year. Please note that stepchildren must reside with you to be eligible.
 - The dependent child must not provide more than one-half of his or her own support.
 - For a dependent child who is age 19 or over to be eligible for coverage, he or she must attend an accredited college or university on a full-time basis and also meet the criteria indicated above. You must provide proof of full-time student status within 31 days of the beginning of each school semester.

Coverage for such unmarried children will end on the earlier of (a) the end of the year of attainment of age 23 or (b) when they no longer meet the criteria indicated above. If they are no longer eligible for coverage because they are no longer attending an accredited college or university on a full-time basis, coverage will end as follows:

- Dependent coverage ends as of the end of the month in which he or she is no longer a full-time student.
- 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.

If a dependent is no longer eligible for coverage and you do not remove that dependent from your coverage within the applicable period indicated in the Qualifying Event section, your dependent will be removed from your coverage as of the date the Benefits Office is notified.

ENROLLMENT

Eligible employees may enroll in one of the dental programs within 30 days of their date of hire. Once you enroll, you must continue participation in the program until the end of the calendar year or your termination date of employment, if earlier. If you do not enroll for coverage within 30 days of your date of hire, you will be required to wait until the next Open Enrollment Period or when you have a Qualifying Event to elect coverage.

To enroll, you must complete an enrollment form and list all dependents you want covered. Enrollment forms are available through the Benefits Office. By completing the form, you will authorize the necessary payroll premiums for the coverage you select. The coverages available are:

- Employee only.
- Employee and one dependent.
- Employee and two or more dependents.

You cannot enroll your eligible dependents without also enrolling yourself for dental coverage nor can you enroll them in a different dental program than the one you select for yourself.

Coverage begins on your date of hire if you complete all enrollment forms and submit them to the Benefits Office within 30 days of your date of hire.

DENTAL PROGRAMS AVAILABLE

Eligible employees and their dependents may enroll in the Delta Dental Indemnity Plan, the Delta Dental DMO Plan (DeltaCare USA), or the Delta Dental PPO Plan.

DELTA DENTAL INDEMNITY PLAN

The Delta Dental Indemnity Plan allows you to use any dentist to care for you and your family. It is a fee-for-service plan and provides reimbursement for a portion of the cost of covered dental services based on a schedule.

Benefits Provided

The Delta Dental Indemnity Plan pays a combined maximum of \$1,000 in benefits per calendar year for each covered individual for preventive and diagnostic services plus basic and major dental services. The maximum lifetime benefit for covered orthodontic services is \$1,000 per eligible child.

Schedule of Maximum Allowable Covered Dental Expenses

The maximum allowable amounts specified in the following schedule are not intended to represent what your dentist's charges will be or should be. These are the maximum reimbursement amounts for specified dental services. The claims administrator will pay benefits for dental services that are covered by the plan but not listed below. The claims administrator will determine benefits on the basis of the complexity and severity of the type of service in an amount consistent with the maximum allowance specified for other dental services. Limitations may apply.

The schedule of benefits is at the end of the Dental section. Coverage information indicated is not all inclusive.

Coordination of Benefits

Coverage Under Other Employers' Plans

If you or your covered dependents are eligible to receive benefits under another group dental plan, the benefits from that plan will be coordinated with the benefits from the Delta Dental Indemnity Plan so that up to 100% of the "allowable expenses" incurred during a calendar year will be paid jointly by the plans.

An allowable expense is any necessary, reasonable, and customary expense covered in full or in part under any one of the group plans involved.

In the case of dependent children who are covered by more than one group plan, the insurance plan of the parent whose birthday occurs earlier in the calendar year will be the primary insurance plan for the children.

To obtain all the benefits available, you and your family members must file claims under each plan.

Claims

How to File a Claim

You have the following options to file a claim under the Delta Dental Indemnity Plan.

- Your dentist can submit the claim electronically or
- Send a claim form to:

Delta Dental of New York, Inc.
P.O. Box 2105
Mechanicsburg, PA 17055-2105

Claim forms are available in the Benefits Office or on the Web at: www.bnl.gov/hr/Benefits/dental/linkablefiles/DeltaCImFrm.pdf.

