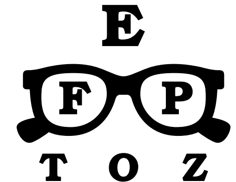
2026 Open Enrollment Benefits Guide

For Active Employees
of Savannah River Nuclear Solutions



Open Enrollment is October 2-24, 2025

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Time to choose the right plan for you and your family!

**Enroll at any time
between October 2-24, 2025.**

Ready to shop for 2026 benefits?

Your benefits from 2025 will not "roll over" to 2026. You must actively complete enrollment or select "waive." To enroll, go to the eApplications™ module on InSite and confirm your 2026 benefit elections. Remember to review your dependents listed under each plan and make changes as needed. After enrolling in your benefit options, you will immediately receive an email confirmation of your decisions. Take the time to review the confirmation statement carefully and keep a copy for your records.

No changes will be accepted after midnight October 24.

2026 Open Enrollment Benefits Guide

For Active Employees of Savannah River Nuclear Solutions

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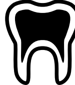
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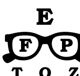

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To view this guide online, go to ***InSite>Services>Workforce Services & Talent Management >What can we help with today?>Benefits>Open Enrollment***
or off-site at ***www.srs.gov/general/jobs/benefits/index_e.htm***

While SRNS intends to continue providing comprehensive benefit programs, the company reserves the right to modify or terminate any of the benefit plans at any time. SRNS will provide advance notification of any future substantial and material benefit changes. This open enrollment communication is also intended to summarize and notify you of any material modifications to the Plan (“Summary of Material Modifications”).

Using your Open Enrollment Benefits Guide

We believe our employees are the best. That's why we're proud to offer benefits covering all areas of your life, including:

- Comprehensive medical, dental and vision coverage
- Critical Illness and Accident Insurance
- Identity Theft Protection
- Legal Plans
- Hospital Indemnity Insurance
- Flexible Spending Accounts (FSA) for health care and dependent care expenses
- A Health Savings Account (HSA) funded with pretax contributions used to pay for eligible health care expenses and only available if you enroll in the Basic Plan

This SRNS Open Enrollment Benefits Guide outlines what is included in your benefits package and what benefit choices you have for yourself and your eligible dependents. We encourage you to:

- Read this guide and share the information with family members who are also eligible.
- Think about your current covered dependents. If you are adding new dependents to your plan, be prepared to provide proof of eligible dependent status.

Once you reviewed the options available to you, follow the enrollment instructions on this page and make your elections before midnight on October 24, 2025.

How to Enroll

Open Enrollment this year will be "Active." Your benefits from 2025 will not "roll over" to 2026. You must actively complete enrollment or select "waive." To enroll, go to the eApplications™ module on InSite and confirm your 2026 benefit elections. Remember to review your dependents listed under each plan and make changes as needed. After enrolling in your benefit options, you will immediately receive an email confirmation of your decisions. Take the time to review the confirmation statement carefully and keep a copy for your records.

No changes will be accepted after midnight October 24.

This year is an "Active" enrollment. All SRNS employees must enroll or select "waive" in the following plans:

• Medical (Basic or Standard)

• Health Savings Account (HSA)

(with Basic Medical Plan only)

• Flexible Spending Accounts (FSA)

(Traditional, Limited Purpose or Dependent Care)

• Dental (Prime or Standard)

• Vision (High Option or Low Option)

• Critical Illness and Accident Insurance

• Identity Theft Protection

• Legal Plans

• STD Buy Up Option

If you don't complete the Open Enrollment process you will be defaulted into the Basic Medical Health Plan, with Employee Only coverage and all other plans (dental, vision, FSA, HSA, STD Buy Up, voluntary benefits and Aflac) will be set to "waive." You will not be able to drop coverage until the next Open Enrollment period, or if you have a qualified life event.

No changes will be accepted after midnight October 24.

Option A employees: If you are an Option A employee, you must complete a Personalized Enrollment Form and include your User ID on the form. Return the form to SRNS Service Center via email at Service-Center@srs.gov or in person at Bldg. 992-2W, Savannah River Site, Aiken, SC 29808.

Limited Service Employees (LSE): employees: Your benefits from 2025 will not "roll over" to 2026. You must actively complete enrollment or select "waive."

To enroll, go to the eApplications™ module on InSite and confirm your 2026 benefit elections. Remember to review your dependents listed under your medical plan and make changes as needed. After enrolling you will immediately receive an email confirmation of your election. Take the time to review the confirmation statement carefully and keep a copy for your records. You will not be able to drop coverage until the next Open Enrollment period, or if you have a qualified life event.

Special Enrollment Opportunity

Additionally, this year there is a Special Enrollment that will include an opportunity to increase your Optional/Contributory life insurance benefits and to enroll in a Hospital Indemnity benefit.

The Special Enrollment dates are October 2-24 (same as OE dates) and will include an opportunity to increase your optional/contributory life insurance benefit and to enroll in a Hospital Indemnity benefit. These two benefits WILL NOT be through the eApplications™ module on InSite. **If you do not want to enroll in these two specific benefits below you do not have to take any action.** If you do not elect to enroll, your Hospital Indemnity coverage will be waived, and your current life insurance benefit amount will not change.

To learn more or enroll in these benefits, you must go to the Prudential Insurance Company Portal at:

https://gateway.on24.com/wcc/experience/ElitePruWSG/2610477/4155995/savannah-river-nuclearsystems

Changes for 2026

Here's a quick look at some of the benefits changes for next year. The "What's New" mailer is also available online at ***https://www.srs.gov/general/jobs/benefits/documents/take_a_look.pdf***. All changes take effect January 1, 2026.

New Premium Rates

Medical premiums will have a 6% increase. Dental, Vision and Aflac Accident Plan premiums will remain the same for 2026. Check out the new rates in this booklet.

HSA Maximum Contribution Increase

For 2026, you can contribute up to $4,400 for Employee Only coverage, and up to $8,750 for all other coverage levels. Individuals over 55 may contribute $5,400 for Individual only coverage and up to $9,750 for all other coverage levels.

FSA Contribution Limits Increase

The limits for both the Healthcare Traditional and Limited Purpose FSAs were increased in 2025 to $3,300 (formerly $3,200). This will be the limit for 2026, unless a new limit is deemed by the IRS which will be communicated to participants. For those re-enrolling in the FSA, the roll over amount will be $660.

The Dependent Care FSA is increasing to $7,500 (if married filing jointly) If you care for a child, adult, or elder who is incapable of self-care, who lives in your home for at least eight hours each day, and whom you can claim as a dependent on your income taxes, you may be able to take advantage of the dependent care FSA.

Basic Medical Plan, HDHP, deductible to increase

The employee-only coverage deductible will increase to $2,000 and family coverage deductible will increase to $4,000. Keep an eye out for a new BlueCross BlueShield insurance card with the new deductible listed on it. The My Health Toolkit App will automatically update the card on January 1.

Short Term Disability (STD) Buy Up Option Enrollment for 2026

Buy-Up STD coverage provides for a higher level of STD coverage. The Buy-Up STD Plan is paid for by both you and your employer and provides a greater level of income protection. There will be no premium increase for the STD Buy-Up in 2026.

Employees can elect to purchase the Buy-Up STD Plan to receive 100% of their base salary for up to the full 1,040 hours of STD. The Buy-Up Option will cost participants .224 cents for every $100 of their base pay.

Example: If an employee's annual base pay is $100,000:

$100,000 divided by 100 = 1,000 x .224 = $224 annual premium.

The employee would pay an annual premium of $224.00 for the Buy-Up option.

Legal Plans - MetLife

Most people think legal help only comes in handy when trouble strikes but people turn to attorneys for all kinds of reasons, from negotiating new home contracts to estate planning. With MetLife Legal Plans, you get unlimited access to a network attorney to help you with life's events – big and small. This group benefit features:

- Assistance for a wide range of legal needs, including wills and other estate planning documents, real estate matters, traffic offenses, adoptions, identity theft defense, and much more.
- Cost-effective monthly premium for unlimited use and no copays when using a Network Attorney for a covered matter.
- Access to digital estate planning to create wills, living wills, and powers of attorney online.
- Easy access to more than 18,000 experienced Network Attorneys.

