



Summary Plan Description

Medical Plan: Part One

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Health Savings Account

Savannah River Nuclear Solutions, LLC

Amended and Restated Effective January 1, 2026

Savannah River Nuclear Solutions, LLC Summary Plan Description

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The COVID-19 Public Health Emergency ended May 11, 2023

Effective May 12, 2023 The following changes will be made to the SRNS Medical Plans:

COVID-19 Testing

- o At-Home and Over-the-Counter (OTC) Tests. At-Home and Over-the-Counter (OTC) Tests will no longer be covered (reimbursed).
- o Polymerase chain reaction (PCR) and Rapid Tests ordered and administered by a health professional. Regular coverage and cost sharing will apply to the test and associated doctor visit according to plan benefits.
- o Regular coverage and cost sharing applies, according to plan benefits.(cost sharing refers to the members out of pocket cost, deductible, coinsurance, copayments, or similar charges).

COVID-19 Antivirals

- o Pharmaceutical treatments (e.g., Paxlovid™) will be covered according to the plan's terms of coverage and subject to cost sharing requirements.

Effective September 1, 2023

The following changes will be made to the SRNS Medical Plans:

COVID-19 Vaccines

The COVID-19 vaccine and its administration will be covered without cost-sharing, as long as the vaccine is provided by in-network providers. When furnished by an out-of-network provider, the COVID-19 vaccine along with its administration costs will be processed the same as other vaccines under the terms of the plan, excluded from coverage.

Medical Plan benefits are designed to help protect you and your family from the high cost of medical treatment.

Savannah River Nuclear Solutions, LLC (SRNS) maintains medical benefits under the Medical Plan designed to protect you and your family from the high cost of medical treatment. SRNS is also referred to as the Employer or Company in this Summary Plan Description (SPD). BlueCross BlueShield of South Carolina (BlueCross, BCBS or BCBS-SC) provides administrative services for your Employer's Group Health Plan. BlueCross is also referred to as the Corporation. This document is merely a summary of the provisions of the Medical Plan. The Medical Plan consists of the medical plan document prepared by BCBS for SRNS as well as the SRNS Welfare Benefit Plan, referred to as a Wrap Plan. While SRNS intends to continue the Medical Plan indefinitely it may amend or terminate the Medical Plan, for any reason, at its sole discretion. If there is a conflict between this SPD and the terms of the Medical Plan, the terms of the Medical Plan will control. .

This SPD describes the Plan as of January 1, 2026. Please read this summary carefully. This document explains how the Plan works, how you qualify for and ultimately receive Plan benefits, what benefits are available to you, and what your rights are as a Plan participant. The Plan provides an annual Open Enrollment booklet with a summary of upcoming material plan changes.

The benefits described in this document are sponsored by the Company under a self-funded administrative service contract with BCBS-SC. The Company has designated the SRNS Health and Welfare Benefit Committee as the Plan Administrator for this Plan. The Plan Administrator is responsible for maintaining the enrollment and other records related to, and administration of, the Plan.

You should contact the Company through the SRNS Service Center for questions about enrollment and eligibility in the Plan. As a Claims Administrator, BlueCross provides claims payment services. You should contact them with general questions about the Plan and specific questions about claim determinations and appeals and payment of your claims. The Plan Administrator and Claims Administrator have discretionary authority to decide all issues of fact.

The benefit(s) described in this summary plan description is also governed by the terms of the SRNS Welfare Benefit Plan, referred to as a Wrap Plan.

Contacts for questions and pre-authorizations

Claims/Customer Service

BlueCross BlueShield of South Carolina
1.800.325.6596; www.SouthCarolinaBlues.com;
Monday-Thursday 8 a.m.-6 p.m.; Friday 8 a.m.-4 p.m. EST;
Claims Processing Center,
P.O. Box 100300, Columbia, SC 29202

Hospital Preauthorization & Medical Case Management

In South Carolina (BlueCross BlueShield of South Carolina)
1.800.327.3238
Outside SC (BlueCross BlueShield 1.800.334.7287)

Imaging Preauthorization

866.500.7664
for MRI, MRA, CAT, MSK or PET scans

Mental Health & Substance Abuse Pre-authorization

1.800.868.1032 (Companion Benefit Alternatives
through BlueCross BlueShield of South Carolina)

Employee Assistance Program

On-site: 803.557.5729
First Sun: 1.800.968.8143
www.firstsuneap.com

Traveling Outside the U.S.:

BlueCross BlueShield Global Core Customer Service
1.800.810.Blue (2583) or 1.804.673.1177
www.bcbsglobalcore.com

COBRA Administrator

HealthEquity® (formerly WageWorks)
P.O. Box 660212
Dallas, TX 75266-0212
Customer Service: 866.924.6937
<https://mybenefits.wageworks.com>

SRNS Service Center

803.725.7772 or 800.368.7333
Service-Center@srs.gov
Service Center
992-2W Savannah River Site, Aiken, SC 29808

SRNS Workforce Services

Plan Administrator
803.952.5767
992-2W Savannah River Site, Aiken, SC 29808

Pharmacy Benefit Manager

OptumRx
Prescription Mail Order: P.O. Box 2975, Mission, KS 66201
Phone: 1.855.811.2218
Prescription Reimbursement Form: OptumRx Claims Department,
P.O. Box 29044, Hot Springs, AR 71903

Oncology Case Management
Companion Care Solutions
1.800.790.5770

Medical benefits at a glance

Expenses	Standard		Basic	
	Network	Non-Network (7)	Network	Non-Network (7)
Annual Deductible	\$600	\$600	\$2,000 (1)	\$2,000 (1)
Individual				
Family	\$1,200 (No one family member can exceed the Individual amount)	\$1,200 (No one family member can exceed the Individual amount)	\$4,000 Family (Aggregate: All Family Members Combined)	\$4,000 Family (Aggregate: All Family Members Combined)
Out-Of-Pocket Maximum (2)				
Individual	\$2,000	\$2,000	\$4,500 (1)	\$4,500 (1)
Family	\$4,000 (No one family member can exceed the Individual amount)	\$4,000 (No one family member can exceed the Individual amount)	\$7,150 (Aggregate: All Family Members Combined)	\$7,150 (Aggregate: All Family Members Combined)
Physician Office Visit (3)				
Primary	\$20 Copay	15% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)
Specialist	\$30 Copay			
Preventive Care Office Visits (based on schedule)	\$0	Not covered	\$0	Not covered
Allergy or hormone injections by nurse in physician's office	15% Allowable Charge (after Deductible) \$20 copay if other services provided	15% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)
Chiropractic Services including spinal manipulation/subluxation, related X-rays, modalities and office visits (4)	15% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)
Physical and Occupational Therapy	15% Allowable Charge (after Deductible)	15% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)
Ambulance Service (including air ambulance)	15% Allowable Charge (after Deductible)	15% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)
Hospital, Surgical and most other medical services (3) (5)	15% Allowable Charge, (after Deductible)	15% Allowable Charge, (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)

Emergency Room Services (life threatening acute or urgent care)	15% Allowable Charge, (after Deductible)	15% Allowable Charge, (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)
Emergency Room Services (for routine use)	30% Allowable Charge (after Deductible)	30% Allowable Charge (after Deductible)	30% Allowable Charge (after Deductible)	30% Allowable Charge (after Deductible)
Diagnostic Services (lab, x-ray and other tests) when not performed in a physician's office (6)	15% Allowable Charge (after Deductible)	15% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)
Home Health Care, Hospice Care, Durable Medical Equipment (5)	15% Allowable Charge (after Deductible)	15% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)
Blue CareOnDemand	\$10 Copay (before Deductible)	N/A	\$59 before Deductible; \$10 Copay after Deductible	N/A
Musculoskeletal Precertification Program	15% Allowable Charge (after Deductible)	15% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)

1. Under Basic: If you cover one or more dependents, the family Deductible applies before reimbursement and the family Out-of-Pocket applies.
2. Your Deductibles, Copays and Coinsurance amounts (10%, 15%, 20% or 30% for most services) count toward your Out-of-Pocket Maximums.
3. Includes eligible mental health and chemical dependency services (physician office visits are considered under the Primary Copay level.)
4. Limited to \$750 total per person/benefit year
5. Pre-Authorization required
6. Preauthorization is required for out-patient major diagnostic procedures (MRI, MRA, CT scans, PET scans, etc.)
7. Members may be subject to balance billing by the non-network provider. (Refer to the "No Surprise Act" section for more information)

Note: All Admissions, Rehabilitation Services, Behavioral Health Services and some Out-Patient services require Preauthorization. If Preauthorization is not obtained, charges may be denied.