Questions About Claims

If you have a question about your Delta Dental Indemnity Plan claim, you should contact the claims administrator at Delta Dental at (800) 932-0783. When discussing your claim, please refer to the explanation of benefits, the claim form, and any other correspondence that you may have received.

How to Appeal a Claim

Your explanation of benefits will identify if a claim is denied and the reason for the denial. You may request a review of the denied claim in writing to Delta Dental at One Delta Drive, Mechanicsburg, PA 17055 within 180 days of the date of the notice of denial. You should state the reasons why you feel your claim should not have been denied, including any additional documents which you believe support your claim. In normal cases, a decision will be rendered within 30 days of the date your request for review is received.

Phone Number

Delta Dental: (800) 932-0783

DELTA DENTAL DMO PLAN (DELTACARE USA)

The Delta Dental DMO Plan (DeltaCare USA) provides services through a network of participating dentists. It is a dental maintenance organization, DMO, and services are based on a fee schedule. If you choose to participate in this plan, you must select a participating dentist. You may select different participating dentists for you and your dependents. By contacting Delta Dental, you may change participating dentists as of the first day of the month after you request the change provided the request is made by the 21st of the month. Coverage is not provided for providers who are not in the Delta Dental DMO (DeltaCare USA) network. If you require the care of a dental specialist, your participating dentist must give you a referral to a specialist in Delta Dental's DMO (DeltaCare USA) network.

Benefits Provided

The Delta Dental DMO Plan (DeltaCare USA) provides coverage for preventive, basic and restorative dental services, and orthodontia for both adults and children. The schedule of benefits is at the end of the Dental Section.

Please note that the cost of dental services is subject to change and is based on provisions of the Delta Dental DMO Plan (DeltaCare USA) at the time the service is provided. The cost of other dental services covered by the Delta Dental DMO Plan (DeltaCare USA) are included in the Delta Dental Care patient charge schedule which can be obtained at no cost through the Benefits Office or directly from Delta .

Emergency Services

Delta Dental will pay for up to \$100 in dental expenses for each emergency if (1) the need for treatment occurs at least 35 miles from the participant's contracted dentist's facility or (2) the participant is unable to contact the designated participating dentist. You are responsible for the copayment(s) as well as any charges over the \$100.

Emergency is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned contract dentist.

Specialty Referrals

When specialized dental care services are required, your designated participating dentist must initiate the referral process and refer you to a specialist in Delta Dental's DMO (DeltaCare) network.

Coordination of Benefits

If you or any of your covered dependents are eligible to receive benefits under another group dental plan, benefits from that plan will be coordinated with the benefits from the Delta Dental DMO Plan (DeltaCare USA).

How to File a Claim

There are no claim forms to file under the Delta Dental DMO Plan (DeltaCare USA). You just pay the dentist the scheduled fee.

Questions About Claims

If you have any questions about costs or procedures under the Delta Dental DMO Plan (DeltaCare USA), you should contact Delta Dental at (800) 422-4234.

How to Appeal a Claim

You may request a review of the denied claim in writing to DeltaCare, Quality Management Dept., P. O. Box 6050, Artesia, CA 90702 or by telephone to the Delta Dental DMO Plan (DeltaCare USA). You should state the reasons why you feel your claim should not have been denied. In normal cases, the insurance company will render a decision within 30 days of the date your request for review is received.

Phone Number

Delta Dental DMO Plan (DeltaCare USA): (800) 422-4234

Provider Directory

Provider directories are available on the Web at: www.deltadentalins.com

DELTA DENTAL PPO PLAN

Under the Delta Dental PPO Plan, services are provided through a network of participating dentists, but benefits are also provided for use of providers who are not in the network. You do not need to enroll with a specific dentist to receive coverage under this plan. In-network benefits are provided if you use a provider in Delta's dental PPO or Premier network. Out-of-network benefits are provided if you use a provider who is not in Delta's dental PPO or Premier network. The plan is a preferred provider organization, PPO, and provides reimbursement for a portion of the cost of covered dental services based on a schedule. To receive reimbursement of covered expenses you or your provider must submit a claim.

