DENTAL PLAN 01-01-2023

The Dental Plan provides benefits for preventive, diagnostic, restorative, and orthodontic dental services. Enrollment in the Dental Plan is optional. The dental benefits available under the Dental Plan are generally described in this section of the booklet as well as in the Certificate of Coverage issued by Delta Dental. Taken together, this booklet section and the Certificate of Coverage constitute the official Summary Plan Description ("SPD") for the Dental Plan. **Please note that the Employer reserves the right to amend or terminate this Dental Plan at any time and for any reason.**

You can find copies of this booklet, the Certificate of Coverage and any future Dental Plan Amendments at: http://www.bnl.gov/hr/Benefits.

WHO IS ELIGIBLE FOR THE DENTAL PLAN?

Enrollment in the Dental Plan is optional and is open to only those employees (and their eligible dependents) who are otherwise eligible to enroll in the Dental Plan as described below.

Active Employees

- All regular employees of Brookhaven Science Associates, LLC (the "Employer") who work at least 20 hours per week are eligible to participate in the group Dental Plan on the first day of active employment.
- An employee is a "regular employee" if he/she is classified and treated for federal income tax purposes by the Employer as a regular full-time or regular part-time employee of the Employer (as opposed to a temporary, seasonal or casual employee, intern, independent contractor or consultant, agency worker or leased employee), even if the Employer's classification is later determined to be incorrect.

Ineligible Employees

The following employees are not eligible for the Dental Plan:

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

Eligible Dependents

The following members of your family are also eligible for the Dental Plan:

- Your spouse (which may include your same-sex spouse) to whom you are legally married.
- Your eligible same-sex domestic partner 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. Additional information is available through

the BSA Benefits Office. Children of your eligible domestic partner must meet the same criteria for a “child” under the Dental Plan.

- Your children are eligible until the end of the calendar year in which they attain age 23 if they meet all of the following criteria:
    - The child must be the taxpayer’s child, including an adopted child and stepchild.
    - The child must be unmarried.
    - The 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 child must not provide more than one-half of his or her own support.
- Coverage may be continued beyond the end of the calendar year of attainment of age 23 for dependents 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 from the date of incapacity or 31 days from the child’s 23rd birthday, whichever is later.

When a dependent is no longer eligible for coverage you should contact the BSA Benefits Office to remove him or her. If you do not timely notify the BSA Benefits Office, you will be required to reimburse the Dental Plan for any benefits paid to or on behalf of an ineligible dependent and may be subject to further sanctions if your failure was willful.

Your dependents can become eligible for dependent insurance on the later of:

- The day you become eligible for yourself; or
- The day you acquire your dependent

provided you timely enroll him or her as described below.

NOTE: If both you and your spouse or same-sex domestic partner work for the Employer, the spouse or same-sex domestic partner may enroll as a dependent or as an employee; or you and your spouse or same-sex domestic partner may enroll separately as employees. If you and your spouse or same-sex domestic partner enroll separately, you may NOT enroll the same dependents on each other’s plan. If both parents are covered as employees, children may be covered as the dependents of either parent, but not of both.

Dependents of Deceased Participants

If you are participating in the Dental Plan and you die while in active service or while on an authorized leave of absence, your covered dependents may continue in the Dental Plan under the COBRA provisions to the extent they are eligible by paying the applicable COBRA cost for such coverage. See the “COBRA” section for additional information.

See the “Termination of Coverage” section for information on when your coverage will terminate. In addition, coverage for dependents will terminate on the date the surviving spouse remarries.

Coverage under COBRA will be offered in accordance with the law.

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 until you have a Qualifying Event to elect coverage (see the Qualifying Event section).

To enroll, you must complete an enrollment form and list all eligible dependents you want covered, including each dependent's Social Security Number and date of birth. You must provide a marriage certificate for a spouse, proof of domestic partnership for a domestic partner, a birth or adoption certificate for a child. Enrollment forms are available through the BSA 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 have selected for yourself.