Prescription benefits at a glance

Standard

Basic

Expenses	Standard		Basic	
	Network	Non-Network (1)	Network	Non-Network (1)
Prescription Drugs²	<i>after</i> Deductible	<i>after</i> Deductible	<i>after</i> Deductible	<i>after</i> Deductible
Generic	10%	10%	\$10	\$10
Preferred	20%	20%	20% (max \$35)	20% (max \$35)
Non-Preferred	30%	30%	30% (max \$50)	30% (max \$50)
Specialty Drugs	30%	Not Covered	30% (max \$50)	Not Covered
ACA Covered Prescription Drugs²	<i>before</i> Deductible	<i>before</i> Deductible	<i>before</i> Deductible	<i>before</i> Deductible
Generic	0%	0%	0%	0%
SRNS/BSRA Preventive Drug List²	Not Applicable	Not Applicable	<i>before</i> Deductible	<i>after</i> Deductible
Generic			\$10	\$10
Preferred			20% (max \$35)	20% (max \$35)
Mail Order (90-day supply)²	<i>after</i> Deductible	Not Covered	<i>after</i> Deductible	Not Covered
Generic	10%		\$25	
Preferred	20%		20% (max \$ 87.50)	
Non-Preferred Brand	30%		30% (max \$125)	
Mail Order (90-day supply) Specialty Drugs	30%	Not Covered	30% (max \$125)	Not Covered
SRNS/BSRA Preventive Drug List Mail Order (90-day supply)²	Not Applicable	Not Applicable	<i>before</i> Deductible	Not Covered
Generic			\$25	
Preferred			20% (max \$87.50)	

1. Prescription drug programs are subject to the BlueCross Mandatory Generic, Step Therapy and Quantity Management Programs.

2. Mail Service Saver Program: OptumRx Mandatory mail order requirement for "maintenance medications."

Fertility Services:

Fertility Services:

- Fertility Services: Employees and their spouses who are covered under the SRNS Health Plan are eligible for Fertility Services for a combined Medical & Pharmacy Lifetime Maximum of \$25,000.
- Fertility coverage is an inclusive benefit and does not require a diagnosis of 'infertility' for access.
- Both the Standard and Basic Plans include fertility services: the applicable plan deductible, co-insurance and out-of-network provisions apply (see examples below).

1. Service Considerations:

- Therapeutic services for inclusion in the fertility coverage are for the treatment of Fertility when provided by or under the direction of a Physician. Benefits under this section are limited to only the following procedures:
 - Assisted Reproductive Technologies (ART), including Reciprocal Fertility Services
 - Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos.
 - ICSI - (intracytoplasmic sperm injection)
 - Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI))
 - Embryo transportation related network disruption
 - Ovulation induction (or controlled ovarian stimulation)
 - Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm
 - Surgical Procedures: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, transcervical catheterization, cystoplasty, metroplasty
 - Electroejaculation
 - Pre-implantation Genetic Diagnosis (PGD) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo

2. Enhanced Benefit Coverage

- Embryo biopsy for Pre-implantation Genetic Testing for Aneuploidy (PGT-A)** used to select embryos for transfer in order to increase the chance for conception.
- Fertility Preservation for Medical Reasons** - when planned cancer treatment or other medical treatment is likely to produce Infertility/sterility. Coverage is limited to: collection of sperm; cryopreservation of sperm; ovarian stimulation and retrieval of eggs; oocyte cryopreservation; ovarian tissue cryopreservation; in vitro fertilization; and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.
 - Cryopreservation: Cryopreservation is the process of freezing reproductive materials. Cryopreservation is covered **only when**:
 - Undergoing fertility treatment in the FBB process stated with in this section. For item b above, **coverage is limited to 12 months of storage.**
- Reciprocal Fertility Services (IVF) is inclusive of the Fertility Benefit.



3. Additional Benefit considerations



- Any combination of Medical and Pharmacy, Network Benefits and Non-Network Benefits are limited to \$25,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the SRNS Health Plan.
- Medical and Pharmacy for treatment of infertility are subject to deductible, coinsurance, and copayment under both the Basic Plan and the Standard Plan. Your share of the expenses (deductible, coinsurance and copayments) applies toward your Out-of-Pocket Maximum.
 - For more information, call the BlueCross number on the back of your ID card, 1-800-325-6596.
- Please note that when you become pregnant, you are encouraged to enroll in the Maternity Lifestyle Health Coaching program.

4. Exclusions:

- Diagnosis or treatment of infertility for a subscriber or a spouse if either member has had a tubal ligation or vasectomy.
- A covered child's infertility treatment, pregnancy or complications from pregnancy or childbirth.
- Payment for medical services or supplies rendered to a surrogate for purposes of childbirth.

5. Example Scenarios

Scenario #1	
Employee is enrolled in Employee Only coverage under the Basic Plan and has \$12,000 in applicable fertility claims (allowed amounts) in 2022 (\$10,000 in medical, \$2,000 in Rx (3 generic Rxs totaling \$500 and 3 preferred brand Rxs totaling \$1,500))	
Basic Plan	EE only coverage - assume claims are processed in the following order
	Deductible 
	Member is responsible for \$1,450 deductible; \$1,450 applies to the OOPM (assumes medical claim is processed first)
	After deductible is met, member is responsible for the following: 
	Medical: EE: \$1,710 (20% coinsurance), ER: \$6,840 (80% coinsurance)
	Generic Rxs (3) EE: \$30 in copays, ER: \$470
	Preferred Brand Rxs (3) EE: \$105 (20% coinsurance, max copay \$35/script), ER: \$1,395 (80% coinsurance)
	\$1,845 of EE copays/coinsurance applies to OOPM
	Total Employee Costs: \$3,295
	Fertility Lifetime Max: \$8,705 of the \$25,000 lifetime benefit was used; \$16,295 of lifetime benefit remaining
	Employee has met \$3,295 of the 2022 Out-of-Pocket Maximum.

Scenario #2	
Employee is enrolled in family coverage under the Standard Plan and has \$34,000 in applicable fertility claims (allowed amounts) in 2022 (\$27,000 in medical, (3 specialist office visits totaling \$900 and the remaining services subject to coinsurance), \$7,000 in Rx (5 generic scripts totaling \$2,500 and 5 preferred brand totaling \$4,500))	
Standard Plan	Family coverage – assume claims are processed in this order
	Deductible 
	Assumes member has already met \$600 individual deductible
	Since deductible is met, member is responsible for the following: 
	Medical office visits (\$900 total): EE: \$90 in copays (3 specialist visits), ER: \$810
	Medical outpatient services (\$26,100 total) EE: \$1,310 (15% coinsurance), ER: \$24,190, Not covered: \$600 (EE responsible - \$25,000 maximum met)
	Generic Rxs (3 totaling \$2,500) EE: \$2,500 (\$25,000 maximum met), ER: \$0
	Preferred Brand Rxs (3 totaling \$4,500) EE: \$4,500 (\$25,000 maximum met), ER: \$0

	\$1,400 of EE copays/coinsurance applies to Employee OOPM
	Total Member Costs: \$9,000 (including services incurred after the lifetime benefit maximum is met)
	Fertility Lifetime Max: \$25,000 lifetime benefit was used; \$0 of lifetime benefit remaining
	Member has met their individual out of pocket maximum. Any non-fertility related benefits will be 100% covered by the plan.