Benefits Provided

The Delta Dental PPO Plan pays a combined maximum of \$1,000 in benefits per calendar year for each covered individual for preventive and diagnostic services plus basic and major dental services. The maximum lifetime benefit for covered orthodontic services is \$1,000 per eligible child.

Coordination of Benefits

Coverage Under Other Employers' Plans

If you or your covered dependents are eligible to receive benefits under another group dental plan, the benefits from that plan will be coordinated with the benefits from the Delta Dental PPO Plan so that up to 100% of the "allowable expenses" incurred during a calendar year will be paid jointly by the plans.

An allowable expense is any necessary, reasonable, and customary expense covered in full or in part under any one of the group plans involved.

In the case of dependent children who are covered by more than one group plan, the insurance plan

of the parent whose birthday occurs earlier in the calendar year will be the primary insurance plan for the children.

To obtain all the benefits available, you and your family members must file claims under each plan.

Claims

How to File a Claim

You have the following options to file a claim under the Delta Dental PPO Plan.

Claim forms are available in the Benefits Office or on the Web at: www.bnl.gov/dental/linkablefiles/DeltaCImFrm.pdf.

- Your dentist can submit the claim electronically or
- Send a claim form to:

Delta Dental of New York, Inc.
P.O. Box 2105
Mechanicsburg, PA 17055-2105

Questions About Claims

If you have a question about your Delta Dental PPO Plan claim, you should contact Delta Dental at (800) 932-0783. When discussing your claim, please refer to the explanation of benefits, the claim form, and any other correspondence that you may have received.

How to Appeal a Claim

Your explanation of benefits will identify if a claim is denied. You may request a review of the denied claim in writing to the insurance company within 365 days of the receipt of the notice of denial. You should state the reasons why your claim should not have been denied, including any additional documents which you believe support your claim. In normal cases, the insurance company will render a decision within 30 days of the date your request for review is received.

Phone Number

Delta Dental PPO Plan: (800) 932-0783

Provider Directory

Provider directories are available on the Web at: www.deltadentalins.com

DUAL COVERAGE

Prior to January 1, 2006, dual coverage allowed both spouses to participate in the dental program where they could elect to cover each other and their eligible dependents provided they paid the required premiums. Dual coverage was eliminated as of January 1, 2006. Dual coverage was also eliminated for all members of the IBEW union as of January 1, 2011.

EXCLUSIONS

The following dental expenses are not covered by the Delta Dental Indemnity Plan, the Delta Dental Care Plan (DeltaCare USA), or the Delta Dental PPO Plan:

- Cosmetic treatment, experimental treatment, dietary planning, plaque control, oral hygiene instructions, treatment for the correction of any congenital or developmental malformation.
- Replacement of a lost or stolen appliance, extra appliances, or a dentally acceptable bridge, cap, crown, or denture.

- Replacement of a bridge, denture, cap, crown, etc. within five years of its original installation unless this is necessary owing to installation of an original opposing full denture, the extraction of natural teeth, or irreparable damage as a result of an accident while the denture is in place.
- Replacement of a fixed or removable prosthodontic or orthodontic appliance that has been made useless due to patient abuse, misuse, or neglect, or has been lost, stolen, or damaged.
- Appliances or restorations to alter vertical dimensions, stabilize teeth, restore occlusion, or diagnose or treat conditions or dysfunction of the temporomandibular joint.
- Installation of an initial appliance replacing teeth that were already missing when you or a dependent became insured.
- Any procedure or service associated with the placement or prosthodontic restoration of a dental implant. (Delta Dental DMO only)
- Services related to an injury or illness paid under Workers' Compensation, no-fault automobile or uninsured motorist insurance law, government laws, regulations, public programs, or similar laws.
- Charges in excess of Reasonable and Customary limits.
- Charges for unnecessary services or charges which would not have been made had no benefit existed or which you would not be legally required to pay.
- Services covered by a group medical plan.
- Prescription drugs.
- Charges for broken appointments or for completion of claim forms.