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

Open Enrollment Period

Open enrollment is held once a year. During an Open Enrollment Period, you may change dental programs, drop coverage and/or add or drop eligible dependents from your coverage. Employees who did not previously elect dental coverage may elect it during the Open Enrollment Period. Participants receiving LTD Plan benefits who are terminated from employment may not 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 cannot be changed for the remainder of the calendar year unless you notify the BSA Benefits Office of a Qualifying Event within 31 days from the date of the event.

Qualifying Event

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

Change in legal marital status

1. marriage
2. death of spouse
3. divorce
4. legal separation
5. annulment

Change in the number of dependents

1. birth
2. adoption

3. placement for adoption
4. death of a dependent
5. entering into or terminating a same-sex domestic partnership

Change in employment status

1. termination or commencement of employment of the employee, spouse, same-sex domestic partner or dependent (other than for termination of the employee for misconduct)

Changes in work schedule

1. an increase or decrease in the number of hours of employment by the employee, spouse, same-sex domestic partner 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

The dependent satisfies or ceases to satisfy the requirements for dependent coverage attainment of age

1. student status

A change in the place of residence or work site of the employee, spouse, same-sex domestic partner or dependent

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), and (e)(1). The change requested must relate to the change that affects eligibility for dental coverage. Changes are made by completing an enrollment form available in the BSA Benefits Office. The completed form must be submitted, with proof of the Qualifying Event, to the BSA Benefits Office. Your premiums will then be changed for the remainder of the calendar year. Coverage will become effective as soon as administratively feasible after the Plan Administrator has approved the change in status, except that a new child may be added as of the date of birth, date of adoption or date of placement for adoption.

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

If the Plan Administrator notifies you that the cost of your coverage under the Dental Plan significantly increases during the Plan Year or there is a significant curtailment of coverage midyear, you will have the opportunity to stop or change your coverage as permitted by the Plan Administrator.

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.

DENTAL PROGRAMS AVAILABLE

Eligible employees and their dependents have three alternatives for dental coverage under the Dental Plan: the Delta Dental Indemnity Plan, the Delta Dental DMO Plan (DeltaCare USA), or the Delta Dental PPO Plan. When you enroll, your specific benefit will be governed by a coverage booklet that provides additional information on your dental coverage, including a detailed summary of your benefits. You can request copies of the coverage booklets from the

BSA Benefits Office or obtain the coverage booklets online at http://www.bnl.gov/HR/Benefits/dental.php. The applicable coverage booklets will provide details regarding, among other things, specific services or supplies that are excluded from coverage.

Delta Dental Indemnity Plan

The Delta Dental Indemnity Plan allows you to use any dentist to care for you and your family. Services are provided through a network of dentists participating in Delta Dental's PPO and Premier networks, but benefits are also provided for use of providers who are not in the networks. You do not need to enroll with a specific dentist to receive coverage under this plan. It is a fee-for-service plan that provides reimbursement for a portion of the cost of covered dental services based on a schedule of benefits which can be found at the end of this document. To receive reimbursement of covered expenses you or your provider must submit a claim.

The Delta Dental Indemnity Plan pays a combined maximum of $1,000 in in-network and out-of-network 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.

Additional information on benefits, exclusions, and limitations is provided in your Delta Dental Indemnity Plan Evidence of Coverage booklet.

Claim forms are available in the BSA Benefits Office or on the Web at: https://www.bnl.gov/hr/Benefits/docs/dental/Delta-Claim-Form.PDF.

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 prior 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.

The DMO provides coverage for preventive and diagnostic services plus basic and restorative dental services, and orthodontia for both adults and children.