Hearing Aid coverage continues

Added to your BCBS Medical Plan - Covered in network and out of network.

The plan allows up to a maximum of $3,000 per device (pair) every 36 months once the plan deductible has been met. Coinsurance applies. Covered Medical Expenses include charges incurred for hearing aids, as prescribed by a physician. Charges for hearing aids and associated exam for device testing and fitting, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound. Must be enrolled in the BCBS medical plans for this coverage.

Identity Theft – ID Watchdog plans are still available

With ID Watchdog you have a more convenient and affordable way to help better protect and monitor your identity. You'll be alerted to potentially suspicious activity and enjoy greater peace of mind knowing you don't have to face identity theft alone. Take action with award-winning ID Watchdog identity theft protection that includes:

- Control & Manage your Credit Report
- Advanced Identity Theft Detection
- Dedicated Identity Resolution Specialists
- Extensive Family Coverage
- Cybersecurity Protection

Aflac Plans are still available

Critical Illness Insurance and Accident Insurance are still available options for 2026. If you did not enroll in these benefits for 2025, now is the time to review the details of those plans and consider them as options for 2026. There are no premium rate changes for these plans for 2026.

SRNS Marketplace

SRNS Marketplace is open for business and allows SRNS employees to access thousands of discounts that cannot be found anywhere else in one location. The easy-to-use online marketplace allows employees to find deals on pet insurance, restaurants, shopping, family care, car rentals, favorite local establishments and much more!

Sign up and start saving!

1) Go to ***https://srnsmarketplace.benefithub.com/***

2) Enter Referral Code: HRNGNX

3) Complete registration

Pharmacy Mail Saver Program continues in 2026

The SRNS Active Medical Plan will require that reoccurring prescriptions be ordered through the OptumRx mail order process.

This program continues to require participants to have prescriptions for drugs that are considered "maintenance" filled through an OptumRx Mail pharmacy.

More details can be found on Page 14 of this booklet. **Remember that your deductible will reset on January 1, 2026.**

Special Enrollment For Life Insurance and Hospital Indemnity

As outlined on Page 5 Special Enrollment for these two benefits below (Life Insurance increase and the Hospital Indemnity benefit) WILL NOT be through the eApplications™ module on InSite.

To learn more, check rates, and enroll in these benefits, you will go to the Prudential Insurance Company Portal at:

https://gateway.on24.com/wcc/experience/ElitePruWSG/2610477/4155995/savannah-river-nuclearsystems

See all the details about these benefits below.

Hospital Indemnity – Prudential Life Insurance Company

(Enrollment for this benefit is completed through the Prudential Life Insurance Portal)

Hospital stays can be expensive, and they are usually unexpected. Hospital Indemnity Insurance can help provide a financial cushion for out-of-pocket expenses associated with hospitalization, so you can stay on track financially and focus on your recovery.

- Pays a tax free benefit amount for covered medical services, such as a stay in a hospital or intensive care unit. Hospitalized for maternity stays are also included.
- Helps fill gaps not covered by your medical plan, paying in addition to other insurance you may have.
- Payments are paid directly to you, and you can spend them however you wish. There's no coordination of benefits with other coverages (such as medical), which means you'll receive the full cash amount provided by your plan.
- Payments may be used for deductibles, co-pays, household bills, or even everyday expenses such as babysitters and take-out food.
- Guaranteed coverage, regardless of your health. You don't have to answer health questions. You just need to be actively at work on the day your coverage starts.

Special Enrollment Period for Life Insurance

(Enrollment for this benefit is completed through the Prudential Life Insurance Portal)

Employees who have not previous enrolled in Optional/Contributory Life Insurance now have the opportunity to elect Optional/ Contributory Life Insurance 1x-8x to $1.5 million of the employee's base salary (the base salary that is used for the calculation is the base salary as of Dec. 1 of the previous year). All employee coverage amounts will require Evidence of Insurability (EOI) and short medical questions.

Employees who are currently enrolled in Optional/Contributory Life Insurance now have the opportunity to elect to increase their current election of Optional/Contributory Life Insurance to 1x-8x to $1.5 million of the employee's base salary (the base salary that is used for the calculation is the base salary as of Dec. 1 of the previous year). All employee coverage increases will require Evidence of Insurability (EOI) and short medical questions.

Employees may increase or enroll in coverage for their spouse up to $60,000 (increased from $30,000) **without** having to provide Evidence of Insurability or answer any medical questions.

Frequently Asked Questions

How do I...

... add or remove dependents?

You can add or remove dependents during Open Enrollment without a qualifying life status change. Review your dependents carefully. If you missed an enrollment period earlier in the year, now is the time to add them. You will need to provide documentation to support that the dependent meets the eligibility requirements of the plan (spouse, eligible dependent child under the age of 26, etc.).

To delete a dependent: Do not select them for coverage.

To add a dependent: You must add any new dependent(s) through the SRNS Service Center before you can enroll them in the PeopleSoft eApplications Module online. During Open Enrollment, you can complete the OSR 5-377, but during the calendar year for a life event you will complete the OSR 5-200.To do this, go to Forms on InSite and use Form OSR 5-200 (Health Care Programs Enrollment/ Change Form). To complete the process, email the signed OSR 5-200 and supporting documentation to ***service-center@srs.gov*** or mail it to: SRNS Service Center, Building 730-1B Savannah River Site, Aiken, SC 29808

Outside of the Open Enrollment period, there must be a Qualifying Life Status Change.

A few examples of qualified life status changes include:

- Marriage or divorce
- Birth, adoption or placement for adoption of a child
- A dependent losing eligibility for coverage (child reaches maximum age, or spouse loses coverage or retires from his or her company)
- Death of a spouse or dependent
- You or your spouse become eligible or ineligible for Medicare or Medicaid

Adding or deleting a dependent will require you to provide a copy of the official documents confirming your status change. Examples include birth and marriage certificates, divorce decrees or legal guardianship documentation. A list of the acceptable documentation can be found at ***www.srs.gov/general/jobs/benefits/documents/Acceptable_Dependent_Documentation.pdf***

If you experience a qualified life status change, contact the SRNS Service Center at (803) 725-7772, (800) 368-7333 or email service-center@srs.gov within 60 days of the qualifying event to request your change. Request made after 60 days of the qualifying life event will not be acceptable and the change can be made during the next open enrollment period.

... receive a confirmation statement?

After you complete your enrollment, you will receive an immediate confirmation email to your SRS email account, so please be sure to look for it. Please review the confirmation email to ensure your selections are correct. If the email confirmation does not show the changes you intended, you can go back into the PeopleSoft self-service e-Applications make corrections and resubmit your changes. You can do this as many times as you need to between October 2-24, 2025. It is important for you to complete all your changes before midnight October 26. Please save your email confirmation statements until you receive the final confirmation letter that has been posted to your account once Open Enrollment closes.

... pay for my benefits?

You and SRNS share the cost of your benefit coverage. The amount deducted from your paycheck depends on the options and coverage level you elect for each plan.

- Employee only
- Employee + one
- Employee + two or more

2026 Premium Rates for Medical, Dental and Vision Plans

Medical Plan	Basic		Standard	
Type	Monthly Premium	Weekly Premium	Monthly Premium	Weekly Premium
Employee only	$93	$23.25	$194	$48.50
Employee + one	$189	$47.25	$386	$96.50
Employee + two or more	$347	$86.75	$696	$174
Dental Plan	**Prime**		**Standard**	
Type	Monthly Premium	Weekly Premium	Monthly Premium	Weekly Premium
Employee only	$27	$6.75	$9	$2.25
Employee + one	$53	$13.25	$19	$4.75
Employee + two or more	$80	$20	$28	$7
Vision Plan*	**High Option**		**Low Option**	
Type	Monthly Premium		Monthly Premium	
Employee only	$9.57		$6.59	
Employee + one	$19.64		$13.53	
Employee + two or more	$29.81		$20.54	

*Note: If the participant is paid weekly, the vision monthly amount will be deducted from the first paycheck of that month.

