

Brookhaven Science Associates, LLC has established the Health Reimbursement Account Program (the "HRA Program"), a component program of the Brookhaven Science Associates, LLC Retiree Welfare Benefits Plan (the "Plan") for the benefit of its retirees and the retirees of its participating affiliates (collectively referred to as the "Employer"). The purpose of the HRA Program is to reimburse Medicare-Eligible retirees, Medicare-Eligible Brookhaven Science Associate, LLC (BSA) Long Term Disability (LTD) Plan participants and their Medicare-Eligible dependents for certain health care expenses which are not otherwise reimbursed. The HRA Program is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended ("Code"), as well as a health reimbursement arrangement as defined in Internal Revenue Service Notice 2002-45. **Please note that the Employer reserves the right to amend or terminate this Health Reimbursement Account Program at any time and for any reason.**

This Summary Plan Description ("SPD") describes the material provisions of the HRA Program, including what the HRA Program covers, and the limitations, exclusions, and requirements that apply within the HRA Program.

While every effort has been made to describe the terms of the HRA Program accurately, if there is a conflict or discrepancy between the terms of this SPD and the complete text of the Plan document, then the Plan document will govern. Please consult the Plan document for further information. This SPD does not grant any rights or benefits in addition to or different from the rights and benefits granted under the Plan document. Therefore, you cannot rely on this SPD or other summary of the Plan to create any right not specifically provided under the Plan. Further, no verbal statement by any person may alter or amend the terms of the Plan. Any questions concerning the Plan will be determined in accordance with the Plan document.

Many words used in this document have special meanings. These words appear in capital letters and are defined for you the first time they are used or in the "Definitions" section of this document. Please note that "you" and "your" when used in this document refer to you, the retiree or participant.

PURPOSE OF THE PROGRAM

The primary purpose of the HRA Program is to reimburse enrolled Participants for Eligible Expenses which are not otherwise reimbursed by any other plan or program through monthly Benefit Credits provided by the Employer. Reimbursements for Eligible Expenses paid by the HRA Program generally are excludable from the Participant's taxable income. However, the Employer cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

ELIGIBILITY

Enrollment in the HRA Program is optional and is open to only those Eligible Retirees, Eligible Spouses, Eligible LTD Plan Participants, and Eligible Children, as described below, who are Medicare-Eligible.

Eligible Retiree

A retired former Eligible Employee of the Employer who is Medicare-Eligible, resides in the United States (unless otherwise specifically provided below), who immediately prior to retirement was participating in the BSA Medical Plan (but who is not the covered dependent of another person who is enrolled in the BSA Medical Plan program or the BSA Health Reimbursement Account Program) and who satisfies one of the eligibility descriptions outlined below, is referred to in this SPD as an “Eligible Retiree:”

- Was participating in the BSA Medical Plan as a retiree on or after December 31, 2014.
- Terminates employment with the Employer on or after attaining age fifty-five (55), has at least ten (10) years of Continuous Service (as defined below) with an Employer, and has a total of the sum of age and years of Continuous Service equaling seventy (70) or more.
- Previously participated in the HRA Program as an Eligible Retiree, but subsequently lost or suspended coverage under the HRA Program due to employment elsewhere or coverage through a spouse’s employer.
- Terminates employment with the Employer after completing thirty-five (35) years of Continuous Service.
- Is eligible for coverage pursuant to the terms of a collective bargaining agreement with Brookhaven Science Associates, LLC.
- Terminates employment with the Employer on or after attaining age 50, has at least twenty-five (25) years of Continuous Service, and was employed in one of the following positions: Fire Chief, Deputy Fire Chief, Fire Captain, Police Chief, Police Captain, Police Lieutenant or Police Security Training Instructor.
- Immediately prior to participating in the BSA Phased Retirement Policy (the “Retirement Policy”) was participating in the BSA Medical Plan and who is eligible for and participating in the Retirement Policy based on satisfaction of its age and service requirements.
- Residing outside of the United States and who was previously an Eligible Employee who retired from employment with a foreign affiliate of BSA and returns to the United States immediately following retirement, if satisfies the applicable age and service criteria above, taking into account Continuous Service with the foreign affiliate.

“Continuous Service” means service with the Employer from the Eligible Employee’s most recent hire date. Service performed prior to a break in employment is not included in Continuous Service. Continuous Service will be reduced by periods on approved Leave of Absence and will not include periods when the Eligible Employee is not eligible for medical benefits. Continuous Service shall include Continuous Service, if any, with Associated Universities, Inc., Battelle Memorial Institute, Research Foundation of the State University of New York or the State University of New York at Stony Brook immediately prior to a transfer of employment to Brookhaven Science Associates, LLC.