General information

This section includes important information about your Health Care Plan. The “Benefits at a Glance” chart is intended to cover some of the more common services and is not intended to be all inclusive. For more information, please refer to the BlueCross BlueShield of South Carolina Plan of Benefits available on InSite under Services > Human Resources Home > SRNS Benefits>Benefit Providers Contact Info>and on the BlueCross BlueShield webpage at www.SouthCarolinaBlues.com.

Preventive Care Benefits

One of the most important steps you can take for your health is to schedule regular checkups. Use these schedules as a reference tool during discussions with your doctor to determine the best options for you and your family. It is your responsibility to understand your company’s benefit plan and coverage for preventive care. These schedules of preventive services are based on recommendations of numerous national organizations. The schedules listed below are partial lists. These lists are subject to change. For the most current list, please refer to www.Healthcare.gov.

www.healthcare.gov/preventive-care-adults/

www.healthcare.gov/preventive-care-children/

www.healthcare.gov/preventive-care-women/

As part of the Affordable Care Act (ACA), certain preventive services must be covered at 100% of the Allowable Charge at an in-network provider without charging you a copayment or coinsurance even if you have not met your deductible. This applies to both the Standard and Basic Plans. The Plans will pay 100% provided the claim is filed as routine/preventive care. If your provider charges you a copayment or coinsurance, it is a good indication that they do not plan to file the claim under the preventive care guidelines. Make sure you work with your provider on filing the claim.

Preventive care includes health services like screenings, check-ups, and patient counseling that are used to prevent illnesses, disease, and other problems, or to detect illness at an early stage when treatment is likely to work best. Getting recommended preventive series and making healthy lifestyle choices are key steps to good health and well-being. Recommendations may vary, so be sure to discuss screening options with your doctor.

Certain vaccinations are available through your provider’s office as a benefit under the Medical portion of the Plan. Certain vaccinations are also available through your pharmacy. Please see the section on seasonal and non-seasonal vaccines.

Remember, these preventive services are only free when delivered by a doctor or other provider in the Plan’s network.

Seasonal and Non-Seasonal Vaccine Network

Covered employees and their dependents can get vaccines covered under their pharmacy benefit at no charge to SRNS Medical Plan participants. To have coverage, members must use a pharmacy in the OptumRx Network that offers the vaccines. Non-seasonal vaccines usually include tetanus, shingles (Zostavax) and hepatitis B.

The flu vaccine does not require a prescription, but some non-seasonal vaccines may require a prescription. Some pharmacies may administer without a prescription, so it is best to call ahead and check the requirements.

A complete list of the participating pharmacies is available under MyHealthToolkit on the www.SouthCarolinaBlues.com website. Select “Benefits” then select Pharmacy Benefits, then View your Pharmacy Benefits, next select Member Tools and then Pharmacy locator.

If you have questions concerning this benefit, contact BlueCross Customer Service at 1.800.325.6596. Contact BlueCross directly to determine which specific vaccine and delivery method is covered under the Vaccine Network.

You can find the most current and complete information about the BlueCross preventive care schedule for immunizations on their web site at www.SouthCarolinaBlues.com and by logging into My Health Toolkit > Wellness > Preventive Care Guidelines. Benefits for these services are not covered if you use non-Network Providers.

Individual Case Management

BlueCross administers an Individual Case Management Program which is available if a catastrophic or long-term illness occurs. A registered nurse case manager assists the patient and family in coordinating the necessary care from various sources. Participation is voluntary.

Depending on the individual situation, the case manager may authorize coverage for a proposed treatment that ordinarily would not be covered. The treatment must be approved by you and your physician and must be determined by the case manager to be less costly to the Plan than its alternative covered treatment.

Hearing Aid Coverage

- 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.

Oncology Case Management

Support for members with cancer

Finding out you have cancer can cause a flood of emotions. You may feel shocked, sad, angry, afraid or powerless. It's normal to have these emotions or to feel nothing at all. Everyone reacts differently, and your feelings may change from one moment to the next. Companion Care Solutions is a program offered at no cost to help you through these difficult times.

How this program can help

The goal of all Companion Care Solutions programs is to help you have the best quality of life possible. The program will link you with a personal case manager, a registered nurse with experience in cancer care. Your case manager will partner with you to help you reach your health goals, coordinate care, navigate the health care system, and make the most of your health insurance benefits. Coping with cancer can be complicated. You may need intensive treatments and changes to your lifestyle, medications and diet. Our program offers extra help and support to help you navigate these changes.

Your case manager can:

- Coordinate care among all your providers. This might include a primary care physician, oncologist and others.
- Provide support and education.
- Make sure you get counseling to help improve your quality of life.
- Help you in managing the costs associated with your condition by making the most of your health insurance benefits.

For more information about the Companion Care Solutions Oncology Case Management program, please call 1.800.790.5770.

Proactive Member Messaging

The SRNS Medical Plan provides you with access to BlueCross Proactive Member Messaging, a program that offers opportunities to save money, wellness reminders and program specific promotions. Opportunities to save on prescriptions and medical services are offered through Ways to Save® alerts, a product of Change Healthcare. To sign up for Ways to Save® alerts, log into My Health Toolkit. Wellness reminders and program promotions are offered through Relay®, a text marketing communications channel. To participate, call 1.844.206.0623. Relay Network, LLC and Change Healthcare are independent companies that provide the Proactive Member Messaging program on behalf of BlueCross.

Blue CareOnDemand Telehealth Service

Blue CareOnDemand is a convenient telehealth service from BlueCross BlueShield of South Carolina.

With Blue CareOnDemand, you can consult a U.S. board-certified physician using a smartphone, tablet or computer rather than visiting an office or urgent care facility.

All you need is your computer or mobile device to see a doctor any time, day or night. During your video visit, the doctor will ask questions, answer questions, diagnose your symptoms and, if appropriate, call in a prescription to your local pharmacy.

Blue CareOnDemand is not a replacement for your primary care doctor. You should continue scheduling office visits for regular checkups and preventive care. For true emergencies and life-threatening issues, go to the emergency room or call 911.

Blue CareOnDemand doctors treat these types of conditions and more:

- Cold and flu symptoms
- Bronchitis and other respiratory infections
- Sinus problems
- Pinkeye
- Ear infections
- Allergies
- Migraines
- Rashes and other skin irritations
- Urinary tract infections

There are two easy ways to use Blue CareOnDemand. Don't wait until you're sick. Create your user account now, so it's ready when you need it.

- From your computer, go to www.BlueCareOnDemandSC.com
- From your mobile phone or tablet, download the "Blue CareOnDemand" app for your Apple or Android device.

Copayment for Blue CareOnDemand

Standard: \$10 copay for most services

Basic: varies depending on the service.

Participating in the Medical Plan

Membership in the Plan is the responsibility of SRNS. Questions about eligibility and qualifying changes in status should be directed to the SRNS Service Center at 800.368.7333 or 803.725.7772.

If you are a full-service employee (Non-Craft or a Craft Option A) and regularly scheduled to work a minimum of 20 hours per week, you are eligible to enroll for Medical Plan coverage on your first day of active service with the Company, unless otherwise excluded.