Terms you really should know

What is a deductible? The amount you owe for health care services or supplies before the plan begins to share costs with you

What is coinsurance? The percentage you and the plan pay after reaching your deductible

What is a copay? A fee you pay for services such as office visits and prescription drugs

What is an out-of-pocket maximum? The maximum amount you will have to pay out of pocket before the plan pays 100% of allowable costs for the remainder of the plan year

HIPAA: Notice of Privacy Practices (January 1, 2025)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of privacy practices (this “Notice”) applies to the health plans and programs (the “Group Health Plan”) sponsored by Savannah River Nuclear Solutions, LLC (the “Company”). The Group Health Plan includes the following Company-sponsored plans and benefits that are subject to the administrative simplification section of the Health Insurance Portability and Accountability Act and its implementing regulations: the Active Medical Plan the Pre-65 Retiree Medical Plan, the Active Dental Plan, the Pre-65 Retiree Dental Plan, the Active Vision Plan, the Employee Assistance Program, and Flexible Spending Accounts (Traditional and Limited).

This Notice of Privacy Practices summarizes the Group Health Plan’s responsibilities and your rights concerning protected health information, which is information that identifies you and relates to your physical or mental health, treatment, and payment for health care services. The Group Health Plan is required to abide by the terms of this Notice, which is currently in effect.

1. **Uses and Disclosures of Information that the Group Health Plan May Make Without Written Authorization.** The Group Health Plan may use or disclose protected health information for the following purposes without your written authorization as long as the legal requirements are met. The examples provided are not meant to be exhaustive.

   Treatment. The Group Health Plan may use or disclose protected health information so that health care providers may provide treatment to you. For example, the Group Health Plan may disclose medical information about you to doctors, nurses, technicians, or other hospital or medical facility personnel who are involved in taking care of you.

   Payment. The Group Health Plan may use or disclose protected health information to determine or fulfill its responsibility for coverage and the provision of benefits under the Group Health Plan. Examples of payment activities include but are not limited to: determining eligibility or coverage for Group Health Plan benefits, facilitating payment for the treatment or services you receive from health care providers, coordinating benefits under the Group Health Plan and facilitating the adjudication or subrogation of health care claims. The Group Health Plan also may use or disclose protected health information to review health care services for medical necessity, appropriateness of care and justification of charges and to facilitate utilization review activities, including pre-certification and preauthorization of services concurrent and retrospective review.

   Health Care Operations. The Group Health Plan may use or disclose protected health information for certain operations that are necessary to run the Group Health Plan. Examples of Group Health Plan operations include but are not limited to: conducting quality assessment and improvement activities; underwriting or premium rating for purposes of creation, renewal, or replacement of Group Health Plan benefits; coordinating or managing care; and conducting or arranging for medical review. The Group Health Plan is prohibited from using or disclosing protected health information that is genetic information of an individual for underwriting purposes.

   Plan Sponsor. In accordance with the terms of the Group Health Plan, the Group Health Plan may disclose protected health information to designated employees of the Company, which is the sponsor of the Group Health Plan, solely for purposes of administering the Group Health Plan.

   To Comply with Federal and State Requirements. We will disclose medical information about you when required to do so by federal, state, or local law. For example, we may disclose medical information when required by the U.S. Department of Labor or other government agencies that regulate us; to federal, state, and local law enforcement officials; in response to a judicial order, subpoena, or other lawful process; and to address matters of public interest as required or permitted by law (for example, reporting child abuse and neglect, threats to public health and safety, and for national security reasons). We are required to disclose medical information about you to the Secretary of the U.S. Department of Health and Human Services if the Secretary is investigating or determining compliance with HIPAA, or to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law. We may disclose your medical information to a health oversight agency for activities authorized by law (such as audits, investigations, inspections, and licensure).

   Public Health Activities. The Group Health Plan may use or disclose protected health information for certain public health activities, including to report information to the appropriate authority to prevent or control disease, injury or disability.

Abuse or Neglect. The Group Health Plan may disclose protected health information to an appropriate government agency if it believes it is related to child abuse or neglect or in certain circumstances if it believes it is related to a victim of abuse, neglect or domestic violence.

Health Oversight Activities. The Group Health Plan may disclose protected health information to governmental health oversight agencies for activities authorized by law, such as audits, investigations, and inspections. "Health oversight activity" does not include an investigation or other activity relating to you.

Judicial and Administrative Proceedings. The Group Health Plan may disclose protected health information in response to an order of a court or administrative tribunal, a subpoena, discovery request or other lawful process as provided by law.

Law Enforcement. The Group Health Plan may disclose protected health information, subject to specific limitations, for certain law enforcement purposes, including in response to legal process or as otherwise required by law; to identify or locate a suspect, fugitive, material witness or missing person; to provide requested information about the victim of a crime; to alert law enforcement that a person may have died as a result of a crime and to report a crime that has occurred on a hospital's premises.

Coroners, Medical Examiners and Funeral Directors. The Group Health Plan may disclose protected health information to coroners, medical examiners, or funeral directors as necessary for them to carry out their duties.

Organ Donation. The Group Health Plan may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes or tissue.

Research. The Group Health Plan may use or disclose protected health information for limited research purposes. Usually, an authorization is required to use and disclose protected health information for research.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone who is able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

National Security. The Group Health Plan may disclose protected health information to authorized federal officials for national security activities and for the provision of protective services to the President and other authorized officials.

Persons in Custody. The Group Health Plan may disclose protected health information about an inmate or person in lawful custody of law enforcement in certain circumstances.

Workers' Compensation. The Group Health may disclose protected health information as authorized by and to comply with workers' compensation laws and other similar legally established programs that provide benefits for work-related injuries or illness.

Business Associates. The Group Health Plan may disclose protected health information to third party "business associates" who perform various activities involving protected health information (e.g., claims payment or case management services) for the Group Health Plan. The Group Health Plan will require its business associates to agree to appropriately safeguard protected health information and to limit their use or disclosure of protected health information.

2. **Uses and Disclosures of Information that the Group Health Plan May Make Unless You Object.** The Group Health Plan may use and disclose protected health information in the following instances without your written authorization, unless you object.

   Disclosure to Others Involved in Your Care. We may disclose medical information about you to a relative, a friend, or to any other person you identify, provided the information is directly relevant to that person's

involvement with your health care or payment for that care. For example, if a family member or caregiver calls us with prior knowledge of a claim and asks us to help verify the status of a claim, we may agree to help them confirm whether or not the claim has been received and paid.

Notification. Unless you object, the Group Health Plan may use or disclose protected health information to notify or assist in notifying a family member, personal representative or other person responsible for your care of your location, general condition or death. Among other things, the Group Health Plan may disclose protected health information to a disaster relief agency to assist in notifying family members.

3. Uses and Disclosures of Information that We May Make With Your Written Authorization.

Other uses and disclosures of protected health information about you will be made only with your written authorization unless otherwise required by law. The Group Health Plan must obtain authorizations to use and disclose protected health information for marketing, sale of protected health information and that involve psychotherapy notes. You may revoke your authorization at any time by submitting a written revocation to the Privacy Contact identified below, except to the extent that the Group Health Plan has taken action in reliance on your authorization.

4. Your Rights Concerning Protected Health Information.

Right to Request Additional Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. If the Plans do agree to a request, a restriction may later be terminated by your written request, by agreement between you and the Plans (including orally), or unilaterally by the Plans for health information created or received after the Plans have notified you that they have removed the restrictions and for emergency treatment.

To request restrictions, you must make your request in writing and must tell us the following information:

- What information you want to limit.
- Whether you want to limit our use, disclosure, or both.
- To whom you want the limits to apply.

Right to Receive Communications by Alternative Means. You have the right to request that the Group Health Plan use alternative means or alternative locations for communications involving protected health information. You must submit your request in writing to the Privacy Contact identified below. The Group Health Plan will accommodate reasonable requests if you clearly state that the disclosure of all or part of the information to which the request pertains could endanger you. The Group Health Plan may condition the accommodation on information as to how payment will be handled or specification of an alternative address or other method of contact.

Right to Inspect and Copy Records. You have the right to inspect and obtain a copy of protected health information that is used to make decisions about you. You may access protected health information by submitting a written request to the Privacy Contact identified below. The Group Health Plan may charge you a reasonable cost-based fee for providing the records to you. The Group Health Plan may deny your request in writing in certain circumstances In most cases, if access is denied, then you will have the right to have the denial reviewed.