If a retired former Eligible Employee was permanently hired by the Employer in connection with the National Synchrotron Light Source II (“NSLS”) project, the NSLS-II Experimental Tools (“NEXT”) project, or the Electron-Ion Collider (“EIC”) project, such retired former Eligible Employee may receive credit for their immediate, uninterrupted prior employment at an employer operated by an entity under a contract with the United States Department of Energy (“DOE”) in calculating their years of Continuous Service. This prior service credit applies to employees permanently hired by the Employer (a) on or after October 1, 2005 and before March 19, 2015 to work on the NSLS project operated by the Employer, (b) on or after October 1, 2011 and before August 4, 2017 to work on the NEXT project operated by the Employer, or (c) on or after April 1,

2020 and before the completion of the EIC project to work on the EIC project. In addition, if the spouse of a retired former Eligible Employee described in the preceding sentence is also employed by the Employer on or after October 1, 2005 and before March 19, 2015, on or after October 1, 2011 and before August 4, 2017, or on or after April 1, 2020 and before the completion of the EIC project, respectively, such spouse's Continuous Service under this section shall include any immediate, uninterrupted prior employment at an employer operated by an entity under a contract with the DOE, regardless of whether such spouse is employed by the Employer to work on the NSLS project, the NEXT project, or the EIC project, respectively. Retired former Eligible Employees who joined the EIC project prior to approval of the Electron-Ion Collider Incentive Program will be grandfathered to April 1, 2020 or the date the Eligible Employee joined the EIC project, whichever comes later, and will be eligible to receive the aforementioned treatment.

Eligible LTD Plan Participant

A terminated Eligible Employee receiving LTD Plan benefits under the Employer's LTD Plan is referred to in this SPD as an "Eligible LTD Plan Participant" if he/she is Medicare-Eligible. However, an "Eligible LTD Plan Participant" does not include any terminated Eligible Employee receiving LTD Plan benefits who was approved for such LTD Plan benefits prior to January 1, 2009 (January 1, 2012, in the case of a terminated Eligible Employee who was covered under a collective bargaining agreement between the Employer and the International Brotherhood of Electrical Workers ("IBEW")).

Eligible Spouse

The Spouse of an Eligible Retiree or Eligible LTD Plan Participant is referred to in this SPD as an "Eligible Spouse" if the Spouse is Medicare-Eligible. The term "Eligible Spouse" shall also include the surviving Spouse of a former Eligible Employee who would have qualified as an Eligible Retiree at his or her death, provided that such surviving Spouse is Medicare-Eligible.

In addition, an Eligible Spouse shall also include the Spouse of a non-Medicare Eligible Retiree or non-Medicare Eligible LTD Plan Participant who is participating in the BSA Medical Plan, provided that such spouse is Medicare-Eligible.

Eligible Child

The Child of an Eligible Retiree or Eligible LTD Plan Participant is referred to in this SPD as an "Eligible Child" if the Child is Medicare-Eligible. The term "Eligible Child" shall also include the Child of a non-Medicare Eligible Retiree or non-Medicare Eligible LTD Plan Participant who is participating in the BSA Medical Plan provided such child is Medicare-Eligible.

PARTICIPATION

An Eligible Retiree, Eligible LTD Plan Participant, Eligible Spouse, or Eligible Child will become a Participant in the HRA Program upon becoming Medicare-Eligible, as follows:

- **Medicare-Eligible and Participating in the BSA Medical Plan on December 31, 2014.** Participation in the HRA Program begins on January 1, 2015.
- **Medicare-Eligible on or After January 1, 2015.** Participation in the HRA Program begins on the date of Medicare eligibility.

ENROLLMENT

You will actually become a Participant in the HRA Program after you have completed the enrollment procedures set forth below.

If you meet the eligibility and participation requirements of the HRA Program, you must first enroll for Medicare Part B. Then, no later than the end of the month prior to your Medicare Part B effective date, you must enroll in a Medicare Advantage Plan or Medigap Plan through SelectQuote Senior. The Coverage Effective Date of your Medicare Advantage Plan or Medigap Plan should coincide with the effective date of Medicare Part B coverage to ensure no lapse in coverage. Your first Benefit Credit will be based on the Coverage Effective Date. If you do not elect a medical plan through SelectQuote Senior when you first become eligible, you will not be eligible for coverage under the HRA Program at a later date (unless you have otherwise suspended coverage).

If you are an Eligible Retiree or Eligible LTD Plan Participant you can suspend the coverage through BSA (a) if and when you are subsequently employed elsewhere and obtain coverage through your employer or (b) as of your last day of employment with BSA, if you have coverage available through your spouse's employer or (c) if and when you obtain coverage through your spouse's employer. Contact the BSA Benefits Office for additional information about suspending coverage.

If you do not enroll in a Medicare Advantage Plan or Medigap Plan through SelectQuote Senior when you first become Medicare-Eligible and have suspended coverage or you want to make changes to your enrollment due to a Qualifying Event, you will have the opportunity to do so during a subsequent Medicare open enrollment period or when you have a qualifying event. Qualifying events include marriage, the death of an Eligible Spouse or Eligible Child, or when someone becomes your Eligible Spouse or Eligible Child. For example, if you marry after your initial enrollment date, you can add your newly acquired Eligible Spouse as a Participant in the HRA Program outside of the open enrollment period.