Additional exclusions may apply. Contact the Benefits Office at (631) 344-2877 or (631) 344-5126 for additional information, including a copy of the dental schedules.

EMPLOYEE PREMIUMS

Employees who elect to participate in the Dental Plan must pay the required premiums. Your premiums are based on the Plan you elect and whether you elect to cover (a) yourself only, (b) yourself and one dependent or (c) yourself and two or more dependents. You may pay your premiums with before-tax or after-tax dollars. Before-tax premiums are deducted from your pay before state and federal income taxes and Social Security taxes are withheld, resulting in a lower actual cost to you. After-tax premiums are deducted from your pay after taxes are withheld and result in no tax savings to you.

If your annual salary is below the Social Security wage base and you pay your premiums with before-tax dollars, your future Social Security benefits may be reduced.

Employee premiums are indicated at the end of the Dental Plan section.

OPEN ENROLLMENT PERIOD

Open enrollment is held once a year. During an Open Enrollment Period, you may change dental programs, drop coverage and/or add or drop dependents from your coverage. Employees who did not previously elect dental coverage may elect it during the Open Enrollment Period. Changes you elect during the Open Enrollment Period will be effective January 1 of the following calendar year. Your elections will be in effect for the remainder of the calendar year unless you notify the Benefits Office of a Qualifying Event within a limited period of time from the date of the event.

QUALIFYING EVENT

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

- (a) Change in legal marital status
 1. marriage
 2. death of spouse
 3. divorce

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

In addition, 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.

You have 31 days from the date of a Qualifying Event to make changes to your dental coverage for all items indicated above except (a)(3), (a)(4) and (e)(1). You have 60 days from the date of a Qualifying Event to make changes to your dental coverage for items (a)(3), (a)(4), (e)(1) and changes related to CHIPRA. The change requested must relate to the change in your family status that affects eligibility for dental coverage. Changes are made by completing an enrollment form, available in the Benefits Office. The completed form must be submitted, with proof of the Qualifying Event, to the Benefits Office. Your premiums will then be changed for the remainder of the calendar year. Coverage will become effective as of the date of the event.

If you do not make a change to your dental coverage within the applicable period indicated above, you must wait until the next Open Enrollment Period. If a dependent is no longer eligible for coverage and you do not remove that dependent from your coverage within the applicable period indicated above, your dependent will be removed from your coverage as of the date the Benefits Office is notified.

MISCELLANEOUS

General Information

Information regarding the plan identification number, plan year, plan funding, type of plan, plan sponsor, plan administrator, agent for legal process, your rights under ERISA, prudent actions by plan fiduciaries, modification, suspension, or termination of the plan, and privacy of information can be found

in the General Information section of this booklet.

Leave of Absence

If you are on an approved Leave of Absence, including for military duty, you may continue your dental coverage during the term of the approved leave from the starting date of your leave by paying the required active employee premiums. This coverage will cease when the employee is no longer on the approved Leave of Absence. Participants on approved military leave may drop dental coverage for themselves while continuing to cover their dependents.

Continuation of insurance is not allowed while on leave for other employment when (1) the other employer offers coverage or (2) the other employer is an agency or prime contractor of the federal government that will cover you under its insurance program.

If you drop dental coverage while on an approved Leave of Absence, you may enroll again upon your return to work in an eligible status.

Participants Receiving Long Term Disability Benefits

Employees who qualify for Long Term Disability (LTD) Plan benefits may continue dental coverage for themselves and their eligible dependent(s) by payment of the required active employee premiums. This coverage will cease when the employee is no longer eligible to receive LTD Plan benefits.

Reasonable and Customary (R&C)

Under the Delta Dental PPO Plan, a charge is considered Reasonable and Customary if it is the normal charge made by the provider for a similar service or supply and it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by Delta Dental.