Participant Classification	Eligible	Not Eligible
Active, Full-Service Employees (Non-Craft) Employees regularly scheduled to work a minimum of 20 hours per week and not covered under the Savannah River Remediation Plan as an employee or dependent	✓	
Active Full-Service Employee Craft Option A (Craft Ben)	✓	

Active Full-Service Employee Craft Option B (Union Ben) – Union Employees of the Employer and the collective bargaining agreement does not provide for you to participate in the Plan		<input checked="" type="checkbox"/>
Terminated Employees		<input checked="" type="checkbox"/>
Retirees Incumbent Employees meeting the eligibility under the Pension Plan as described in the Pension Plan Summary Plan Description. Refer to the Pre-65 Health Plan Summary Plan Description.		<input checked="" type="checkbox"/>
DuPont Retiree (rehires and their spouses) Employees retired from DuPont Savannah River Plant, and were rehired by WSRC or BSRI on April 1, 1989		<input checked="" type="checkbox"/>
Limited-Service Employees (LSE) Regularly scheduled to work a minimum of 20 hours per week and not covered under the Savannah River Remediation Plan as an employee or dependent, Co-op students, LSE post-bachelor student, LSE professional, summer intern, LSE technical school intern, and any other employee classified as an LSE	<input checked="" type="checkbox"/> Basic Medical Only	<input checked="" type="checkbox"/>
Independent Contractor Classified by the employer as an independent contractor (regardless of whether that classification is controlling for federal employment tax purposes or under any other applicable federal, state, or local law and regardless of whether you are classified differently by a court of a federal, state, or local agency)		<input checked="" type="checkbox"/>
Long Term Disability (LTD) Under age 65, while still approved for LTD*	<input checked="" type="checkbox"/> Maximum 24 months	
Long Term Disability (LTD) Over age 65, still approved for LTD, and with Medicare as Primary*	<input checked="" type="checkbox"/> Maximum 24 months	
Retired-Rehired Please refer to the Coverage Continuation in Special Situations Section under special rules for retiree rehires		

*See "Coverage Continuation in Special Situations" section for information on when coverage ends in the event of termination of employment for Long Term Disability and/or Leaves of Absences.

Eligible Dependents

Your dependents that are eligible for enrollment in the Medical Plan include your lawful spouse (and your children). Eligibility for spouses is through either the validation of a state-recognized marriage certificate, including same sex marriage when recognized by state law through a valid marriage license or common law marriage. Common law marriages under South Carolina will be recognized with the same documentation requirements for attestation as any other marriages, along with documentation proving that the common law marriage was established prior to July 24, 2019. You will be required to provide the date of birth, Social Security Number and acceptable documentation to provide proof of eligibility for all covered dependents. A list of “acceptable documentation.”

Note: If you are divorced, your ex-spouse and stepchildren (unless you have legal guardianship or a Medical Support Order) are no longer eligible to be covered as your dependent under the Medical Plan as of the date of your divorce decree. You have an obligation to notify us within 60 days of the effective date of your divorce and no claims will be eligible for payment from the plan after the date of the divorce. Coverage continuation for your ex-spouse may be available through COBRA (Consolidated Omnibus Budget Reconciliation Act) Continuation Coverage.

The coverage under this Plan for your Incapacitated Dependent as well as the coverage for your other dependents will end when your eligibility for benefits under this Plan ends or you die. See the COBRA Continuation Coverage section for more information on extending your coverage.

The Plan reserves the right to request, at any time, documentation as proof of any dependent’s eligibility, as well as the right to remove any ineligible dependent retroactively from coverage, in the event of fraud or intentional misrepresentation, without reimbursement of premiums paid for the coverage. The Plan may also seek reimbursement for claims paid on behalf of any ineligible dependent including offsetting future claim amounts owed by the Plan on your behalf or on behalf of any other eligible dependents, until any claim amounts paid by the Plan on behalf of an ineligible dependent are recouped. The Claims Administrator also has the right to reprocess the claims, in such a case you will have the responsibility for paying any outstanding amount to the provider.

Spouse/Dependent Type	Eligible	Not Eligible
Spouse Lawful spouse through either the validation of a state-recognized marriage certificate, including same sex marriage when recognized by state law through a valid marriage license or common law marriage. Common law marriages under South Carolina will be recognized with the same documentation requirements for attestation as any other marriages, along with documentation proving that the common law marriage was established prior to July 24, 2019. You will be required to provide the date of birth, Social Security Number and acceptable documentation to provide proof of eligibility for all covered dependents.	✓	
Ex-Spouse Effective with date of divorce		✗
Domestic Partners		✗
Children Up to age 26 <ul style="list-style-type: none"> • Your own children: Newborn children are not automatically added to coverage. See below. • Your stepchildren (while married to custodial parent) * • Legally adopted (from the time they are legally placed with you) * • Over which you have legal guardianship • Incapacitated children over age 26: Must satisfy all Incapacitated Dependent qualifications <ol style="list-style-type: none"> 1. Incapable of financial self-sufficiency by reason of mental or physical disability; and 2. Dependent upon the Employee for at least 51 percent of his or her support and maintenance. <p>A child must meet both requirements to qualify as an Incapacitated Dependent. The employee must update items 1 and 2 each year or upon BlueCross’s request. A child who is not incapacitated by the maximum dependent child age of 26 will not be covered. The incapacitated dependent will be covered up to age 65.</p>	✓ ✓ ✓ ✓ ✓	

**Legal/court supported documentation required. You will be required to provide proof to the Service Center for authorization of eligibility by the Plan of legal guardianship, adoption or Qualified Medical Child Support Order that requires you to provide coverage for the child. This documentation must be signed by a court official or a judge. Documentation witnessed by a notary does not suffice.*

Special Rules for “Dual” Couples

If you and your spouse are both employees or retirees of Savannah River Nuclear Solutions, LLC (SRNS), Savannah River Remediation (SRR), Savannah River Mission Completion (SRMC), and/or Battelle Savannah River Alliance (BSRA), you cannot be covered as both an employee or retiree and as a dependent under any Plans offered by the companies.

A dependent child may not be covered by more than one SRR, SRMC, BSRA or SRNS employee or retiree. For example, you may elect to cover your eligible spouse and child, while your spouse elects to waive his/her coverage. Alternatively, you may elect coverage for yourself and your child, while your spouse elects employee only coverage. (If you make this latter choice in this example, you and your spouse may elect to be covered by different medical options.)

You must be enrolled in the Plan to add a dependent. If the Plan receives a medical support order that it determines to be valid requiring coverage for your dependent, and you are not enrolled in the Plan, you may be compelled to enroll in the Plan (including payment of required premiums) in order for your dependent to be covered as required under the medical support order.

Enrolling for Coverage

During the annual open enrollment process, you will be asked to elect a choice of Medical plan (or no medical coverage), as well as a coverage level. The chart below outlines the plan and coverage level choices.

Your Plan	Standard Preferred Provider Organization	OR	Basic High Deductible Health Plan	OR	Waive No medical coverage
Your Coverage Level	Employee Only Coverage for yourself only	OR	Employee +1 Your plus one dependent	OR	Employee +2 or more Your plus two or more dependents

You can elect coverage, add or delete eligible dependents from your coverage during the annual open enrollment period for the coverage to be effective at the beginning of the next calendar year. This is the only time you will be able to enroll your dependents without a Qualifying Event.

Initial Enrollment as a New Hire

During new hire orientation, you will be asked to enroll yourself and your eligible dependents in the Plan. You will have two weeks from your date of hire to make any changes to your elections. Your coverage will be effective on your first day of employment.