How to Establish your Health Reimbursement Account

You must be enrolled and maintain coverage in Medicare Part A and Medicare Part B and ***you must enroll in a Medicare Advantage Plan or Medigap Plan through SelectQuote Senior by the applicable Medicare open enrollment deadline or your Medicare Special Enrollment deadline***, before you can ***establish your Health Reimbursement Account (HRA) under the HRA Program***.

Taben/Navia (also referred to as Navia Benefit Solutions), the company who administers the HRA for SelectQuote Senior, will set up your HRA and send you information to establish automatic HRA reimbursements.

After you and your Eligible Spouse or Eligible Child (if any) are enrolled in a Medicare Advantage Plan or Medigap Plan through SelectQuote Senior and your HRA has been set up, you will receive the monthly HRA Benefit Credit. See the "Benefits" section of this document for more details.

BENEFITS

Health Reimbursement Account

Once your HRA is set up, the Employer establishes a notional bookkeeping account for all Participants. Each month, the Employer automatically credits a specified amount of employer contributions to your HRA, called a Benefit Credit.

The monthly Benefit Credit that will be allocated on behalf of each Participant is \$180. Separate Benefit Credits will be made for each Participant, even if they are in the same family. For example, if both an Eligible Retiree, his or her Eligible Spouse and his or her Eligible Child participate in the HRA Program, then each month, the Employer will credit \$180 related to the Eligible Retiree, \$180 related to the Eligible Spouse, and \$180 related to the Eligible Child, for a total monthly allocation of \$540 to the HRA.

HRA Monthly Benefit Credit				
Eligible Retiree/ Eligible LTD Participant Only	Eligible Retiree/ Eligible LTD Participant + Eligible Spouse	Eligible Retiree/ Eligible LTD Participant + Eligible Child	Eligible Spouse Only or Eligible Child Only	Eligible Retiree/ Eligible LTD Participant + Eligible Spouse + Eligible Child
\$180	\$360	\$360	\$180	\$540

The amount in a Participant's HRA will be reduced from time to time by the amount of any Eligible Expenses for which the Participant is reimbursed under the HRA Program. At any time, the Participant may receive reimbursement for Eligible Expenses up to the amount in his or her HRA. Note that the law does not permit Participants to make any contributions to their HRAs.

An HRA is merely a bookkeeping account on the Employer's records; it is not funded and does not bear interest or accrue earnings of any kind.

You may access your HRA through the online portal by going to the website of Taben/Navia. The online portal allows you to file a claim online or download claim forms, view statements, notifications, and account history, and update your contact information and/or update banking information for direct deposit. Contact Taben/Navia for more information about online access to your HRA. See the "General Information" section for additional information.

Before the end of the fourth quarter of each calendar year, Taben/Navia will send a statement to Participants who have a balance left in their HRA. This will help to remind you to file claims for unused funds. Any unused HRA balance will carry over to the next year.

Eligible Expenses

The HRA Program will reimburse Participants for Eligible Expenses incurred by the Participant, up to the unused amount in the Participant's Health Reimbursement Account.

A Participant shall be entitled to reimbursement under this HRA Program only for Eligible Expenses incurred on or after the Coverage Effective Date and before his or her participation terminates. Eligible Expenses are "incurred" when the health care is provided, not when you or

your Eligible Spouse or Eligible Child are billed, charged, or pay for the expense. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a physician) will not be reimbursed until the service or treatment giving rise to the expense has been provided. In no event shall any benefits under this HRA Program be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Eligible Expenses.

Only health care expenses that have not been or will not be reimbursed by any other source may be Eligible Expenses (to the extent all other conditions for Eligible Expenses have been satisfied). You must first submit any claims for health care expenses to the other plan or plans before submitting the expenses to the HRA Program for reimbursement.

Eligible Expenses include (1) medical, prescription drug, vision, dental and Medicare Part B Premiums paid to an insurance carrier on an after-tax basis; (2) medical, prescription drug, vision, dental and Medicare Part B copayments, deductibles and coinsurance; and (3) expenses for "medical care," as defined by Internal Revenue Code Section 213(d). "Medical care" expenses include amounts paid for the diagnosis, treatment, or prevention of disease, and for treatments affecting any part or function of the body. The expenses must be to alleviate or prevent a physical defect or illness. Expenses for solely cosmetic reasons generally are not expenses for "medical care." Examples include face lifts, hair transplants, and hair removal (electrolysis). Also, expenses that are merely beneficial to one's general health (for example, vacations) are not expenses for "medical care."

For more information about what items may and may not be Eligible Expenses, consult IRS Publication 502, "Medical and Dental Expenses," under the headings "What Medical Expenses Are Includible" and "What Expenses Are Not Includible." (Be careful in relying on this Publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1040, Schedule A, not what is reimbursable under a health reimbursement account.) If you need more information regarding whether an expense is an Eligible Expense under the HRA Program, contact the Third Party Administrator as provided in the "General Information" section.