Termination of Coverage

Dental coverage for active employees, participants receiving LTD Plan benefits, and their dependents under the Dental Plan will cease on the earlier of the date your employment terminates, the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay the required premiums. Coverage for terminated employees, who continue benefits under COBRA, will cease on the earlier of the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay the required premiums.

Individual dependent coverage will also cease when the dependent becomes ineligible. Coverage for your spouse also ceases due to divorce or legal separation from you. Coverage for your dependent children also ceases when the child no longer meets the eligibility requirements of this plan.

COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your 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.

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 previously 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."

When is COBRA Coverage Available?

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

Notification Requirements

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

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

If you do not elect continuation coverage within 60 days from the date of loss of coverage due to one of the events described above, your group dental insurance coverage will end retroactively to the date of the event that caused the loss of coverage.

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

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part

B, or both), 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 Benefits Office 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. You must notify the Benefits Office within 60 days after the qualifying event occurs and provide documentation of the event.

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.

COBRA Premium Requirements

You, or your dependents, will be required to pay 102% of the full cost of the continuation coverage under the provisions of COBRA. You will be billed for the required premium on a regular basis. COBRA premiums are indicated at the end of the Dental Plan section.

Termination of Coverage Under COBRA

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

- The Benefits Office is notified by you or your dependent to discontinue coverage.
- 18 months after continuation coverage begins (if coverage was continued due to termination or resignation of the employee).
- 29 months after continuation coverage begins (if coverage was continued due to disability).
- 36 months after continuation coverage begins (if coverage was continued because of death of the employee, divorce, legal separation or loss of dependent status).
- The individual becomes eligible for Medicare after the date of the COBRA election.
- An individual becomes covered under another group plan, unless a pre-existing condition prevents you or your dependent from being covered by the other plan.
- For a spouse or dependent child: If the Benefits Office is not notified within 31 days of the date of divorce or legal separation.
- For a dependent child: If the Benefits Office is not notified within 31 days of the date the dependent status ends.

- Payment for continuation coverage is not paid on time.
- The group health care plan is terminated for active employees.

ERISA

Refer to the General Information section of this booklet for information regarding your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

**EMPLOYEE PREMIUMS
(January 1, 2011)**

Coverage	Delta Dental Indemnity Plan (Delta Dental) or Delta DMO		Delta PPO	
	Weekly	Monthly	Weekly	Monthly
Employee only	\$1.15	\$ 5.00	\$2.33	\$10.11
Employee + 1 dependent	\$2.31	\$10.00	\$4.81	\$20.86
Employee + 2 or more dependents	\$4.38	\$19.00	\$7.90	\$34.23

**COBRA PREMIUMS
(January 1, 2011)**

Coverage	Monthly Premium		
	Delta Dental Indemnity Plan	Delta Dental DMO (DeltaCare)	Delta Dental PPO
Employee only	\$14.35	\$17.90	\$31.58
Employee + 1 dependent	\$30.49	\$36.36	\$67.07
Employee + 2 or more dependents	\$42.75	\$54.11	\$94.06

These premiums are subject to change.