Right to Request Amendment to Record. You have a right to request that incomplete or inaccurate protected health information be amended. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plans.

You may request the amendment by submitting a request in writing to the Privacy Contact identified below and you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend any of the following information:

- Information that is not part of the medical information kept by or for the Plans.
- Information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment.

• Information that is not part of the information which you would be permitted to inspect and copy.

• Information that is accurate and complete.

The Group Health Plan may deny your request in writing in certain circumstances If the Group Health Plan denies your request, then you have a right to submit a statement of disagreement and to have the statement attached to the record. The Group Health Plan then has the right to add a rebuttal statement.

Right to an Accounting of Certain Disclosures. You have the right to request and receive an accounting of disclosures the Group Health Plan has made of protected health information about you for certain purposes within the last six years. An accounting will not include disclosures: made to you; for treatment, payment, or health care operations; to family members or others involved in your health care or payment; for notification purposes; for incidental disclosures; for national security or intelligence purposes; for certain correctional institution or law enforcement purposes; for information that is part of a limited data set; or pursuant to an authorization. You have a right to receive the first accounting within a 12-month period free of charge. In certain circumstances, the Group Health Plan may temporarily suspend your right to an accounting. The Group Health Plan may charge a reasonable cost-based fee for all requests made after your first request during that 12-month period. You may request an accounting by submitting a written request to the Privacy Contact identified below.

Right to a Copy of the Notice. You have the right to obtain a paper copy of this notice upon request. You have this right even if you have agreed to receive the notice electronically.

Actions on Your Behalf. You have the right to have a personal representative exercise your rights and take other actions on your behalf.

5. **Group Health Plan Duties.** The Group Health Plan is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

6. **Changes to This Notice.** The Group Health Plan reserves the right to change the terms of this Notice at any time, and to make the new notice of privacy practices effective for all protected health information that the Group Health Plan maintains.

7. **Complaints.** You may complain to the Group Health Plan or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by the Group Health Plan. You may file a complaint with the Group Health Plan by notifying the Privacy Contact identified below. The Group Health Plan will not retaliate against you for filing a complaint.

Additional Information. If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the below address. There will be no retaliation for filing a complaint.

Office for Civil Rights
Department of HHS
Jacob Javits Federal Building
26 Federal Plaza - Suite 3312
New York, NY 10278

Voice Phone (212) 264-3313
FAX (212) 264-3039
TDD (212) 264-2355

For Further Information. If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the SRNS Privacy Officer by phone at (803) 952-8749 or at the following address: 730-2B Room 115; Aiken, SC 29808. This Notice of Privacy Practices is also available on our SRNS web page at https://www.srs.gov/general/jobs/benefits/index_e.htm.

Medical Plans: Basic and Standard

SRNS offers a choice of medical plans and coverage levels so you can decide what is best for you and your family. Both plans are administered by BlueCross BlueShield of South Carolina (BlueCross). Limited Service Employees (that are scheduled to work 20 hours per week) are only eligible to participate in the Basic Medical Plan (with the Prescription Plan included), for themselves and their eligible dependents.

Each plan works somewhat differently. However, there is one exception— under all plans, most in-network preventive care is covered at 100%. Preventive care services include such as:

- Routine exams (such as well baby visits and annual physicals for children and adults)
- Health screenings, such as mammograms and colonoscopies
- Most immunizations

Basic

The Basic plan is a High Deductible Health Plan (HDHP). Here's how the Basic HDHP plus the Health Savings Account (HSA) add up to a great benefit.

- **You pay less each month:** When you enroll in the Basic plan, you pay less for weekly and monthly premiums, which means more money in your paycheck.
- **Save money for the future:** You can deposit the money you save on premiums in an HSA. Use these funds to pay for qualified medical, dental and vision expenses or save them for future health care needs. And to help you meet your savings needs, SRNS will make an employer contribution to your HSA.

See the Health Savings Account section on Page 19 to learn more about the way you can save by using this special, tax-advantaged account for eligible medical expenses.

Plan Features

- You can choose to see in-network or out-of-network providers, but the plan pays more when you go in-network.
- When you need medical care other than in-network preventive care, you must pay for the full cost of your services until you reach your deductible.
- Office visits, prescriptions (see Page 17 for more information), treatments, procedures and labs go toward your deductible.
- Once you reach your deductible, the plan covers up to 80% of your health care costs (called "coinsurance").
- You are protected by the out-of-pocket maximum.

Standard

The Standard plan is a Preferred Provider Organization (PPO).

- You have a choice each time you need care.
- You can receive care within the plan's network or choose to visit an out-of-network provider.
- When you visit an in-network provider, the plan pays a higher portion of the cost of your care.
- When you need medical care other than preventive care, you are responsible for a portion of the cost, either a copay or coinsurance.
- Prescriptions, treatments, procedures, and labs go toward your deductible.
- You are protected by the out-of-pocket maximum.

Need an In-Network Provider?

Contact BlueCross Customer Service at (800) 325-6596 or ***www.southcarolinablues.com***.

Medical Plans Comparison

	Basic		Standard	
Type	In-network	Out-of-network[2]	In-network	Out-of-network[2]
Deductible (Individual/Family	$2,000 / $4,000[1]	$2,000 / $4,000[1]	$600 / $1,200	$600 / $1,200
Out-of-Pocket Maximum (Individual/Family)	$4,500 / $7,150	$4,500 / $7,150	$2,000 / $4,000	$2,000 / $4,000
Office Visit: Primary Office Visit: Specialist	20% after deductible	20% after deductible	$20 copay $30 copay	15% after deductible [2]
Preventive Care	$0	Not covered	$0	Not covered
Chiropractic Treatment [3]	20% after deductible	20% after deductible	15% after deductible	20% after deductible
Allergy/Hormone Injections	20% after deductible	20% after deductible	15% after deductible	15% after deductible [2]
Physical and Occupational Therapy	20% after deductible	20% after deductible	15% after deductible	15% after deductible[2]
Ambulance Services	20% after deductible	20% after deductible	15% after deductible	15% after deductible [2]
Hospital and Surgical Services	20% after deductible	20% after deductible	15% after deductible	15% after deductible [2]
Emergency Room: Life threatening Emergency Room: Non-emergency	20% after deductible 30% after deductible	20% after deductible [2] 30% after deductible [2]	15% after deductible 30% after deductible	15% after deductible [2] 30% after deductible [2]
Diagnostic Services [4]	20% after deductible	20% after deductible	15% after deductible	15% after deductible
Home Health, Hospice and Durable Medical Equipment Services	20% after deductible	20% after deductible	15% after deductible	15% after deductible
Blue Care OnDemand	*Cost varies by service. See Summary Plan Description for details*	N/A	*Cost varies by service. See Summary Plan Description for details*	N/A
HSA: SRNS Annual Contribution [5]	Employee Only: $500 All Other Coverage Levels: $1,000		None	

[1]All family members combined. [2]Based on allowable charge; you pay the balance after the provider's charge. [3]Limited to $750 total per person, per year. [4] Pre-certification is required for major diagnostic services (MRI, MRA, CT scans, PET scans, etc.) Certain musculoskeletal non-emergent in-patient and out-patient surgeries and outpatient pain management services now require preauthorization. [5]HSA Employer Annual contributions are deposited at a prorated monthly amount.

Admissions, rehabilitation, behavioral health and some outpatient services require precertification. If you do not receive a precertification before receiving services, your charges may be denied, and you will be responsible for the full cost. For more detailed information on your plan benefits, view the Summary Plan Description on ***InSite>Services>Workforce Service & Talent Management>Departments>Benefits>Active Employee Benefits*** *or off-site at* ***www.srs.gov/general/jobs/benefits/index_e.htm*** *or by contacting BlueCross Customer Service at (800) 325-6596 or* ***www.southcarolinablues.com***.

Prescription Drug Plan

You automatically receive prescription drug coverage through BlueCross when you enroll in a medical plan. Your coinsurance begins after you reach your deductible. Visit ***www.southcarolinablues.com*** for more information and for prescription drug lists. The Basic plan Prescription Drug Plan is designed to help you save money by offering:

More low-cost medications available on the Preventive Drug List. Preventive drugs are used to prevent conditions such as high blood pressure, high cholesterol, heart attack, stroke, and prenatal nutrient deficiency.