If you fail to make an election during the first two weeks, you can't elect coverage, add or delete eligible dependents until the annual open enrollment period and coverage will not be effective until the beginning of the next calendar year. This is the only time you will be able to enroll your dependents without a Qualifying Event. If, at date of hire, you have coverage from a former employer, you may provide a certificate of coverage from that employer and you may enroll at the beginning of the next month.

Eligibility for SRNS/SRR/SRMC/BSRA Employees Retired and Rehired, and Under Age 65

In general, the following rules apply if both you and your spouse are both under the age of 65: If you are eligible for coverage as a Pre-65 retiree under a Medical Plan of SRNS, SRR, SRMC, or BSRA, and you are currently an active SRNS employee, you will only be eligible for the Active Employee Medical Benefit Plan. You will continue to be ineligible for the SRNS, SRR, SRMC, or BSRA retiree Pre-65 Health plan until your employment with SRNS terminates. Your Pre-65 Retiree coverage will be placed in a Waive status. After your employment terminates you will be eligible for the same Health benefits as similarly situated retirees.

Eligibility for SRNS/SRR/SRMC/BSRA Employees Retired and Rehired, and Over Age 65

In general, the following rules apply if both you and your spouse are over the age of 65: If, at the time of being hired as an active SRNS employee, either you or your spouse are over the age of 65 and have an active SRNS/SRR/SRMC/BSRA Health Reimbursement Account you have the option of continuing your participation in your SRNS/SRR/SRMC/BSRA Health Reimbursement Account or electing coverage as an active SRNS employee. You or your dependents are not eligible to participate in both the SRNS/SRR/SRMC/BSRA Health Reimbursement Account and the SRNS Medical Plan for Active employees. You should consider your options carefully as there may be penalties, delayed enrollment, and medical underwriting when rejoining Medicare and/or a Medicare Supplement Plan when your employment ends. You will not be able to select some retiree benefits and some active employee benefits.

Do not call BlueCross with information on a Qualifying Change in Status or an address change. Instead, contact the Service Center at 803.725.7772.

Requesting Election Changes and Qualifying Events

You will only be able to add or delete a dependent and change your level of coverage (employee, employee plus one dependent, employee plus two or more dependents) under your medical care elections as a result of a Qualifying Event. You will not be able to change the Plan option (Standard or Basic) that you elected during Open Enrollment. You must be enrolled in the plan to enroll a new dependent.

When can I make changes?

Generally, you are permitted to make Medical Plan election changes only during the annual enrollment period, which will be effective beginning January 1 of the following year. Your Medical Plan elections must stay in effect for the full calendar year (also known as the Plan Year). You cannot change your benefit level of coverage during the calendar year unless you have a Qualifying Event for benefit coverage purposes. Certain rules specify the events under which you may change a benefit election during the year, effective with the date of the event through the remaining portion of the calendar year.

If you, your spouse or dependent child experiences a Qualifying Event and you wish to change your benefit elections, you must submit a written request of the benefit election change to the Service Center within 60 days after the event occurs.

Add or Delete Dependent

To add or delete dependents from your coverage due to a Qualifying Event, complete SRNS Form OSR 5-200 (available on InSite and/or by contacting the Service Center). Submit the form and supporting documentation to the SRNS Service Center, Bldg. 992-2W Savannah River Site, Aiken, SC 29808 within 60 days of the Qualifying Event. Any change you request to make under the Plan must be consistent with your Qualifying Event. Proof of the Qualifying Event will be required.

Newborn Children

Newborns are not automatically covered under the parent's coverage for the baby's initial hospitalization. The new parent should submit an OSR 5-200 with a copy of the birth certificate as soon as possible after the birth. Coverage can begin retroactive to the birth date, but the request must be submitted within 60 days of the birth date.

You should submit your request to add your new baby to the SRNS Service Center even if the Social Security number hasn't been assigned. You will be required to submit the Social Security number as soon as it is available due to ACA reporting requirements.

Whenever you are adding new eligible dependents to your coverage, you must name the dependents to be covered, provide their date of birth, and their Social Security number. If you do not have the Social Security number for your dependent at the time you enroll them in coverage (a newborn), you should submit the Social Security number to the SRNS Service Center as soon as you receive it.

Legally Required Documentation

Whenever you are adding or removing dependents from coverage, you may be requested to supply a copy of an official document such as a birth certificate, marriage certificate, adoption certificate, divorce decree, legal guardianship as signed by a judge, etc. that supports the dependent's eligibility for Plan coverage and the effective date of the coverage change. The document should be in English. If the document is not in English a translation along with a translator's certificate should also be provided. (You can find the list of acceptable documentation at https://www.srs.gov/general/jobs/benefits/documents/Acceptable_Dependent_Documentation.pdf)

If you, your spouse or dependent child experiences a Qualifying Event but you do not need to change your coverage level, you must still immediately notify the Service Center for the child to be covered at BlueCross. Accurate records are important to ensure proper coverage for you and your dependents.

The Plan Administrator has the right to request, at any time, documentation as proof of a Qualifying Event and eligibility for benefits and will have the final decision-making authority regarding any allowable changes.

The benefit changes you want to make must be consistent with the Qualifying Change in Status. That is, the event must result in the employee, spouse or dependent child gaining or losing eligibility for coverage under either the Medical Plan or the spouse's or dependent child's employer's plan. Documentation will be required.

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage and you subsequently lose such coverage, the event may be a Qualifying Event and you may be able to enroll yourself or your dependents in this Plan, provided that your written request for enrollment is received by the Service Center within 60 days after your other coverage ends.

The events listed on the next page may be considered a Qualifying Event if they result in a change in eligibility for health care. The change must be made as of the effective date (unless added during Annual Open Enrollment).

Qualifying Event for an Employee, Spouse or Dependent

Change in legal marital status	Marriage, death of a spouse, divorce, legal separation, annulment
Change in number of dependents	Birth, adoption, placement for adoption, death of a dependent child, acquisition of a step-child who will reside in your household as the result of a judgment, decree, or order including a Qualified Medical Child Support Order.

Change in employment status	Termination of employment for employee, spouse, or dependent child; Commencement of Employment for employee, spouse or dependent child
Change in work schedule	Permanent reduction or increase in hours by the employee, spouse or dependent child (including a switch between part-time and full-time); a strike or lock-out; Commencement, or return from, an unpaid leave of absence
Change in which a dependent child satisfies or ceases to satisfy the Plan's eligibility requirements	Attainment of age 26. Any circumstance that qualified or disqualifies the child under the Plan
As related to the Medical Plan	A change due to loss of coverage under a group health plan, Enrollment in Medicare, Medicaid or Tricare, or a special enrollment right due to loss of coverage elsewhere
Newborn	A newborn Child will have coverage upon the date of the Child's birth provided he or she has been enrolled for coverage and the coverage has been paid for under this Plan of Benefits within 60 days after the Child's birth for the Child to have coverage from the date of birth. If a newborn Child is not enrolled within the time frame set forth in the prior sentence, coverage will begin on the date chosen by the Employer and upon the payment of the applicable Premium. You must be enrolled to cover your child.
Dependent children reaching age 26	If SRNS Form OSR 5-200 is not submitted to remove your age 26 dependent, that dependent will automatically be dropped from the Plan at the end of the month in which they turn 26. If this changes your level of coverage, the level will be changed automatically on your behalf.

It is your responsibility to remove your dependents from the Plan when they no longer meet the Plan eligibility requirements. If your written enrollment change request is not received within 60 days of the event: your covered dependent will not be eligible for COBRA continuation coverage. Enrolling an ineligible dependent or otherwise failing to comply with the Plan's eligibility requirements may constitute fraud or an intentional misrepresentation and will result in the retroactive rescission of coverage. The Plan may seek recovery for any claim payments paid past the claimant's eligibility date and you may not be able to receive a refund of any premium contribution overpayments. (refer to Medical Plan Summary Plan Description Part TWO "Subrogation and Reimbursement") In the event of a divorce, the "60-day clock" begins on the date of the final divorce decree. Submit SRNS Form OSR 5-200, "Health Care Enrollment/Change Form" to the Service Center to remove your dependents from the Plan.