DENTAL PROGRAMS			
DELTA DENTAL			
	PPO	Indemnity	DMO
Network	PPO and Premier Networks	PPO and Premier Networks	DeltaCare
Provider	In-Network Participating Provider	In- and Out-of-Network Any Provider	In-Network Only Participating Provider
Claim Process	Dentist will charge you applicable coinsurance	Must submit claim to Delta Dental	Pay dentist scheduled fee
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.) For the family Deductible to apply, at least three family members must reach their individual Deductible.	\$25/\$75 (in- and out-of-network combined)	\$25/\$75	N/A
Calendar Year Maximum Benefit Per Person (for all services other than orthodontia.)	\$1,000 (in- and out-of-network combined)	\$1,000	N/A
Eligibility for Orthodontia Coverage	Children: To age 19. Employee/Spouse: not eligible.	Children: To age 19. Employee/Spouse: not eligible.	Children: To age 19. End of year age 23 if full-time student. Employee/Spouse: eligible.
Predetermination of Benefits	Predetermination of Benefits allows you to determine what services will be covered and what payments will be made before your dental treatment is performed. The procedure is as follows: The dentist informs the claims administrator of the proposed course of treatment by itemizing services and charges. The claims administrator then determines the amount the plan will pay and informs you and your dentist. You and your dentist should discuss the result before the work is done. If a Predetermination of Benefits is not requested, the claims administrator will pay the claims based on the information provided. If your dentist submits a treatment plan for Predetermination of Benefits and then changes the treatment plan, the claims administrator will adjust the payments accordingly. If any major changes in the treatment plan are made, your dentist should send in a revised course of treatment to the claims administrator.		
Services Provided After Eligibility Ceases	Normally, the plans will not pay for services or supplies beyond termination of your coverage or when dependent is no longer eligible for coverage, even if a Predetermination of Benefits has been made before coverage ceases. However, there are three exceptions for which benefits are payable: - A prosthetic device (such as full or partial denture) if the dentist took the impressions and prepared the abutment teeth while the patient was covered; - A crown if the dentist prepared the tooth for the crown while the patient was covered by the plan; - Root canal therapy if the dentist opened the tooth while the patient was covered.		

Network	PPO		Indemnity		DMO
	PPO and Premier Networks	N/A	PPO and Premier Networks	DeltaCare	
Medical	In-Network	Out-of-Network	In- and Out-of-Network	In-Network Only	
	The Medical Plan, specifically the OAP medical program, administered by Cigna Healthcare, covers a limited number of specific dental procedures. When dental benefits are available under both the OAP medical program and the Delta Dental Indemnity or PPO plans, the benefits payable under the Delta Dental Indemnity or PPO plans will be coordinated with the benefits payable under the OAP medical program so that up to 100% of allowable expenses will be paid jointly by the plans. In all such cases, the Delta Dental Indemnity or PPO program is considered the primary policy to which you must submit claims first.				
Coverage Based On	Reduced Contracted Fees	Reasonable & Customary Fees	Reimbursement Schedule	Fee Schedule	
	Amount insurance company pays		Amount insurance company pays		Amount participant pays
Diagnostic & Preventive Services					
Periodic exams (limits apply) (D0120)	80%	70%	\$22.00	\$0.00	\$0.00
Bitewing x-rays/radiographs four films (limits apply) (D0274)	80%	70%	\$23.00	\$0.00	\$0.00
Panoramic film (D0330)	80%	70%	\$50.00	\$0.00	\$0.00
Prophylaxis (cleaning) (limits apply) (D1110)	80%	70%	\$38.00	\$0.00	\$0.00
Restorative					
Fillings: Amalgam - one surface (D2140)	60%	45%	\$26.00	\$0.00	\$0.00
Resin-based composite - one surface, anterior (D2330)	60%	45%	\$30.00	\$5.00	\$5.00
Resin-based composite - one surface, posterior (D2391)	60%	45%	Not Covered	\$55.00	\$55.00
Inlay - metallic - one surface (D2510)	50%	35%	\$125.00	\$170.00	\$170.00
Onlay - metallic - two surfaces (D2542)	50%	35%	Not Covered	\$185.00	\$185.00
Inlay - porcelain/ceramic - one surface (D2610)	50%	35%	Not Covered	\$295.00	\$295.00
Onlay - porcelain/ceramic - two surfaces (D2642)	50%	35%	Not Covered	\$325.00	\$325.00
Inlay - resin based composite - one surface (D2650)	50%	35%	Not Covered	\$195.00	\$195.00
Onlay - resin based composite - two surfaces (D2662)	50%	35%	Not Covered	\$250.00	\$250.00
Crowns: Resin with high noble metal (D2720)	50%	35%	\$200.00	\$320.00	\$320.00