Rollover of Unused Benefit Credits

If you do not use all of the amounts credited to your HRA during a plan year, those amounts will be carried over to subsequent Plan Years for reimbursement of Eligible Expenses.

Payments for Insurance

You will pay your healthcare plan premiums directly to the insurance company for the coverage you elect. You will then file a request for claim reimbursement with Taben/Navia. If approved, you will receive reimbursement from your HRA, either by a check mailed to you or by direct deposit to the account designated by you. For additional information, see the "Receive Your Reimbursement" under the "Reimbursement Procedure" section.

REIMBURSEMENT PROCEDURE

Submitting a Claim for Reimbursement

You are responsible for paying your healthcare plan premiums directly to the insurance company. Most insurance companies will allow you to pay your premiums either by check or by having money withdrawn directly from your bank account. In addition, Medicare Advantage, Medicare Part D Prescription Drug plans, and Medicare Part B allow you to have your premiums

withheld from your Social Security check. You are responsible for paying your Eligible Expenses directly to the provider. You as the participant are responsible for filing a request for claim reimbursement.

You can submit a HRA Premium Authorization Form for automatic monthly premium reimbursement or you can manually file a request for claim reimbursement each time you have an Eligible Expense. You may submit your claims for Eligible Expenses to Taben/Navia through the online portal, email, fax, or postal mail. Refer to the “General Information” section for additional information.

Receive Your Reimbursement

You can be reimbursed from the HRA in two ways once your claim for reimbursement is approved. Your claim is deemed filed when it is received by Taben/Navia. If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Reimbursements will be paid by check mailed directly to your mailing address or direct deposit to your bank account. If direct deposit is desired, you must register the deposit account information with Taben/Navia when establishing your HRA. See the “General Information” section of this summary for contact information. Claims are paid in the order in which they are received by Taben/Navia.

Processing of claims submitted through Taben/Navia will routinely be processed within two business days. A paper form mailed and submitted to Taben/Navia generally takes three to five business days to process from the date they are received. If a direct deposit account is set up, reimbursements will be deposited directly into the designated bank account within 24 hours of approval or the date Benefit Credits are allocated by the Employer, whichever occurs first.

Claims submitted and approved over the amount currently available can be reimbursed by future Benefit Credits. Claims will be considered back to the Coverage Effective Date for a Participant and paid as Benefit Credits become available.

Submission Deadline for Reimbursement

Per the program guidelines, as long as you are eligible there is no submission deadline. In the case of death, submission deadlines do apply. Additional information is provided under “Death of a Participant”.

Cancellation of a Recurring Expense

In order to cancel a recurring expense, you must call Taben/Navia at 1-800-669-3539.

APPEALING DENIAL OF A CLAIM FOR REIMBURSEMENT

Denial Notices

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after Taben/Navia receives your claim. If it is determined that an extension of this time period is necessary due to matters beyond its control, you will be notified within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days from receipt of the notice to provide the

additional information, and this will have the effect of suspending the time for a decision on the claim until the specified information is provided. The notice of denial will contain:

- The specific reason for the decision;
- A reference to the specific provisions of the HRA Program on which the determination was based;
- A description of any additional information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- A description of the Plan's procedures and time limits for appeal of the decision, the right to obtain information about those procedures and the right to sue in federal court; and
- If the decision was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, or protocol, or if this is not practical, a statement that such rule, protocol, or criterion was relied upon in making a decision and a copy will be provided free of charge upon request.

First Level Appeal

If your request for reimbursement under the Plan is denied in whole or in part and you do not agree with the decision on the claim, you or your authorized representative may file an appeal with the Third Party Administrator. You may request access to all relevant documents in order to evaluate whether to request review of a denied claim.

An appeal of a denied claim must be requested in writing within 180 days from the date that you received notice that the claim was denied. If you do not file an appeal within this timeframe, all rights to appeal and to file suit in court will be forfeited. Your written appeal should include any additional documents, written comments, and any other information in support of your claim. The review of the denied claim will take into account all new information, whether or not such information was available when the claim was initially decided. NO deference will be given to the initial claim denial.

The Third Party Administrator will decide the first level appeal within a reasonable time, but no later than 30 days after receipt of the request for appeal. The Third Party Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reason for the decision;
- A reference to the specific provisions of the HRA Program on which the determination was based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If the decision was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, or protocol, or if this is not practical, a statement that such rule, protocol, or criterion was relied upon in making a decision and a copy will be provided free of charge upon request;
- A statement of the right to sue in federal court; and

- Appropriate information on the steps to take to appeal the Third Party Administrator's decision, including the right (unless the denial was based on your failure to meet the HRA Program's eligibility requirements) to submit written comments and have them considered.
- If the decision was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, or protocol, or if this is not practical, a statement that such rule, protocol, or criterion was relied upon in making a decision and a copy will be provided free of charge upon request.

Second Level Appeal

If the decision on appeal affirms the initial denial of your claim, you or your authorized representative may file a second level appeal with the Plan Administrator. You may request access to all relevant documents in order to evaluate whether to request a second level appeal.