Multiple levels of prescription options. The amount you pay depends on the level of medication that you choose or the brand that is available.

Preventive Drugs

Prescription drugs classified as preventive by Health Care Reform are covered at 100% and are not subject to the deductible under either plan.

This list is subject to change as the Patient Protection and Affordable Care Act guidelines are updated or modified. If you have questions, call (800) 325-6596.

An expanded Preventive Drug List is available for the Basic plan, making certain preventive and maintenance medications more accessible and affordable for members. These drugs will require copays but are not subject to the deductible. To determine if the drug you are taking is on the list, go to ***https://www.srs.gov/general/jobs/benefits/index_e.htm then go to Medical>BCBS - Prescription Drugs.***

Pharmacy Administration

Your pharmacy benefit is administrated by OptumRx, an independent company contracted by BlueCross BlueShield of South Carolina. Most plan members will see little or no effect. Changes include a new mail-service pharmacy, OptumRx Home Delivery and a new preferred specialty pharmacy, BriovaRx.

Pharmacy Benefit Manager: OptumRx: (800)325-6596 • Specialty Pharmacy: BriovaRx: (877)259-9428

Retail Pharmacy *(30 day supply)*

Retail	Basic *After you meet the deductible, you pay...*		Standard *After you meet the deductible, you pay...*	
30 day supply	In-network	Out-of-network[1,2]	In-network	Out-of-network[1,2]
Generic	$10	$10	10% coinsurance	10% coinsurance
Preferred	20% coinsurance, up to $35 max	20% coinsurance, up to $35 max	20% coinsurance	20% coinsurance
Non-preferred brand	30% coinsurance, up to $50 max	30% coinsurance, up to $50 max	30% coinsurance	30% coinsurance
Specialty	30% coinsurance, up to $50 max	Not covered	30% coinsurance	Not covered

[1]Based on allowable charge; you pay the balance after the provider's charge. [2]Prescription drug programs are subject to the BlueCross Mandatory Generic, Step Therapy and Quantity Management Programs.

Mail Order *(90 day supply)*

Mail	Basic *After you meet the deductible, you pay...*		Standard *After you meet the deductible, you pay...*	
90 day supply	In-network	Out-of-network	In-network	Out-of-network
Generic	$25	Not covered	10% coinsurance	Not covered
Preferred	20% coinsurance, up to $87.50 max	Not covered	20% coinsurance	Not covered
Non-preferred brand	30% coinsurance, up to $125 max	Not covered	30% coinsurance	Not covered
Specialty	30% coinsurance, up to $125 max	Not covered	30% coinsurance	Not covered

Pharmacy Mail Service Program

Participants in the medical plans will be required to have prescriptions for drugs that are considered "maintenance" filled through the OptumRx Home Delivery Program. If you are not already getting your maintenance medications through the mail pharmacy, you will need a new prescription from your doctor written specifically for a 90-day supply. You can continue to get 30-day prescriptions for any acute (short-term) medications, such as antibiotics or pain medications, at any in-network retail pharmacy. Specialty drugs and controlled substances are not included in this program. The program only includes drugs that are taken to treat chronic conditions such as high blood pressure, asthma and high cholesterol, or drugs that are taken routinely, such as birth control pills. Additionally, OptumRx will cover the cost of postage for this program and provide the benefit for the participant to pay for the 90 script in smaller payment options. ***Please note:*** If you do not enroll in the OptumRx Home Delivery Program, your maintenance prescriptions will not be covered by your pharmacy benefit once your grace fills are used.

Grace fills

You can get up to two 30-day prescriptions for each maintenance drug you may be getting at any in-network retail pharmacy before the requirement to fill through the mail pharmacy goes into effect.

What Do I Need To Do?

Talk to your doctor about obtaining 90-day prescriptions for your maintenance medications. You can get started with mail service in several ways:

- Contact OptumRx Mail Service by phone at (800) 325-6596.
- Have your doctor's office call in a 90-day prescription to (800) 791-7658 or have your doctor e-prescribe to OptumRx Mail Service.
- You can complete a mail service order form and send it to OptumRx Mail Service with your doctor's prescription.

Health Savings Account

A Health Savings Account (HSA) is a tax-advantaged savings account that helps you pay eligible medical, dental and vision costs on a tax-free basis. When you take charge of your health and manage how your health care dollars are spent, you can keep more money in your HSA.

Note: Craft Option A employees and Limited Service employees are not eligible.

If you enroll in the Basic plan, you and SRNS can contribute to a tax-advantaged account administered through HSA Bank. Your deposits to this account (and any resulting investment earnings) are entirely exempt from federal income taxes as long as they are used to pay for eligible health care costs, which include medical and dental services, prescriptions, eyeglasses and many other types of expenses.

HSA tax savings advantages

- Contributions from your check are pre-tax.
- Unused funds remain in the account and can grow — with interest — from year to year. There are no "use it or lose it" rules for an HSA (like there are for FSA). So, you can save your HSA funds for future health care needs, such as retiree medical expenses. And, when you take charge of your health and manage how your health care dollars are spent, you can keep more money in your HSA.
- Investment income is tax-free.
- An HSA allows you to save for the future — tax-free, as long as it is used for qualified expenses.
- The HSA is portable; you can take it with you when you leave or retire.

Are you eligible to enroll in the HSA?

You must enroll in the Basic plan in order to be eligible for the HSA.

In addition, you may NOT be eligible if:

- You or your spouse is participating in a Health Care Flexible Spending Account through another employer or with SRNS.
- You are enrolled in Medicare.
- You are claimed as a dependent on another person's tax return.
- You are covered under TRICARE or other health coverage except what is permitted by the IRS
- You are a veteran who has received medical treatment through the Veterans Health Administration within the last three months (excluding all dental care, all vision care, preventive prescription drugs and preventive medical treatments for you or your children, or treatments received related to a disability incurred while in military service).

How to use your HSA
First time enrollees will receive a debit card from HSA Bank, which you can use like your personal debit card to pay for health care expenses directly. You can also pay bills online or request personal checks. Contact HSA Bank at (866) 471-5946 or www.hsabank.com with questions. If you are a current enrollee, check the expiration date on your card; contact HSA Bank to request a new card if your current card is expired.

Contribution Levels and Amounts	
Type	Amount
SRNS Contribution***	Individual Only: $500 All Other Coverage Levels: $1,000
New! Maximum Contribution[1] (Under 55)	Individual Only: $4,400 All Other Coverage Levels: $8,750
New! Maximum Contribution[1] (Over 55)	Employee Only: $5,400 All Other Coverage Levels: $9,750

[1] Including SRNS contribution
**** HSA Employer Seed Funding: The SRNS Employer's HSA contribution funding will be deposited on a monthly proration in the participant's account. The amounts are not changing for 2026 and will continue to remain $500 for single coverage and $1,000 for family coverage. SRNS will make a monthly contribution of 1/12 of the eligible funding which will be deposited at the end of each month as long as the employee is eligible (when the retiree ages out of the Pre-65 plan or becomes ineligible to participate, then the retiree is no longer eligible to receive the employer contribution. Dependents are not eligible to elect an HSA or receive HSA contributions through SRNS.)*

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) can help save you money on eligible out-of-pocket medical, dental, vision and dependent care expenses. You never pay taxes on the money you contribute to an FSA. However, it is a "use it or lose it" account. Note: Craft Option A employees and Limited Service employees are not eligible.

SRNS offers three types of FSAs:

- **Health Care Traditional FSA** to pay for medical, prescription drugs, dental, hearing and vision expenses
- **Health Care Limited Purpose FSA** for dental and vision expenses for those enrolled in the Basic Medical Plan only. You may want to consider maxing out the HSA before you contribute to the Health Care Limited Purpose FSA. The HSA has much more flexibility.
- **Dependent Care FSA** for child or elder care expenses, (Including, but not limited to: day care, adult day care, before or after school programs, summer camps, and preschool)

You can contribute pretax dollars to these accounts during the year, and then be reimbursed for those expenses as you incur them. The full value of your Health Care Traditional and Limited Purpose FSA is available to you beginning January 1, 2026, based on the amount of your election. Dependent Care FSA dollars aren't advanced for your use; they are available only as you contribute to the account.