Network	PPO		Indemnity	DMO
	PPO and Premier Networks	Out-of-Network		
	In-Network	Out-of-Network	In- and Out-of-Network	In-Network Only
Implants				
Surgical placement of implant body, endosteal implant (D6010)	50%	35%	\$1,000.00	Not Covered
Surgical placement of interim implant body for transitional prosthesis: endosteal implant (D6012)	50%	35%	\$1,000.00	Not Covered
Surgical replacement: endosteal implant (D6040)	50%	35%	\$1,000.00	Not Covered
Surgical replacement: transosteal implant (D6050)	50%	35%	\$1,000.00	Not Covered
Abutments (D6057)	50%	35%	\$370.00	Not Covered
Endodontics				
Pulp Cap:				
direct (excluding final restoration) (D3110)	60%	45%	\$20.00	\$0.00
indirect (excluding final restoration) (D3120)	60%	45%	\$20.00	\$0.00
Root Canal/endodontic therapy:				
anterior tooth (excluding final restoration) (D3310)	60%	45%	\$187.00	\$110.00
bicuspid tooth (excluding final restoration) (D3320)	60%	45%	\$225.00	\$200.00
molar (excluding final restoration) (D3330)	60%	45%	\$282.00	\$350.00
Apicoectomy/periradicular surgery:				
anterior (D3410)	60%	45%	\$187.00	\$130.00
bicuspid (first root) (D3421)	60%	45%	Not Covered	\$140.00
molar (first root) (D3425)	60%	45%	\$75.00	\$150.00
Periodontics				
Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant (D4210)	60%	45%	\$150.00	\$145.00
Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant (D4240)	60%	45%	\$56.00	\$150.00

Network	PPO		Out-of-Network	Indemnity		DMO
	PPO and Premier Networks	N/A		PPO and Premier Networks	DeltaCare	
	In-Network	Out-of-Network		In- and Out-of-Network	In-Network Only	
Oral and Maxillofacial Surgery						
Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (D7140)	60%	45%	\$37.00	\$8.00		
Removal of impacted tooth - soft tissue (D7220)	60%	45%	\$100.00	\$60.00		
Removal of impacted tooth - partial bony (D7230)	60%	45%	\$130.00	\$80.00		
Removal of impacted tooth - completely bony (D7240)	60%	45%	\$150.00	\$110.00		
Biopsy of oral tissue - does not include pathology laboratory procedures (D7286)	60%	45%	\$95.00	\$30.00		
Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant (D7311)	60%	45%	Not Covered	\$85.00		
Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant (D7321)	60%	45%	Not Covered	\$100.00		
Orthodontic Benefits						
Limited orthodontic treatment of the adolescent dentition - adolescent to age 19 (D8030)	50%	50%	\$1,000.00	\$1,150.00		
Limited orthodontic treatment of the adult dentition - adults, including covered dependent adult children (D8040)	Not Covered	Not Covered	Not Covered	\$1,350.00		
Interceptive orthodontic treatment of the primary dentition (D8050)	50%	50%	\$1,000.00	\$1,150.00		
Interceptive orthodontic treatment of the transitional dentition (D8060)	50%	50%	\$1,000.00	\$1,150.00		
Comprehensive orthodontic treatment of the transitional dentition - child or adolescent to age 19 (D8070)	50%	50%	\$1,000.00	\$1,900.00		
Comprehensive orthodontic treatment of the adult dentition - adults, including covered dependent adult children (D8090)	Not Covered	Not Covered	Not Covered	\$2,100.00		
Pre-orthodontic treatment visit (D8660)	50%	50%	50%	\$25.00		

Network	PPO		Indemnity	DMO
	PPO and Premier Networks	Out-of-Network		
	PPO and Premier Networks	N/A	PPO and Premier Networks	DeltaCare
	In-Network	Out-of-Network	In- and Out-of-Network	In-Network Only
Orthodontic retention (removal of appliances, construction and placement of removable retainers) (D8680)	50%	50%	50%	\$275.00
Orthodontic Lifetime Maximum Benefit Per Person	\$1,000 (in- and out-of-network combined)		\$1,000.00	N/A
Adjunctive General Services				
Deep sedation/general anesthesia - first 30 minutes (D9220)	60%	40%	Covered with Allowable Oral Surgery Procedures	\$165.00
Deep sedation/general anesthesia - each additional 15 minutes (D9221)	60%	40%	Not Covered	\$80.00
Intravenous conscious sedation/analgesia - first 30 minutes (D9241)	60%	40%	\$37.00	\$165.00
Intravenous conscious sedation/analgesia - each additional 15 minutes (D9242)	60%	40%	Not Covered	\$80.00

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

GENERAL INFORMATION

This booklet contains only a summary of the benefit plans. Nothing herein should be deemed to waive or alter any of the terms or conditions of the Plans.