An appeal of a denied first level appeal must be requested in writing within 180 days from the date that you received notice that the first level appeal was denied. If you do not file an appeal within this timeframe, all rights to appeal and to file suit in court will be forfeited. Your written appeal should include any additional documents, written comments, and any other information in support of your claim. The review of the denied claim will take into account all new information, whether or not such information was available when the claim was initially decided. No deference will be given to the initial claim denial or the first level appeal decision.

The Plan Administrator will decide the second level appeal within a reasonable time, but no later than 30 days after receipt of the request for appeal. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reason for the decision;
- A reference to the specific provisions of the HRA Program on which the determination was based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If the decision was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, or protocol, or if this is not practical, a statement that such rule, protocol, or criterion was relied upon in making a decision and a copy will be provided free of charge upon request; and
- A statement of the right to sue in federal court.

How To Appeal A Denial Of Eligibility

The Plan provides one level of appeal for eligibility determinations. If you believe you should be covered under the HRA Program, but your eligibility has been denied, then you may appeal that denial.

You must mail a written request for a review (appeal) to the Plan Administrator within 180 days after the date that you were notified that you are not eligible for the HRA Program. If an appeal is not made within this timeframe, all rights to appeal and to file suit in court will be forfeited. Your appeal should include an explanation of the reasons you believe you should be eligible to

participate in the HRA Program. The review of your claim will take into account all new information, whether or not presented or available at the time of the initial eligibility determination. No deference will be given to the initial determination.

Your request will be provided a full and fair review by the Plan Administrator or its Delegate, and you will be notified of the decision in writing within a reasonable period of time, not to exceed 60 days after the Plan Administrator's receipt of your appeal. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reason for the decision;
- A reference to the specific provisions of the HRA Program on which the determination was based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If the decision was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, or protocol, or if this is not practical, a statement that such rule, protocol, or criterion was relied upon in making a decision and a copy will be provided free of charge upon request; and
- A statement of the right to sue in federal court.

The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals or committees.

TERMINATION OF COVERAGE

Your entitlement to the Benefit Credit automatically ends on the date that coverage ends under the HRA Program. Once a Participant is no longer eligible for coverage under the HRA Program, he or she will not be permitted to re-enroll into the HRA Program and will not receive any future Benefit Credits.

After you are no longer covered by the HRA Program, you may be reimbursed for Eligible Expenses incurred during the Plan Year after your Coverage Effective Date, but before the date your coverage ends. Claims may be submitted to Taben/Navia for 180 days following your termination of coverage date. After 180 days, any unused Benefit Credits in your account will be forfeited.

You will cease being a Participant in the HRA Program on the earlier of:

- The date you cease to be eligible for Medicare;
- The date that you cease to be enrolled in an individual medical insurance policy through SelectQuote Senior;
- The date on which, in the opinion of the Plan Administrator, you intentionally furnished incomplete or incorrect information to Taben/Navia, the Plan Administrator or SelectQuote Senior for the purpose of effecting coverage under the HRA Program;
- The date that the HRA Program is discontinued or amended to terminate applicable eligibility of coverage;

- The date of your remarriage, if you are a surviving Spouse of an Eligible Retiree or Eligible LTD Plan Participant;
- The date you cease to be an Eligible Retiree, Eligible LTD Plan Participant, Eligible Spouse, or Eligible Child under the HRA Program; or
- Your date of death.

In addition, coverage in the HRA Program for an Eligible Spouse or Eligible Child (of a non-Medicare Eligible Retiree or non-Medicare Eligible LTD Plan Participant who is participating in the BSA Medical Plan) will cease when coverage in the BSA Medical Plan ceases for such Retiree or LTD Plan Participant. Continuation of coverage may, however, be available if such coverage ceased due to death of the non-Medicare Eligible Retiree or non-Medicare Eligible LTD Plan Participant. Refer to the Death of a Participant section for additional information.

A former Spouse is not eligible for coverage under the HRA Program, except as provided under COBRA. Eligibility for a Participant's former Spouse ends as of the date the divorce between the Eligible Retiree and Eligible Spouse is final.

If you, your Eligible Spouse, or Eligible Child loses eligibility as described above, you must notify the BSA Benefits Office within 31 days of the loss of eligibility. If you do not notify the BSA Benefits Office within 31 days of the loss of eligibility, coverage will retroactively terminate once notification has been received, and there will be no right to continue coverage after the loss of eligibility. Continuation of coverage after loss of eligibility is permitted only as required by COBRA.

If your coverage is retroactively terminated, you will be liable for all claims after the date coverage ends and for refunding any Benefit Credits reimbursed that you were not eligible to receive. See "Overpayments" section for additional information.

Other Events Ending Your Coverage

Your coverage may be retroactively terminated for fraud or any intentional misrepresentation of a material fact, or because you or your covered dependents knowingly gave the Plan, the Plan Administrator or SelectQuote Senior false material information. Examples include providing false information relating to another person's eligibility or status as a dependent. The HRA Program will provide written notice to Participants that coverage has ended on the date the Plan Administrator identifies in the notice.