Identification Cards

Once you make your medical coverage election, you will receive an identification (ID) card(s) from BlueCross. You will automatically receive two ID cards. If you enroll in Employee plus two or more, you will receive four ID cards. The ID card provides information needed by a hospital, physician or other health care provider to prepare and submit your claim for processing. If you should need additional cards, or a replacement card, contact BlueCross. You may also request additional cards online at www.SouthCarolinaBlues.com/myhealthtoolkit. The ID cards are in the subscriber's name.

Coverage Effective Date and Cost

Your coverage begins on your hire date unless you waive your coverage or have proof of other coverage. If you waive coverage and enroll during the annual open enrollment or upon a Qualifying Event, your coverage is effective as of the beginning of the Plan Year (calendar year), or on the effective date of your Qualifying Event, whichever applies. Coverage for your eligible dependents, if you elect coverage for them, begins at the same time as your coverage or on the effective date of the Qualifying Event, whichever applies.

You and the Company share in the cost of the Medical Plan coverage. The amount of your premium contribution depends on the medical option you elect and whether you elect coverage for yourself only or for you and your dependents. The premium contribution for the coverage you select will be based on your applicable pay period. As of April 1, 2017, premium contributions are pro-rated in accordance with your employment date. Premiums are not prorated for a Qualifying event. Your premium will be determined by the Plan you are enrolled in and the level of coverage (employee only, employee +1, or employee +2 or more) that is in effect at the end of your pay period (or at the time of Payroll processing).

As an active employee, your premium contributions are deducted from your pay before Social Security and Federal and State income taxes are computed and withheld. The Plan will comply with federal and state tax laws that are in effect at the time the coverage is in effect. The premium contribution that you are required to pay is reviewed and adjusted periodically by the Company. Typically, premiums are adjusted at the beginning of each calendar year. You will be notified of your premium contribution amount at the time of annual open enrollment or prior to any future change.

When Coverage Ends

Your coverage ends when:

- you no longer elect to be covered by one of the medical options (waive) during open enrollment or experience a Qualifying Event, or
- you no longer meet eligibility requirements (e.g., termination of employment, death) or

- you fail to make the required premium contributions by their due date.

Coverage for your dependents ends when:

- you no longer elect to cover them (during annual open enrollment), or
- they no longer meet the eligibility requirements, or
- a Qualifying Event occurs (and as a result, you elect to remove a dependent from medical coverage). You will be required to provide proof of the Qualifying Event to the Service Center within 60 days of the event, or
- your coverage ends.

Dependent children can be covered up to age 26.

Coverage under this Plan for you and your dependents ends on the last day of your applicable pay period if you terminate employment or die unless you are approved for Long Term Disability (LTD). If your premiums for medical coverage cannot be deducted from your paycheck or LTD check, you will be billed for the premiums. If you fail to make timely payments by the due date, your coverage will be terminated as of the due date. Premium contributions are not pro-rated in accordance with your termination date. In other words, you'll have to pay the full premium contribution for the pay period in which you terminate employment or die. In certain situations, you and your dependents may be eligible to continue coverage. (See "COBRA Continuation Coverage")

Coverage Continuation in Special Situations

If you are involuntarily laid off and are a full-service employee, you may elect to receive Displaced Worker's Medical benefits, if provided under a workforce restructuring program, in lieu of COBRA Continuation Coverage or you may choose COBRA continuation coverage.

If you terminate your employment, coverage for you and your dependents will end on the last day of the pay period in which you are a full-service employee. You may be able to continue your coverage by electing COBRA continuation coverage.

If you are an "Incumbent" employee under the terms of the Pension Plan and you terminate employment and meet the Pension Plan eligibility for retirement provisions under the Normal, Early, Optional or Incapability Retirement provisions of the Pension Plan, you may be eligible for participation in the Pre-65 Retiree Health Plan or the Retiree Health Reimbursement Account as a retiree unless otherwise excluded. See the Pre-65 Retiree Health Plan SPD or Retiree Health Reimbursement Account SPD for eligibility requirements.

Rights to continuing medical coverage in retirement do not apply to employees with a vested deferred pension from the Pension Plan or to Non-Incumbent Employees who are not eligible to participate in the Pension Plan.

If you are a "Non-Incumbent" employee under the terms of the Pension Plan and you terminate your employment, coverage for you and your dependents will end the last day of the pay period in which you are a full-service employee. You may be eligible for COBRA continuation coverage.

If you are approved for Long-Term Disability under the Disability Income Plan, you will be eligible to continue coverage under the SRNS Pre-65 Medical Plan in lieu of COBRA continuation coverage for as long as you are eligible and/or approved for LTD or up to a maximum of 24 months from the date your employment ends. At the end of this maximum 24-month period, your medical coverage ends; however, you may then become eligible for Medicare. Since your employment has ended after being approved for LTD, your coverage will be transitioned to the Pre-65 Retiree Health Plan on the date your LTD benefit begins. You will be charged according to the current Pre-65 Health Plan premium rate schedule during the period you are approved for LTD. You and your eligible spouse will remain in this Plan even if you are or turn 65 anytime during the 24-month coverage period. If you become eligible for Medicare Part A and/or B, Medicare will become the primary payer and the SRNS medical Plan will become the secondary payor and will not pay for the portion of the service that Medicare would have covered.

If you die, coverage for your dependents will end on the last day of the pay period in which you die. Your dependents may be eligible for coverage under the Pre-65 Retiree Medical Plan if you were an Incumbent employee and had 15 years of Eligibility Service as defined in the Pension Plan. Specific information on survivor benefits is described in the Pre-65 Retiree Medical Plan SPD.

If survivor benefits do not apply, your dependents will be eligible to continue their coverage by electing COBRA continuation coverage. However, your survivors may also be eligible to buy an individual plan through the health insurance marketplace. By enrolling in coverage through the marketplace, you may qualify for lower costs on monthly premiums and lower out-of-pocket costs. Additionally, your survivors may qualify for a 30-day special enrollment period for another group health plan for which they are eligible (such as your surviving spouse's plan), even if that plan generally doesn't accept late enrollees.

If you are on a Company-approved paid leave of absence (LOA), your Medical Plan coverage for yourself and your dependents will continue as if you were actively at work.

If you are on a Company-approved Unpaid LOA, such as a Family and Medical Leave or on an approved furlough, you will be able to continue your Medical Plan coverage for yourself and your dependents, if you elected to cover them, as long as you pay the required monthly premium contribution in advance, which will be on an after-tax basis. When you return from the Unpaid LOA as an active employee, your premium contributions will resume on a pre-tax deduction basis from your paycheck. Before your Unpaid LOA begins, be sure to contact the SRNS Service Center for additional information and instructions on making the required premium contributions.

If, while on a Company-approved Unpaid LOA, you fail to make your premium payments in a timely manner (that is no later than 31 days after the beginning of the month), your Medical Plan coverage for you and your dependents will be terminated retroactively to the beginning of the month for which the premium contribution was not made. When you return as an active employee from the Unpaid LOA, the Medical Plan coverage that you had just prior to the Unpaid LOA will resume, with premium contributions deducted on a pre-tax basis from your paycheck. However, you and your dependents will have forfeited medical coverage during the period of time that you did not pay the required premium contributions. Medical claims incurred by you or your dependents during that uncovered period of time will not be paid by the SRNS Medical Plan.