Additional information on benefits, exclusions, and limitations is provided in your Delta Dental DMO Plan (DeltaCare USA) Evidence of Coverage booklet. Please note that the cost of dental services is subject to change and is based on provisions of the DMO at the time the service is provided. The costs of dental services covered by the DMO are included in the Delta Dental Care patient charge schedule which can be obtained at no cost through the BSA Benefits Office or directly from Delta Dental.

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

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 Dental's PPO or Premier network. Out-of-network benefits are provided if you use a provider who is not in Delta Dental's 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.

The PPO pays a combined maximum of $1,500 in in-network and out-of-network 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.

Additional information on benefits, exclusions, and limitations is provided in your Delta Dental PPO Plan Evidence of Coverage booklet.

Claim forms are available in the BSA Benefits Office or online at: https://www.bnl.gov/hr/Benefits/docs/dental/Delta-Claim-Form.PDF.

DENTAL PROGRAM CONTACT INFORMATION

DENTAL PROGRAM	PHONE NUMBER	PROVIDER DIRECTORY*
Indemnity	(800) 932-0783	http://www.deltadentalins.com
DMO	(800) 422-4234	http://www.deltadentalins.com
PPO	(800) 932-0783	http://www.deltadentalins.com

*Provider directories are available online at the websites indicated above.

CLAIMS AND APPEALS ADMINISTRATOR

The Plan Administrator has full power and discretion to resolve all issues concerning eligibility, status, entitlement to benefits, and any other interpretations under the Plan. Such interpretations or rulings will be binding on all parties. The Plan Administrator has the right to delegate some of these duties to third party providers, such as the Claims and Appeals Administrators for the Plan features. As the Plan Administrator's delegates, the Claims and Appeals Administrators have the authority to make decisions relating to benefit claims.
The Plan Administrator has delegated the claim fiduciary responsibilities of the Dental Plan to Delta Dental. As such, Delta Dental, in its role as the Claims and Appeals Administrator has the discretion to:

- Interpret the terms of the Dental Plan and the benefits defined thereunder;
- Interpret the other terms, conditions, limitations and exclusions of any program offered under the Dental Plan; and
- Make factual determinations related to the Dental Plan program and its benefits.

For a detailed description of the claims and appeals provisions that apply to your dental care benefits, please see the Certificate of Coverage for the Dental Plan.

CLAIMS

How to File a Claim

Typically, your dental care providers will complete all claims information for you and bill Delta Dental on your behalf. If your provider does not file a claim for you or you are requesting coverage for a benefit you must complete a claim form that is available at: http://www.bnl.gov/hr/Benefits and file it with Delta Dental within 12 months of the date of service under the PPO or Indemnity plans or within 90 days of service under the DMO. Return the completed claim forms for the PPO or Indemnity plans to:

Delta Dental
P.O. Box 2105
Mechanicsburg, PA 17055-6999

For the address to submit claims under the DMO plan, please call 1-800-422-4232.

Questions About Claims

If you have a question about your dental benefits, call Delta Dental at (800) 932-0783 (for the PPO or Indemnity plans) or (800) 422-4234 (for the DMO plan), or at the number and/or address listed on the back of your card.

How to Appeal a Claim

You may request a review of the denied claim in writing to the Claims and Appeals Administrator within 180 days of the receipt of the notice of denial. If you do not receive an explanation of benefits within 30 days of submission of your claim, you may submit a first-level appeal within 180 days after this 30-day period has expired.

You should state the claim number or provide a copy of the written denial or explanation of benefits, and indicate the reasons why your claim should not have been denied, including any additional documents which you believe support your claim.

The Claims and Appeals Administrator will respond within 60 calendar days after receiving the appeal. If more time or information is needed to make the decision, the Claims and Appeals Administrator will notify you in writing to request an extension of up to 45 calendar days and to specify any additional information needed to complete the review.

If you have exhausted the administrative claims procedure set forth in the Plan, including both an initial claim and an appeal, you may seek review of your claim before a court of competent jurisdiction within 12 months of the date such claim is finally denied.