Death of a Participant

If you are an Eligible Retiree or Eligible LTD Plan Participant who is survived by your Eligible Spouse or Eligible Child, upon your death, Benefit Credits on your behalf will end on your date of death, but your Eligible Spouse, or Eligible Child may continue to receive his or her Benefit Credits. Your surviving Spouse or Eligible Child will become the account holder of the HRA and may use the entire account balance. Your surviving Spouse or Eligible Child may submit his or her Eligible Expenses for reimbursement after your death until earliest of:

- Your Eligible Spouse's or Eligible Child's Death
- Your Eligible Spouse's Remarriage
- A Child no longer meets the criteria of an Eligible Child under the Plan; or
- The HRA Program being discontinued or amended to terminate applicable eligibility or coverage.

If you are an Eligible Retiree or Eligible LTD Plan Participant and your Eligible Spouse or Eligible Child who was receiving Benefit Credits under the HRA Program dies, coverage for your Eligible Spouse or Eligible Child under the HRA Program will end on his or her date of death. No additional Benefit Credits will be credited on his or her behalf after that date. Claims for expenses incurred by your Eligible Spouse or Eligible Child must be submitted within 180 days of his or her death.

If you are an Eligible Retiree or Eligible LTD Plan Participant and are not survived by an Eligible Spouse or Eligible Child, your Health Reimbursement Account is forfeited upon death, but your personal representative or the executor of your estate may submit claims for Eligible Expenses incurred by you before your death. Claims must be submitted within 180 days of your death.

OVERPAYMENTS

If the Plan pays benefits for expenses incurred, and it later determines that all or some of the payment received was made in error, the Participant will be required to refund the overpayment or erroneous reimbursement to the HRA Program.

If the Participant does not refund the overpayment, the HRA Program reserves the right to offset future reimbursements equal to the overpayment or, if that is not feasible, to withhold such funds from any amounts due to the Participant from the HRA Program. The Plan Administrator may also treat the overpayment as a bad debt, which may have tax implications for the Participant.

LIMITATION OF ACTION

You cannot bring any legal action against the Plan unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring a legal action against the Plan you must do so within one year of the date you are notified of the Plan Administrator's final decision on your appeal or you lose any rights to bring such an action against the Plan.

AMENDMENT OR TERMINATION

The Employer reserves the right to amend any one or more of the underlying HRA Program features at any time, including but not limited to the right to change the classes of persons eligible for participation, the amount credited to HRAs or to reduce or eliminate any amounts currently credited to a Participant's HRA, without the consent of any employee or Participant; except that any amount which became payable under the HRA Program prior to the date an amendment is effective will be paid or payable in accordance with the terms of the HRA Program as in effect immediately prior to the effective date of the amendment.

The Employer expressly reserves the right to terminate the HRA Program, in whole or in part, at any time. No Participant or covered dependent will have a vested right to any benefit under the HRA Program. On termination of the HRA Program, any amounts that became payable under the terms of the HRA Program prior to the date of termination will be paid in accordance with the terms of the HRA Program as in effect immediately prior to the date of such termination.

HRA Program participants will be notified of any amendment or termination of a HRA Program feature or of the HRA Program within a reasonable time.

Employers participating in the HRA Program other than Brookhaven Science Associates, LLC (such as a related affiliate of Brookhaven Science Associates, LLC) may terminate their participation in the HRA Program at any time.

COBRA CONTINUATION COVERAGE

Under a federal law called “COBRA,” Eligible Spouses and Eligible Children who participate in the HRA Program may be considered “qualified beneficiaries” eligible to elect to continue coverage under the HRA Program for a limited time after the date they would otherwise lose coverage because of a divorce, legal separation, or termination of a domestic partnership from the Eligible Retiree or Eligible LTD Plan Participant, the Eligible Retiree or Eligible LTD Plan Participant’s death, or, for an Eligible Child, no longer meeting the criteria of a Child under the Plan. These are called “qualifying events.” While not legally required, Domestic Partners will also be offered COBRA.

Note that qualified beneficiaries are required to notify the Plan Administrator in writing of a qualifying event within 60 days of the event or they will lose the right to continue coverage under the HRA Program.

If qualified beneficiary elects to continue coverage, he or she is entitled to the level of coverage under the HRA Program in effect immediately preceding the qualifying event. He or she may also be entitled to an increase in his or her HRA equal to the amounts credited to the HRA of similarly situated Participants (subject to any restrictions applicable to similarly situated Participants) so long as he or she continues to pay the applicable premium.

In order to continue coverage, the qualified beneficiary must pay a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event.

Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

The date the qualified beneficiary’s HRA is exhausted;

The date the qualified beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;

Any required monthly premium is not paid when due or during the applicable grace period;

The date, after the date of the qualified beneficiary’s election to continue coverage, that he or she becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary; or

The Employer ceases to provide any group health plan.