Plan Identification Numbers

The following are the Plan names and numbers:

Plan Name	Plan Number
BSA Retirement Plan	001
BSA 401(k) Plan	002
BSA Comprehensive Welfare Benefits Plan	501

The Employer Identification Number is 11-3403915.

Plan Year

The plan year for each of the Plans indicated above is the calendar year, January 1 through December 31.

Plan Funding

The Plans indicated above are paid for by the employer and, in some cases, also by employee contributions or premiums.

Type of Plan

Plans 001 and 002 indicated above are classified as pension benefit plans for the purpose of providing retirement benefits. Plan 501 is classified as a welfare plan for the purpose of providing medical insurance, life insurance, long term disability insurance, travel accident insurance, dental insurance, reimbursement account benefits, severance pay benefits, tuition refund benefits, long term care insurance and transit commuter benefits.

Normal Retirement Age

Under plans 001 and 002, your normal retirement age is 65 years old.

Plan Sponsor

The name, address, and phone number of the employer who is the Plan Sponsor are as follows:

Brookhaven Science Associates, LLC
Brookhaven National Laboratory
P.O. Box 5000
Upton, New York 11973
(631) 344-8000

Plan Administrator

The Plan Administrator for Plans 001 and 002 is the Retirement Committee and for Plan 501 is Brookhaven Science Associates, LLC. The Plan Administrator can be reached at the address and phone number indicated above.

Agent for Legal Process

The agent for service of legal process is:

General Counsel
Brookhaven Science Associates, LLC
Brookhaven National Laboratory
P.O. Box 5000
Upton, New York 11973
(631) 344-8000

Service of process may be made upon a plan trustee or plan administrator.

Trustees

You choose to allocate your contributions in the Retirement Plan and the 401(k) Plan to be invested with TIAA-CREF, Fidelity Investment Services, or Vanguard Group. You may contact them at the following addresses and telephone numbers:

For TIAA-CREF and/or Vanguard funds:

TIAA-CREF
730 Third Avenue
New York, NY 10017
(800) 842-2776

For Fidelity funds:

Fidelity Investments
P.O. Box 770002
Cincinnati, OH 45277-0090
(800) 343-0860

Filing Claims for Benefits

To file a claim for benefits under the Retirement Plan or the 401(k) Plan, contact the Trustee(s) with whom you have invested your accounts at the telephone number listed above. Each Trustee may require you to complete certain forms to process your request for benefits. If you need assistance, contact the Benefits Office.

To file a claim under any other plan, contact the insurance company or other provider who administers the benefits under the plan. If you need assistance, contact the Benefits Office.

Claims Appeal Procedure

When a claim is denied, you will receive a written notification of the denial. The notification will explain the reasons for the denial, the additional information or material needed to further review the claim, and the procedure for requesting a review of the denial.

Privacy of Information

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

Your Rights Under ERISA

As a participant in the Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plans and Benefits

- Examine without charge, at the Plan Administrator's office, all documents governing the plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Obtain a statement telling you whether you have a right to receive a benefit in the Retirement and 401(k) Plans and if so, what your benefits would be if you stop working now. If you do not have the right to a benefit, the statement will tell you how many more years you have to work to get the right to a benefit. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

- If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.
- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof, concerning the qualified status of a domestic relations order or medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance With Your Questions

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

The information in this booklet is intended to provide only a summary of BSA's benefits program. Nothing contained in any section of 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.

BSA maintains the right to modify, suspend, or terminate benefit plans in whole or in part at any time.