COST OF THE PLAN

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, but only minimally.

Employee premiums are listed in the Premiums section and are subject to change.

Premiums For Participants Receiving Long Term Disability Plan Benefits Who Are Terminated From Employment

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, fails to pay the required premiums or elects to drop such coverage.

Premiums for Participants on LTD are listed in the Premiums section and are subject to change.

MISCELLANEOUS

Leave of Absence

If you are on an approved Leave of Absence, 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. 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.

TERMINATION OF COVERAGE

Dental coverage for active employees, participants receiving LTD Plan benefits, and your dependents under the Dental Plan will cease on the earlier of the date your employment terminates or (if applicable) LTD benefits terminate, 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 they elect to drop such coverage, the date they are no longer eligible for coverage, or when they fail to pay the required premiums.

Dependent coverage will also cease when the dependent becomes ineligible. Coverage for your spouse or same-sex domestic partner also ceases upon your divorce or dissolution of domestic partnership. You have the option to terminate dependent coverage if you are legally

separated. Coverage for your dependent children also ceases when the child no longer meets the eligibility requirements of this Dental Plan.

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

Your coverage will also end on the date the Employer discontinues the Dental 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 Dental Plan when they would otherwise lose their group dental coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Dental 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 Dental Plan is lost because of the qualifying event. Under the Dental 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 Dental 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 or same-sex domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Dental 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, or your domestic partnership terminates.

Your dependent children will become qualified beneficiaries if they lose coverage under the Dental 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); or
- The child stops being eligible for coverage under the Dental Plan as a "dependent child."

When is COBRA Coverage Available?

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

Notification Requirements

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

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

If you do not elect continuation coverage within 60 days from the date of the notice indicated above or the date of the qualifying event, whichever is later, 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 BSA Benefits Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses or same-sex domestic partners, 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, same-sex domestic partner 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 Dental Plan is determined by the Social Security Administration to be disabled and you notify the BSA Benefits Office in a timely manner, 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 BSA 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 that would otherwise have resulted in a loss of coverage while receiving 18 months of COBRA continuation coverage due to your termination of employment, your spouse or same-sex domestic partner and your eligible dependent children 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 Dental 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 Dental Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Dental Plan had the first qualifying event not occurred.

COBRA Premium Requirements

You, or your eligible dependents, will be required to pay 102% of the full cost of the continuation coverage under the provisions of COBRA. You will be billed for the required premium on a regular basis. COBRA premiums are listed in the Premiums section and are subject to change..

Termination of Coverage Under COBRA

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

- The BSA Benefits Office is notified by you or your dependent to discontinue coverage.
- 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, same-sex domestic partner or dependent child: If the BSA Benefits Office is not notified within 31 days of the date of divorce or legal separation or termination of domestic partnership.
- For a dependent child: If the BSA Benefits Office is not notified within 31 days of the date the dependent status ends.
- Payment for continuation coverage is not paid on time.
- The Dental Plan is terminated for active employees.

AMENDMENT AND TERMINATION

The Employer reserves the right to amend any one or more of the underlying Dental Plan features, including, but not limited to, any dental program, at any time without the consent of any employee or participant; except that any amount which became payable under the Dental Plan prior to the date an amendment is effective will be paid or payable in accordance with the terms of the Dental Plan as in effect immediately prior to the effective date of the amendment.

The Employer expressly reserves the right to terminate the Dental Plan, in whole or in part, at any time. No Dental Plan participant or covered dependent will have a vested right to any benefit under the Dental Plan. On termination of the Dental Plan, any amounts that became payable under the terms of the Dental Plan prior to the date of termination will be paid in accordance with the terms of the Dental Plan as in effect immediately prior to the date of such termination. Upon the termination of the Dental Plan all elections and reductions in compensation relating to the Dental Plan will terminate.