Statement of ERISA Rights

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

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy 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, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Plan Coverage

Continue Plan coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and Plan Document on rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate the 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 the Employer, your union, or any other person, may discriminate against you in any way to prevent you from obtaining benefits or exercising your rights under ERISA.

Enforce Your Rights

If your claim for benefits 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.

- 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 a 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 Plan 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 a 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 your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, 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 (EBSA), U.S. Department of Labor, which is listed in your telephone directory.

You may also contact:

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 at 1-866-275-7922. You may also visit EBSA's website on the Internet at <http://www.dol.gov/ebsa>.

DEFINITIONS

This section defines terms used in this SPD which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Benefit Credit

The amount credited to a Participant's HRA. This credited amount can be used to reimburse Eligible Expenses.

BSA Medical Plan

The medical benefit program under the Brookhaven Science Associates, LLC Comprehensive Welfare Benefits Plan.

Child

A child born to you, an adopted child, a stepchild, a child placed with or under legal guardianship the Eligible Retiree or Eligible LTD Plan Participant for adoption, a child of a Domestic Partner or a child to whom the Plan is required to extend coverage because of a QMCSO.

Code

The Internal Revenue Code of 1986, as amended from time to time.

Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”)

A federal law that requires employers to offer continued health insurance coverage to certain employees and their Dependents whose group health insurance has been terminated.

Coverage Effective Date

The first of the month after a Participant first enrolls. This is the date that is used when calculating Benefit Credits.

Delegate

The Plan Administrator may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on the Plan Administrator’s behalf.

Domestic Partner

The same-sex domestic partner of an Eligible Employee, Eligible Retiree or Eligible LTD Plan Participant and that partner’s eligible child(ren). If you are living in a jurisdiction that recognizes same-sex marriage, you must be married and provide a copy of your marriage certificate. If you live in a jurisdiction that does not recognize same-sex marriage, you must provide a copy of your (a) civil union registry, (b) domestic partner registry, or (c) a completed Affidavit of Domestic Partnership and provide proof of financial interdependence to the Plan Administrator. Additional information is available through the BSA Benefits Office. Children of your eligible domestic partner must meet the same criteria for an “Eligible Child” under the HRA Program.

Eligible Employee

An employee of an Employer who is treated as an employee by the Employer for purposes of withholding federal taxes from wages.

Eligible Expenses

Eligible Expenses include (1) medical, prescription drug, vision, dental and Medicare Part B Premiums paid to an insurance carrier on an after-tax basis; (2) medical, prescription drug, vision, dental and Medicare Part B copayments, deductibles and coinsurance; and (3) expenses for “medical care,” as defined by Internal Revenue Code Section 213(d). For additional details, see “Eligible Expenses” under the “Benefits” section.

Employer

Brookhaven Science Associates, LLC and any related affiliates that participate in the HRA Program.

ERISA

The Employee Retirement Income Security Act of 1974, as amended from time to time.

HRA

The account established for a Participant to reflect his or her Benefit Credits.

Medicare

Part A or B of Title XVIII of the Social Security Act, as amended from time to time, and the applicable regulations issued and effective thereunder.

Medicare-Eligible

A person is Medicare-Eligible if that the person is eligible to receive benefits under Medicare, due to age or disability, or would be eligible to receive such benefits upon application therefor; provided, however, that a person shall be Medicare-Eligible as of the first day of the month he or she attains age sixty-five (65) or the first day of the prior month if born on the first of the month or the first day of the month he or she becomes eligible due to disability, regardless of whether such person actually applies for or is eligible to receive Medicare benefits at that time.

Participant

Any individual who is eligible to participate in the Health Reimbursement Account Program under the Plan and/or who is participating in the Health Reimbursement Account Program.

Plan

The Brookhaven Science Associates, LLC Retiree Welfare Benefits Plan.

Plan Administrator

Brookhaven Science Associates, LLC (see the "General Information" section this SPD, for contact information, including the address for filing a second-level appeal of a denied claim).

Premium(s)

The periodic charges which are required to be paid by you to your insurance carriers and Medicare in order to maintain such coverage.

Spouse

A Spouse is an individual who is the same-sex Domestic Partner of or who is legally married to an Eligible Employee, Eligible Retiree or Eligible LTD Plan Participant, as determined in accordance with federal law.

Third-Party Administrator

Taben/Navia (see the “General Information” section of this SPD, for contact information, including the address for filing a first-level appeal of a denied claim).

LEGAL NOTICES

Mothers’ And Newborns’ Health Protection Act

The Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Women’s Health And Cancer Rights Act

To the extent the Plan provides benefits with respect to mastectomy, it will provide, in the case of an individual who is receiving benefits in connection with a mastectomy and who elects reconstruction in connection with such mastectomy, coverage for all stages of reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to provide a symmetrical appearance, prostheses, and coverage of physical complications at all stages of the mastectomy, including lymphedemas.