FSAs and how they work

- You decide how much to set aside for expenses you expect to have during the year.
- The amount you elect is withheld from your paychecks before taxes are applied, so your tax withholding is less. You can pay for your out-of-pocket costs with pre-tax dollars.
- When you or your IRS eligible dependents have an eligible health care expense, you can use a debit card at the point of purchase, or you can be reimbursed later from your account by filing a manual claim.

Want to participate in an FSA? It depends on your medical plan.

Medical Election	FSA Traditional	FSA Limited	HSA
Standard	yes	no	no
Basic - *Option 1*	no	no	yes
Basic - *Option 2*	no	yes	yes
Basic - *Option 3*	no	yes	no
Basic - *Option 4*	yes	no	no
Waive	yes	no	no

FSAs

	Health Care Limited Purpose FSA	Health Care Traditional FSA	Dependent Care FSA
Use with	Basic	Standard	Either plan
Use for	Vision and Dental expenses ONLY Deductibles, copayments, and coinsurance Orthodontia services Prescription eyeglasses, contacts and hearing aids not covered by medical or vision insurance	Deductibles, copayments, and coinsurance Prescription eyeglasses, contacts, and hearing aids Orthodontia services Diabetic supplies Certain over-the-counter medicines or drugs if you have a prescription from your doctor	A day care center (includes before/after school) A nursery school or preschool An elder/dependent care facility Dependent care services provided outside your home for a dependent child under age 13, or for any other eligible dependent (e.g., a disabled spouse, older child or elderly parent), provided the other eligible individual spends at least eight hours a day in your home
Source of contribution	Paycheck (pre-tax deduction)	Paycheck (pre-tax deduction)	Paycheck (pre-tax deduction)
Annual contribution limits	$96 – $3,300	$96 – $3,300	$96 – $7,500
Fund availability	Annual pledge amount available on January 1	Annual pledge amount available on January 1	Limited to pre-tax contributions as they are made
Unused funds	Balances over $660 are forfeited at year-end	Balances over $660 are forfeited at year-end	Any remaining amounts are forfeited at year-end
Reimbursement process	Flex Debit Card	Flex Debit Card	Flex Debit Card
Fund rollover	Balances over $660 are forfeited at year-end. Must elect your FSA again the following year to receive the carryover.	Balances over $660 are forfeited at year-end. Must elect your FSA again the following year to receive the carryover.	Use it or lose it. Funds are forfeited at year-end

Amounts in the Health Care FSAs under $660 can be rolled over by re-enrolling in an FSA the following year. You will have 105 days into the new calendar year for all programs to file claims against any year end amount. For the Health Care FSAs, amounts over $660 will be forfeited. For the Dependent Care FSA, any prior year amounts not used are forfeited.

For more information on IRS-qualified expenses, go to ***https://www.irs.gov/publications/p502***

Dental Plans

You have two plans to choose from: Prime and Standard. Both plans are administered by BlueCross BlueShield of South Carolina.

Note: Craft Option A employees and Limited Service employees are not eligible.

Plan Benefits

When you take care of your teeth and gums, your whole-body benefits. Under the Plan, you are allowed two cleanings and checkups per year. Going to your checkups helps prevent and detect an early diagnosis for diabetes and heart disease. Claims rendered for services must be during the coverage period to be paid for by the plan.

Find an In-Network Dentist

Using in-network providers gives a larger discount to participants. Participants using out-of-network providers may be subject to balance billing and end up paying higher out-of-pocket costs.

What's balance billing? Balance billing is when a provider bills you for the difference between the provider's charge and the BlueCross allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider cannot balance bill you for covered services.

Dental Plan	Prime	Standard
Deductible	None	$25 per person / $50 per family
Maximum Annual Benefit [1]	$2,000 per person, per year	$1,000 per person, per year
Preventive and Diagnostic [2]	You pay $0	You pay $0
Minor Restorative Services Basic Dental Oral Surgery Periodontic Benefits	You pay 20%	You pay 50%
Major Restorative Services Prosthodontic Benefits Dental Implants	You pay 40%	You pay 50%
Temporomandibular Joint Disorders (TMJ and TMD) Coverage	You pay 50% (Lifetime Maximum: $500)	None
Orthodontics	You pay 50% (Lifetime Maximum: $2,000)	None

[1] *Temporomandibular Joint Disorders (TMJ and TMD) and Orthodontics payments do not count toward the maximum annual benefit under Prime*

[2] *Unless you have reached your Maximum Annual Benefit*

Vision Plans

SRNS offers two vision plans through EyeMed Vision Care. You and your eligible dependents have access to a nationwide network of physicians, optometrists and opticians, both in private practices and in retail. You receive maximum benefits and pay preferred prices when services are provided by EyeMed Vision Care providers.

Note: Craft Option A employees and Limited Service employees are not eligible.

Vision plans comparison

	Low Option		High Option	
Type	In-network	Out-of-network reimbursement[1]	In-network	Out-of-network reimbursement[1]
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Eye Exam with Dilation	$15 copay	$35	$10 copay	$35
Standard Contact Lens fit/follow-up	Up to $40	N/A	Up to $40	N/A
Premium Contact Lens fit/follow-up	10% off retail price	N/A	10% off retail price	N/A
Standard Plastic Lenses				
Standard Single, Bifocal, Trifocal Lenses	$0 copay	$25, $40, $55	$0 copay	$25, $40, $55
Premium Progressive Tier 1-3	$20-$45 copay	$55	$20-$45 copay	$55
Premium Progressive Tier 4	$0 copay plus 20% off retail price, less $120 allowance	$55	$0 copay plus 20% off retail price, less $120 allowance	$55
Frames	$0 copay to $100 allowance for any frame; plus 20% off balance over $100	$50	$0 copay to $160 allowance for any frame; plus 20% off balance over $160	$50
Lens Options				
UV Coating	$15	N/A	$0	$5
Tint (Solid and Gradient)	$0	$5	$0	$5
Standard Scratch Resistant	$0	$5	$0	$5
Standard Polycarbonate	$40	N/A	$0	$5
Standard Anti-Reflective	$45	N/A	$45	N/A
Premium Anti-Reflective Tier 1-2	$57 - $68	N/A	$57 - $68	N/A
Premium Anti-Reflective Tier 3	20% off retail price	N/A	20% off retail price	N/A
Photochromic	$75	N/A	$75	N/A
Other Add-ons and Services	20% discount	N/A	20% discount	N/A
Contact Lenses				
Conventional	$0 copay, 15% off balances over $145	$116	$0 copay, 15% off balances over $160	$116
Disposable	$0 copay, 100% of balance over $145	$116	$0 copay, 100% of balance over $160	$116
Medically Necessary	$0 copay	$200	$0 copay	$200
Laser Vision Correction	15% off retail price or 5% off promotional price	N/A	15% off retail price or 5% off promotional price	N/A

For more information, visit www.eyemed.com or view your Summary Plan Description under ***InSite>Services>Workforce Service & Talent Management>Departments>Benefits>Active Employee Benefits>Vision*** *or from off-site at* ***www.srs.gov/general/jobs/benefits/index_e.htm.***
Note: Option A Craft employees are not eligible for this benefit.

[1]reimbursed up to

Critical Illness and Accident Insurance

Critical Illness Insurance

Having Aflac group Critical Illness insurance means that you have added financial resources to help with medical costs or living expenses. This insurance provides cash benefits if the insured is diagnosed with or treated for a covered critical illness outlined in the plan.

Benefit Features

- Benefits are paid directly to you, unless otherwise assigned
- Coverage is available for you, your spouse, and dependent children
- Coverage may be continued (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Child coverage at no additional cost: Each dependent child is covered at 50% of the primary insured's benefit amount at no additional cost. Children-Only coverage is not available.
- Spousal election is 50% of the elected amount.