Benefits Billing

If you are on an Unpaid LOA or you do not have enough in your pension check to pay your premiums, you will be placed in the Benefits Billing system. If you do not pay your premiums on the first of the month for that month, you will have a 31-day grace period. If payment is not received by the last day of the month, your benefits will be cancelled. An invoice is provided for your convenience but is not required.

If you are away from employment due to military service, under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if you (or your eligible dependents) are covered under the Plan, and if you become absent from work due to military leave, you (or your eligible dependents) may have the right to elect to continue health coverage under the Plan. To be eligible for coverage during the period that you are absent from work on military leave, you must give reasonable notice to the Company of your military leave. During military leave, you are required to pay the Company for the entire cost of such coverage, including any elected dependents' coverage. Be sure to contact your Workforce Services Representative for additional information and instructions on making the required premium contributions.

You will be entitled to COBRA-like rights with respect to your medical benefits in that you and your dependents can elect to continue coverage under the Plan for up to 24 months from the date the military leave commences or the length of uniformed service, whichever is shorter.

An employee returning from military leave is guaranteed the right to reinstatement in the Medical Plan without any waiting periods. If, while on a military leave of absence, you fail to make your premium payments in a timely manner (no later than 31 days after the beginning of the month), your Medical Plan coverage for you and your dependents will be terminated retroactively to the beginning of the month for which the premium contribution was not made. When you return as an active employee from the military leave, the Medical Plan coverage that you had just prior to the military leave will resume, with premium contributions deducted on a pre-tax basis from your paycheck. However, you and your dependents will have forfeited medical coverage during the period of time that you did not pay the required premium contributions. Medical claims incurred by you or your eligible dependents during that uncovered period of time will not be paid by the SRNS Medical Plan.

Medical Plan Choices

Standard and Basic

When you enroll in the Medical Plan, you choose the Plan option that's right for you, or you can elect no medical coverage. Both the Standard (Preferred Provider Option, or PPO) and Basic (High Deductible Health Plan) offer a choice of Network and non-Network care. You should always use "My Health Toolkit" at www.SouthCarolinaBlues.com or call BlueCross customer service at 1.800.325.6596 when searching for Network providers.

Both the Basic and the Standard Plan use the same provider Network. For South Carolina providers, it is the PPO Network. For Georgia providers, it is the Blue Open Access Point of Service (POS) Medical Network. Although we use the Georgia POS medical network, the SRNS Plan is NOT a POS plan.

How the Standard and Basic Options Are Similar:

Both options are alike in many ways. Each option has provisions on deductibles, Out-of-Pocket Maximums, allowed amounts and annual maximums. In addition, both plans...

- Cover the same health care expenses overall
- Exclude the same expenses (see Appendix C, "Expenses Not Covered")
- Use the same BlueCross Network of medical providers
- Are designed so that your share of the cost is limited when the cost of covered treatment exceeds specified amounts (annual Out-of-Pocket Maximum expenses for covered services)
- Have allowed amounts set by provider contract and do not vary by Plan.

Common Terms Used by Both Plans:

For more information on terms, refer to Appendix A, Definitions.

Allowable Charge: The Allowable Charge is the total payment for eligible services, supplies, or equipment as determined by BlueCross that will be paid to Providers participating in the BlueCross Network. When you use non-Network Providers you can be billed for the balance over the Allowable Charge and the amount over the Allowable Charge does not count towards your Deductible or Out-Of-Pocket maximums.

Annual Maximum Benefit: Regardless of the option you choose, there is no annual maximum benefit payable by the Plan for essential health benefits.

Coinsurance: A coinsurance is the percentage you pay after reaching your deductible. If you do not pay a copay, most likely a coinsurance will apply. In most cases you will pay between 15% and 30%. See the "Benefits at a Glance" chart for more information. Any coinsurance amount you pay counts toward your deductible and your out-of-pocket. Coinsurance is required for:

- Laboratory work that your Network physician sends to an outside laboratory or x-rays performed outside the physician's office; or
- Physician hospital services; or
- Surgery performed in the Network physician's office; or
- Allergy injections when performed by a nurse and billed with no other service from that physician's office on that date (other injections may require a copay); or
- Prenatal care billed under surgery code for total obstetrical care;
- Prescriptions, for most tiers (see the "Basic Plan" section).

Copayment (copay): A copay is a fee you pay for office services or prescription drugs. A copay is required for:

- Physician's office visit under the Standard Plan;
- Blue CareOnDemand under the Standard Plan and after deductible is met on the Basic Plan;
- For generic drugs under the Basic Medical Plan.

Deductible: A deductible is an amount you pay each year before the Plan begins to share costs with you. The amount will be evaluated each year and announced during the annual Open Enrollment. There is no carryover of unsatisfied deductible amounts from one year to the next. Your deductible amount starts over each benefit year.

Medically Necessary: Using United States standards, health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: 1) In accordance with generally accepted standards of medical or behavioral health practice; 2) Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; 3) Not primarily for the convenience of the patient, patient's caregiver(s) or Provider; and 4) Not costlier than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

Preventive Care Services under the ACA: Preventive care services are based on the services in the preventive care schedule and are paid at 100% before the deductible when you use a Network physician. They are not covered when you use a non-Network physician. Also, there is a list of ACA-mandated generic drugs that are covered at 100%. Go to www.SouthCarolinaBlues.com to see the list.

Your Share of Expenses: You are responsible for certain expenses:

- The deductible, coinsurance amounts and copays;
- Any expenses above the allowable amount at a non-Network provider (pay particular attention to ambulance services);
- Expenses not covered;
- Charges that exceed the option's limitations on certain services; and
- Any charges for procedures not considered Medically Necessary

Out-Of-Pocket Maximum: Under each option, there is an annual Out-of-Pocket Maximum, which is the most you will pay in copays, deductibles and coinsurance for covered expenses during any one benefit year. Once the maximum is reached, your medical plan option begins to pay 100% of the allowable amounts for eligible expenses. The Out-of-Pocket Maximum is designed to protect you against having to pay extraordinary medical bills in each year. The annual Out-of-Pocket amount will be evaluated each year and announced during Open Enrollment. There is no carryover of unsatisfied Out-Of-Pocket amounts from one year to the next. Your Out-Of-Pocket amount starts over each Benefit Year.

Out-of-Pocket Maximum	Standard Plan	Basic Plan
Employee only	\$2,000 per person	\$4,500
Employee + One Employee + Two or More	\$4,000 No one member can exceed \$2,000. All members combined cannot exceed \$4,000.	\$7,150 Aggregate. Must meet this amount for all family members combined.

Out-of-Pocket Maximum: What counts (and what doesn't)

What counts	What doesn't
Copay and coinsurance amounts from Network Providers	Copayments at Non-Network Providers
Any services that count toward your Deductible also count toward your Out-of-Pocket Maximum	Medical expenses that are not covered by your Medical Plan.
Prescription drugs, unless otherwise excluded (for example, brand name penalties)	Penalties incurred for hospital stays or major out-patient diagnostic procedures (MRI, MRA, CAT scans, PET scans, etc.) that have not been preauthorized
Blue CareOnDemand	Expenses above the allowable charge for each covered service
	Non-covered prescription drugs and penalties under the Mandatory Generic, Step Therapy and Quantity Management Programs and maintenance medication not purchased through the OptumRx Mail Order Pharmacy (Mandatory Mail Order Service Program)
	Preventive Care at Non-Network Provider (not covered)

Medical Plan Choices: Standard Medical Option

The Standard Medical option gives you the choice of receiving medical care from providers participating in the BlueCross Medical Networks or going to a provider who is not part of the Medical Network. The Standard Medical Plan generally provides a higher level of coverage if you use a BlueCross Network provider as you will not be balanced billed by the provider for charges above the Allowable Amount. Preventive care is not covered when you use a non-Network provider.