Protected Health Information under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. A complete description of your rights under HIPAA will be found in the Plan’s privacy notice, which will be distributed to you upon enrollment and will be available from the Plan Administrator.

The Plan and the Plan Sponsor will not use or further disclose health information that is protected by HIPAA except as necessary for treatment, payment, health plan operations and Plan administration functions, or as otherwise permitted or required by law. The Plan will not, without authorization, use or disclose protected health information for employment related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor except as permitted between plans that are part of an Organized Health Care Arrangement under HIPAA’s privacy rule.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. The Plan’s

privacy notice will provide a greater description of your rights and the Plan's obligations under the HIPAA privacy rule.

GENERAL INFORMATION

<p>Name of Plan:</p>	<p>Brookhaven Science Associates, LLC Retiree Welfare Benefits Plan</p>
<p>Type of Plan:</p>	<p>Welfare plan. This SPD describes the health reimbursement account benefit, which is a component program of the Plan.</p>
<p>Name, address, and telephone number of the Plan Sponsor and Plan Administrator:</p> <p>The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. Benefits under the Plan shall be paid only if the Plan Administrator, or its delegate, in its sole discretion determines that a Participant is entitled thereto. The Plan Administrator has delegated the discretionary authority to make benefit determinations to the Third Party Administrator.</p>	<p>Brookhaven Science Associates, LLC Brookhaven National Laboratory PO Box 5000 Upton, NY 11973-5000 (631) 344-8000</p>
<p>Agent for Service of Legal Process:</p>	<p>General Counsel Brookhaven Science Associates, LLC Brookhaven National Laboratory PO Box 5000 Upton, NY 11973-5000 (631) 344-8000</p>
<p>Plan Sponsor's federal tax identification number:</p>	<p>11-3403915</p>

Plan Number:	502
Plan Year:	January - December
Third Party Administrator for HRA Program: Has discretionary authority to make benefit determinations with respect to the HRA Program, including processing claims, and interpreting and enforcing the provisions of the HRA Program according to the terms of the Plan.	Navia Benefit Solutions <hr/> HRA Enrollment Address: Navia Benefit Solutions 10875 Benson Drive, Suite 130 Overland Park, KS 66210 Fax: (913) 649-7847 Email: retireehra@taben.com <hr/> HRA Claims Office Address: Navia Benefit Solutions P.O. Box 53250 Bellevue, WA 98015 Email: claims@naviabenefits.com Website: www.naviabenefits.com <hr/> HRA Account Questions Phone: (800) 669-3539 Fax: (866) 535-9227 Email: service@naviabenefits.com
	Funding: Benefits are paid from the Employer's general assets. There is no trust or other fund from which benefits are paid.

For Enrollment in Medicare Exchanges, or to ask questions with regard to enrollment in Medicare Exchanges, contact:

SelectQuote Senior
 (866) 479-8317 (select option 1)
www.bsa.sqbenefits.com

This information is intended to provide only a summary of BSA's benefits program. If questions arise, official plan documents and insurance agreements are controlling and govern final determination of benefits consistent with applicable laws and regulations.

**Addendum to the
Brookhaven Science Associates, LLC
Health Reimbursement Account Program Summary Plan Description (SPD)**

Extension of Deadlines Due to COVID-19 Emergency

01-01-2023

In accordance with joint guidance issued by the Department of Labor and Internal Revenue Service regarding the COVID-19 National Emergency, you have additional time to take certain actions available under the Health Reimbursement Account Program during the “Outbreak Period.” The Outbreak Period is the period starting on March 1, 2020 (the start of the COVID-19 National Emergency) and ending 60 days after the end of the National Emergency. **As of the date of this SPD, the Outbreak Period is set to expire on May 11, 2023 and these deadline extensions will end accordingly.** These actions include:

- Electing COBRA (COBRA section on page 13 of the SPD)
- Paying your COBRA premium (COBRA section on page 13 of the SPD)
- Notifying the plan of a COBRA qualifying event or disability determination (COBRA section on page 13 of the SPD)
- Filing a claim for benefits (page 6 of the SPD)
- Appealing a claim denial (page 7 of the SPD)

Your extended deadline for taking any of the above actions is measured from the earlier of:

- One year from the original start date; or
- 60 days after the announced end of the COVID-19 National Emergency (currently, July 10, 2023, and then usual Plan deadlines for these events will again apply).

Your extended deadline will not, however, be more than 1 year after the original deadline.

Example: Assume your 60-day period to elect COBRA would (but for the COVID-19 National Emergency) start on January 1, 2022 and end on March 2, 2022. Under this special extension, your 60-day election period does not start running until the earlier of January 1, 2023 or 60 days after the end of the COVID-19 National Emergency. The latest date your COBRA election will be due, however, is one-year from the original deadline (March 2, 2023 in this example).

If you have concerns about this Addendum, your coverage or meeting an applicable deadline due to the COVID-19 National Emergency or questions regarding the end of the COVID-19 National Emergency period, please contact the BSA Benefits Office, to determine if an extension may be available to you.