The Aflac group Critical Illness plan benefits include:

- Health screening benefit
- Critical illness benefit payable for cancer, heart attack (myocardial infarction), stroke, kidney failure (end-stage renal failure), major organ transplant (stem cell transplant), sudden cardiac arrest, coronary artery bypass, non-invasive cancer, skin cancer, severe burn, coma, paralysis, loss of sight/hearing/speech

The benefit options are offered for $10,000 or $20,000 policies. Rates are subject to disclosed tobacco/non-tobacco usage and age. Full rate charts and an Aflac brochure about this benefit can be found on the Benefits homepage at ***www.srs.gov/general/jobs/benefits/index_e.htm*** under the Aflac menu tab. The premium for spousal coverage is based on the age of the employee not the spouse. Spouse tobacco status is based upon the employee tobacco status. Spouse coverage will be 50% of the elected employee plan. Eligible dependent children are automatically covered at 50% of the elected plan for no additional cost.

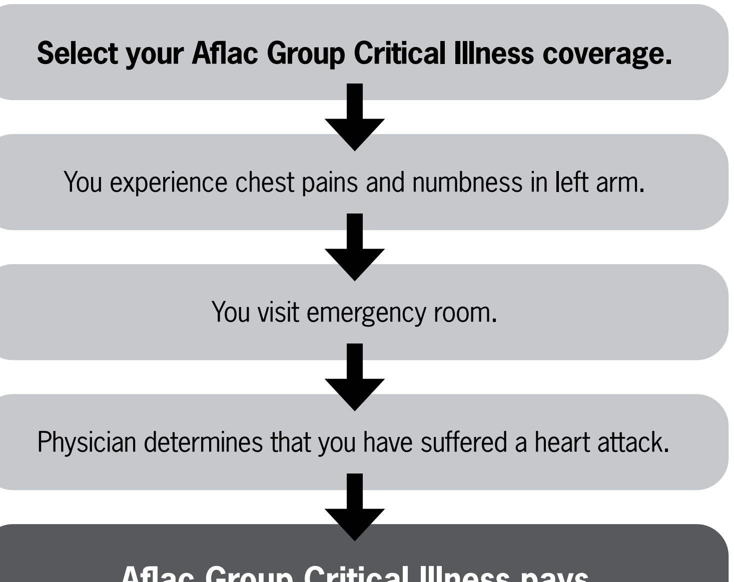
Critical Illness Insurance Rates *(monthly)*

Type	Age Band	Tobacco	Non-tobacco	$10K	$20K
Employee Only	25	no	yes	$3.93	$6.34
Employee + Spouse	25	no	yes	$6.66	$10.27
Employee Only	35	yes	no	$8.00	$14.47
Employee + Spouse	35	yes	no	$12.76	$22.47
Employee Only	45	no	yes	$8.59	$15.66
Employee + Spouse	45	no	yes	$13.64	$24.25
Employee Only	45	yes	no	$12.69	$23.85
Employee + Spouse	45	yes	no	$19.79	$36.54
Employee Only	65	no	yes	$30.26	$59.01
Employee + Spouse	65	no	yes	$46.15	$89.27
Employee Only	65	yes	no	$46.82	$92.13
Employee + Spouse	65	yes	no	$70.99	$138.95

This is a partial rate table and depicts rate samples only. Monthly premiums shown; weekly premiums will be deducted in four equal installments.

How it works

Amount payable based on electing $10,000 coverage option is non-taxable (post-tax premium deduction)



Accident Insurance Rates *(monthly)*

Type	Low Option	High Option
Employee only	$4.57	$8.80
Employee + one	$7.69	$14.60
Family	$10.68	$20.39

Monthly premiums shown; weekly premiums will be deducted in four equal installments.

*Both the Accident and Critical Illness plans have a $50 wellness screening benefit provided by Aflac. By completing a defined wellness screening during the plan year you are covered, participants can receive $50 from Aflac. More details about this benefit can be found on the Benefits webpage at **www.srs.gov/general/jobs/benefits/index_e.htm** under the Aflac menu tab.*

Accident Insurance

After an accident, you may have expenses you've never thought about. Can your finances handle them?

Benefit Features

- Benefits are paid directly to you, unless otherwise assigned
- Coverage is guaranteed issue, which means you may qualify for coverage without having to answer health questions
- Benefits are paid regardless of any other medical insurance

Accident Insurance helps cover expenses such as:

- ambulance rides
- emergency room visits
- surgery and anesthesia
- prescriptions
- major diagnostic testing
- burns

The benefit options are offered at a Low or High policy. Rates and an Aflac brochure about this benefit (including amounts payable) can be found on the Benefits homepage at ***www.srs.gov/general/jobs/benefits/index_e.htm*** under the Aflac menu tab.

Identity Theft

Identity Theft: *ID Watchdog Rates*

Tier Level	Premium
Employee only	$7.50
Family	$13.40

Identity Theft Protection from ID Watchdog

With ID Watchdog as an employee benefit, you have a more convenient and affordable way to help better protect and monitor your identity. You'll be alerted to potentially suspicious activity and enjoy greater peace of mind knowing you don't have to face identity theft alone. Identity theft can affect anyone, from infants to seniors.Take action with award-winning ID Watchdog identity theft protection that includes:

Cybersecurity Protection. Cybersecurity Protection. Personalized Identity Restoration, Cyber Extortion, and Professional Identity.

Up to $2 million Identity Theft Insurance:

- Home Title Fraud
- Cyber Extortion
- Professional Identity Fraud
- Deceased Family Member Fraud

Up to $1 million Stolen Funds Reimbursement

Control & Manage your Credit Report. Lock or unlock access to your Multi-Bureau credit reports (Equifax and TransUnion through your ID Watchdog account, with certain exceptions. Locking your credit report(s) is an effective way to provide additional protection against unauthorized access and to help keep identity thieves from opening new accounts in your name.

Advanced Identity Theft Detection. We scour billions of data points including public records, transaction records, social media and searching for signs of potential identity theft.

Dedicated Identity Resolution Specialists. If you become a victim, you don't have to face it alone. One of our certified resolution specialists will personally manage the case for you until your identity is restored.

Extensive Family Coverage. Our family plan helps you better protect your loved ones with personalized accounts for adult family members, family alert sharing, and exclusive features for children.

Legal Plans – MetLife

With MetLife Legal Pl ans, you get unlimited access to a network attorney to help you with life's events—big and small. This group benefit features:

• Assistance for a wide range of legal needs, including wills and other estate planning documents, real estate matters, traffic offenses, adoptions, identity theft defense, and much more.

• Cost-effective monthly premium for unlimited use and no copays when using a Network Attorney for a covered matter.

• Access to digital estate planning to create wills, living wills, and powers of attorney online.

• Easy access to more than 18,000 experienced Network Attorneys.

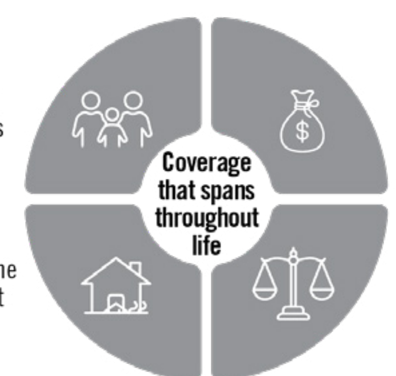
Legal Plans: *Monthly Rates*

Tier Level	Premium
Employee only	$10.85
Employee +1	$14.50
Employee +2 or more	$15.40

Helping your employees navigate life's planned and unplanned events

Family life
- Adoption
- Prenuptial agreement
- Elder care law matters
- Estate planning

Assets
- Buying or selling a home
- Property tax assesment
- Refinancing
- Foreclosure



Financial well-being
- Debt issues, bankruptcy
- Negotiating with creditors
- Tax audit representation
- Financial planning workshops

Protection
- Identity theft
- Small claims assistance
- Pet liabilities
- Civil matters

No copays, deductibles or claim forms when using a network attorney for a covered matter

•

Unlimited consultations even for matters not covered under your plan

•

All employees have access to our website to see coverages, attorneys and use our self-help document library.

COBRA Continuation Coverage

Depending on the reason that coverage was terminated, you, your spouse and your other dependents might be able to continue coverage temporarily under COBRA or the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If coverage ceases because of certain "qualifying events" (for example, termination of employment, reduction in hours, divorce, death or child's ceasing to meet the Plan's definition of dependent) specified in a federal law called COBRA, then you, your spouse and other dependents may have the right to purchase continuing coverage under the Plan for a limited period of time.