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

GENERAL INFORMATION

Name of Plan:	Brookhaven Science Associates, LLC Comprehensive Welfare Benefits Plan
Type of Benefit:	This benefit is a welfare plan providing benefits for dental services.
Name, address, and telephone number of the Plan Sponsor and Plan Administrator: The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. Benefits under the Plan shall be paid only if the Plan Administrator, or it delegate, in its sole discretion determines that a Participant is entitled thereto. The Plan Administrator has delegated the discretionary authority to make benefit determinations to the Third Party Administrator.	Brookhaven Science Associates, LLC Brookhaven National Laboratory PO Box 5000 Upton, NY 11973-5000 (631) 344-8000
Agent for Service of Legal Process:	General Counsel Brookhaven Science Associates, LLC Brookhaven National Laboratory PO Box 5000 Upton, NY 11973-5000
Plan Sponsor's federal tax identification number:	11-3403915
Plan Number:	501
Plan Year:	January - December
Type of Funding:	Benefits provided through the Delta Dental Indemnity Plan and Delta Dental PPO Plan are funded from the general assets of the employer. Benefits provided through the Delta Dental DMO Plan are insured by Delta Dental.
Source of Funds:	This benefit is paid for by a combination of employer and employee premiums.
Type of Administration:	Delta Dental of New York, Inc. provides claims administration and other services

	through administrative contracts for the Delta Dental Indemnity Plan and Delta Dental PPO Plan. Delta Dental provides claims administration and other services through an insurance contract for the Delta Dental DMO Plan.
Benefit and Claims Administrator:	Delta Dental Indemnity Plan and Delta Dental PPO Plan Delta Dental of New York, Inc. PO Box 2105 Mechanicsburg, PA 17055-2105 (800) 932-0783 Delta Dental DMO Plan Delta Dental 575 Madison Avenue New York, NY 10022 (800) 422-4234

PRIVACY OF INFORMATION

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

YOUR RIGHTS UNDER ERISA

As a participant in the 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.

Continue Group Health Plan Coverage

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

This information is intended to provide only a summary of BSA's benefits program. Nothing contained herein should be construed as a promise of employment or continued employment, or to constitute contractual obligations. If questions arise, official plan documents and insurance agreements are controlling and govern final determination of benefits consistent with applicable laws and regulations.

EMPLOYEE PREMIUMS

AND

PREMIUMS FOR PARTICIPANTS RECEIVING LONG TERM DISABILITY BENEFITS WHO ARE TERMINATED FROM EMPLOYMENT

(January 1, 2023)

Coverage	Monthly Premium		
	Delta Dental DMO (DeltaCare USA)	Delta Dental PPO	Delta Dental Indemnity Plan
Employee only	$ 5.00	$10.11	$ 5.00
Employee + 1 dependent	$10.00	$20.86	$10.00
Employee + 2 or more dependents	$19.00	$34.23	$19.00

Note: Premium costs are subject to change

COBRA PREMIUMS
(January 1, 2023)

Coverage	Monthly Premium*		
	Delta Dental DMO (DeltaCare USA)	Delta Dental PPO	Delta Dental Indemnity Plan
Employee only	$20.26	$ 35.58	$15.73
Employee + 1 dependent	$41.17	$ 75.57	$33.42
Employee + 2 or more dependents	$61.26	$106.00	$46.85

*** COBRA premium + 2% administrative fee**

Note: Premium costs are subject to change

Addendum to the
Brookhaven Science Associates, LLC
Dental Plan Summary Plan Description

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 Dental Plan during the "Outbreak Period." The Outbreak Period is the period from 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:

- Requesting HIPAA special enrollment (page 3 of the SPD)
- Electing COBRA (COBRA section on page 9 of the SPD)
- Paying your COBRA premium (COBRA section on page 11 of the SPD)
- Notifying the plan of a COBRA qualifying event or a disability determination (COBRA section on page 10 of the SPD)
- Filing a claim for plan benefits (page 7 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, 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.