For more information about COBRA rights, please refer to the COBRA information that has been previously furnished to you and your spouse (if covered under the Plan), and also refer to the specific COBRA information in the booklets and Plan document. Please contact Human Resources if you need another copy.

The Plan provides no greater COBRA rights than what COBRA requires — nothing in this document is intended to expand your rights beyond COBRA's requirements. COBRA does not apply to any benefits that are not health (medical, dental, vision) benefits (e.g. Life, Long-Term Disability or Accidental Death and Dismemberment benefits).

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the Uniformed Services pursuant to USERRA. More information about coverage available pursuant to USERRA is available from the Employer or in the Summary Plan Description.

Legal Notices

Wellness Program Notice

The SRNS Wellness Program is a voluntary program available to all active employees and pre-65 retirees and their spouses who are enrolled in our health plans (participants). The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Non-discrimination Act (GINA) of 2008 and the Health Insurance Portability and Accountability Act (HIPAA), as applicable, among others. If you choose to participate in the wellness program, you have the option to complete voluntary health and wellness surveys that ask a series of questions about your health-related activities and behaviors. As part of this survey, you may be asked some biometric questions. You are not required to complete the health and wellness survey or to participate in a blood test or other medical examinations.

If you decide to complete to complete any health and wellness surveys, the information from your responses may be used by BlueCross to provide you with information to help you understand your current health and potential risks. You are also encouraged to share your results or concerns with your own doctor. No individual information is shared with SRNS.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. The SRNS wellness program administered through BlueCross may use aggregate information it collects to design a program based on identified health risks in the workplace. BlueCross will never disclose any of your personal information, except as necessary to respond to a request from you for a reasonable accommodation, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment, nor may you be subjected to retaliation if you choose not to participate in the wellness program.

Your protected health information will not be sold, exchanged, transferred or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

Any medical information obtained through the wellness program is maintained by BlueCross, and any information stored electronically will be encrypted. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, you will be notified immediately.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the SRNS Medical Plan Administrator at (803) 952-5746.

Women and Cancer

The SRNS Medical Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema. Call your Plan Administrator at (803) 725-7772 for more information.

Genetic Information Non-Discrimination Act

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Dependent Coverage up to Age 26

The SRNS group health plans provide dependent coverage for the children of a participant until a participant's child attains the age of 26. The adult dependent child can be covered even if they are married and/or are eligible for coverage through their employment. Coverage ends on the last day of the month in which the dependent turns 26.

HIPAA Late Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage); however, you must request enrollment within 60 days after you or your dependents' other coverage ends (or other qualifying event). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents; however, you must

request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 day after the determination of eligibility for such assistance.
- When Medicare is the primary provider for those covered under active medical plan.

To request special enrollment or obtain more information, contact the SRNS Service Center.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit ***www.healthcare.gov***.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or ***www.insurekidsnow.gov*** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled.

This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at ***www.askebsa.dol.gov*** or call 1-866-444-EBSA (3272).

If you live in one of the states listed on the next page, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. You should contact your state for more information on eligibility.

Medicaid/CHIP Premium Assistance Program

State	Website	Phone
ALABAMA	http://myalhipp.com/	1-855-692-5447
ALASKA	http://myakhipp.com/ Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	1-866-251-4861
ARKANSAS	http://myarhipp.com/	1-855-MyARHIPP (855-692-7447)
CALIFORNIA	Health Insurance Premium Payment (HIPP) Program: http://dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	916-445-8322 Fax: 916-440-5676
COLORADO	Health First Colorado: https://www.healthfirstcolorado.com/ CHP+: https://hcpf.colorado.gov/child-health-plan-plus Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com	Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+ Customer Service: 1-800-359-1991/ State Relay 711 HIBI Customer Service: 1-855-692-6442
FLORIDA	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268
GEORGIA	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162 Press 1 Phone: (678) 564-1162, Press 2
INDIANA	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/	Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA	IOWA: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	1-800-338-8366 Hawki: 1-800-257-8563 HIPP: 1-888-346-9562
KANSAS	https://www.kancare.ks.gov	1-800-792-4884 HIPP: 1-800-967-4660

State	Website	Phone
KENTUCKY	https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Email: KIHIPP.PROGRAM@ky.gov KCHIP: https://kynect.ky.gov Kentucky Medicaid: https://chfs.ky.gov/agencies/dms	1-855-459-6328 CHIP: 1-877-524-4718
LOUISIANA	www.medicaid.la.gov www.ldh.la.gov/lahipp	1-888-342-6207 LaHIPP: 1-855-618-5488
MAINE	https://www.mymaineconnection.gov/benefits/s/?language=en_US Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms	1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium: 800-977-6740 TTY: Maine relay 711
MASSACHUSETTS	https://www.mass.gov/masshealth/pa Email: masspremassistance@accenture.com	1-800-862-4840 TTY: 711
MINNESOTA	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1-800-657-3739
MISSOURI	https://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
MONTANA	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Email: HHSHIPPProgram@mt.gov	1-800-694-3084
NEBRASKA	http://www.ACCESSNebraska.ne.gov	(855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
NEVADA	http://dhcfp.nv.gov	1-800-992-0900
NEW HAMPSHIRE	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 15218
NEW JERSEY	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP Website: http://www.njfamilycare.org/index.html	Medicaid: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP:1-800-701-0710 (TTY: 711)
NEW YORK	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
NORTH CAROLINA	https://medicaid.ncdhhs.gov/	919-855-4100
NORTH DAKOTA	https://www.hhs.nd.gov/healthcare	1-844-854-4825
OKLAHOMA	http://www.insureoklahoma.org	1-888-365-3742

State	Website	Phone
OREGON	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	1-800-699-9075
PENNSYLVANIA	https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx	1-800-692-7462 CHIP: 1-800-986-KIDS (5437)
RHODE ISLAND	http://www.eohhs.ri.gov/	855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA	https://www.scdhhs.gov	1-888-549-0820
SOUTH DAKOTA	http://dss.sd.gov	1-888-828-0059
TEXAS	https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	1-800-440-0493
UTAH	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	1-888-222-2542
VERMONT	https://dvha.vermont.gov/members/medicaid/hipp-program	1-800-250-8427
VIRGINIA	https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON	https://www.hca.wa.gov/	1-800-562-3022
WEST VIRGINIA	https://www.mywvhipp.com/ https://dhhr.wv.gov/bms/	Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) Medicaid: 304-558-1700
WISCONSIN	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
WYOMING	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	1-800-251-1269

To see if any more states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

(877) 267 2323

Menu Option 4, Ext. 61565

Contacts

General Questions

SRNS Service Center, Hours: Monday-Thursday, 7 a.m.-4 p.m.

(803) 725-7772 or (800) 368-7333

Service-Center@srs.gov

www.srs.gov/general/jobs/benefits/index_e.htm

Medical and Prescription Drugs

BlueCross Customer Service (800) 325-6596

www.southcarolinablues.com

OptumRx Pharmacy (800) 325-6596

Briova Rx Specialty Pharmacy (877) 259-9428

Employee Assistance Program

On-site Coordinator (803) 952-9836

First Sun (800) 968-8143

Dental

BlueCross Customer Service (800) 325-6596

www.southcarolinablues.com

Vision

EyeMed Vision Care (866) 800-5457

https://eyemed.com/en-us

Health Savings Account

HSA Bank (866) 471-5946

www.hsabank.com

Flexible Spending Account (FSA)

HSA Bank (866) 471-5946

www.hsabank.com

Voluntary Benefits

Aflac Group Customer Service (800) 433-3036

cscmail@aflac.com

www.aflacgroupinsurance.com

Summary Plan Descriptions

Medical, Dental, Vision, Disability, Aflac, Prudential Life Insurance and Flexible Spending Accounts

InSite>Services>Workforce & Talent Management> What can I help you with today?>Benefits>Active Employee Benefits

or off-site at ***www.srs.gov/general/jobs/benefits/index_e.htm***

SRNS Service Center
Building 992-2W
Savannah River Site
Aiken, SC 29808

Important

Open Enrollment Materials

Open Enrollment is October 2–24, 2025

Service Center

service-center@srs.gov
Local: 803.725.7772
Toll-free: 800.368.7333