Standard Option Quick Look

- Higher premiums than the Basic Plan
- Lower deductible than the Basic Plan
- Lower coinsurance than the Basic Plan
- Copayments of \$20/\$30 for office visits
- Lower Out-of-Pocket Maximum than the Basic Plan
- No one family member can exceed individual deductible
- Can be used with Healthcare Traditional Spending Account

Standard Plan Copayments

When you go to a Network primary care physician, such as a family doctor, internist, pediatrician, gynecologist, psychiatrist or psychologist, you pay a \$20 copay for the office service, which might consist of one or more of the following: exam, in-office lab work or in-office x-ray.

When you see a specialist (such as a neurologist, dermatologist or podiatrist, etc.), you pay a \$30 copay.

The copayment does not count toward your deductible but will count toward your Out-of-Pocket Maximum.

Standard: Copay

Primary Care--\$20

Specialist--\$30

Out-of-Pocket Maximum

Your Out-of-Pocket Maximum for covered services is \$2,000 per person (or \$4,000 for your entire family) in a benefit year. The Standard Medical Plan Out-of-Pocket Maximum includes your copays, deductible and coinsurance, but not your charges incurred for non-covered expenses. Preventive care services are not covered at all unless you use Network providers and would not count toward your Out-of-Pocket Maximum. Once you reach the Out-of-Pocket Maximum, the plan will pay 100% of the allowed amount of covered expenses.

Under the Standard Plan, the individual Out-of-Pocket Maximum is the amount that must be paid by one person each calendar year and applies under both the individual and family options. No one family member will exceed the individual (per member) Out-of-Pocket Maximum. If the family Out-of-Pocket Maximum (\$4,000) is met by other family members, then this member will not have to meet the individual Out-of-Pocket Maximum amount since the family's maximum is met.

Note that if all family members combined meet the family Out-of-Pocket Maximum, no one person must meet the \$2,000 individual Out-of-Pocket Maximum.

Standard Option: Annual Deductible

Employee Only--\$600 per person

Entire Family--\$1,200. No one member can exceed \$600. All members combined cannot exceed \$1,200.

Standard Plan Deductibles

Under the Standard Plan, the Employee Only deductible is the amount that must be paid by one person each calendar year and applies under both the Individual and Family options. No one family member will exceed the individual (per member) deductible. If the family deductible is met by other family members, then this member will not have to meet the single deductible amount since their deductible is met. Note that if all family members combined meet the family deductible, no one person must meet the individual deductible.

For services, other than preventive care and doctor visits requiring a copay, you must pay a deductible before the Plan begins to pay. This includes prescription drugs. The individual annual deductible is \$600 per person (\$1,200 for your entire family). For coverage levels other than Employee Only, no one member can exceed the individual deductible amount.

Under the Standard option, the deductible applies to all services except for doctor visit copays, preventive care, and Blue CareOnDemand. The Service Examples chart below highlights a few major expenses; however, the chart is not intended to be all-inclusive.

Standard Option Deductibles: Service Examples

<p>You will pay 100% of these charges UNTIL you meet your deductible</p>	<p>The Plan pays BEFORE you meet your deductible <i>(and so does not count toward deductible)</i></p>
<p>Covered services rendered by Network and non-Network providers (other than office visits)</p> <p>Emergency Room</p> <p>Prescription drugs <i>(unless otherwise excluded; for example: brand name drug penalties or maintenance medications/drugs not purchased through the OptumRx Mandatory Mail Program)</i></p> <p>Chiropractic</p> <p>Non-Network office visit</p>	<p>Copays for Network physician's office visits (\$20/\$30)</p> <p>Blue CareOnDemand \$10 copayment</p> <p>Preventive care (100% at Network Provider)</p> <p>ACA Preventive Drugs (Generics available at \$0)</p>

Prescription Drugs

Covered prescription drugs count toward the annual deductible. After the deductible is met, you will pay a coinsurance amount: The copay is 10% for generic medications, 20% for preferred medications, and 30% for non-preferred brand name drugs. See information regarding mail order and other pharmacy benefit requirements under the "Prescription Drugs" section. There are certain ACA preventive medications that are paid for at 100%. Refer to the ACA preventive drug list at www.SouthCarolinaBlues.com.

Other Expenses

If you go to either a Network or a non-Network provider, for most other covered expenses you will pay between 15% and 30% of the allowable charge (Network allowed amount) after the deductible. If you go to a non-Network provider, the non-Network providers may "balance bill" you up to the amount above and beyond the BlueCross allowable charge.

If you receive certain additional covered services (e.g., surgery performed in the physician's office), after you meet your deductible, your cost will include a coinsurance (percentage of the allowable charge) for the additional covered services plus your \$20 or \$30 copay.

Healthcare Traditional Flexible Spending Account

When you are enrolled in the Standard plan you can also use a Health Care Traditional Spending Account to reimburse yourself for your out-of-pocket medical expenses with pre-tax contributions. Refer to the Flexible Spending Account SPD for more information.

Medical Plan Choices: Basic Medical Option

The Basic Medical Plan (High Deductible Health Plan) offers lower premiums than the Standard Medical Plan, but requires that you meet a higher deductible before reimbursement for most covered services. In addition, a coinsurance is used in most cases as opposed to a copayment. For example, at the first of the year, you are responsible for paying the entire cost of doctor visits as opposed to the Standard plan which has a \$20/\$30 copayment. There is a copayment with the Generic Tier of the Prescription Drug Plan and with the Blue CareOnDemand after you meet your deductible. Also, participants in the Basic plan are Eligible for pre-tax Health Savings Account (HSA) to help pay for current and future unreimbursed medical expenses. This is one of the principal advantages of the Basic Plan. See the section on HSA for additional information.

Basic Option Quick Look

- Lower Premiums than the Standard Plan
- Higher Deductible than the Standard Plan
- Higher Coinsurance than the Standard Plan
- Must pay full cost of office visits and covered services until deductible is met
- Higher Out-of-Pocket Maximum than the Standard Plan
- Must meet entire family deductible before Plan begins to pay for covered expenses
- Eligible for pre-tax HSA to help pay for current and future unreimbursed medical expenses

Basic Plan: Office Visit – Coinsurance

When you go to a Network physician, you pay a 100% of the allowable charge for the office visit until you meet the deductible. This visit might consist of one or more of the following: exam, in-office lab work or in-office x-ray. Once you meet the deductible, you will generally pay 20% of the allowable charge. This will count towards your deductible and your Out-Of-Pocket Maximum.

Basic Option: Out-Of-Pocket Maximum

Employee Only--\$4,500 per person

Entire Family--\$7,150. You must meet the entire family Out-Of-Pocket before the Plan begins to pay at 100% for covered services.

Basic Plan: Out-of-Pocket Maximum

Once you reach the benefit year Out-of-Pocket Maximum, the plan will pay 100% of allowable charge for covered expenses.

Your Out-of-Pocket Maximum for covered services is \$4,500 for Employee Only coverage or \$7,150 for "Employee +1" or "Employee + 2 or More", in a benefit year. The Basic Plan Out-of-Pocket Maximum includes your copays, deductible, and coinsurance, but not your charges incurred for non-covered expenses. Preventive care services are not covered at all unless you use Network providers and would not count toward your Out-of-Pocket Maximum. Once you reach the Out-of-Pocket Maximum, the plan will pay 100% of the allowed amount of covered expenses.

One major difference between the Standard and Basic Plans is the way the Out-Of-Pocket (and the deductible) is met. Under the Basic Plan, the Employee Only Out-of-Pocket Maximum is the amount that must be paid by the individual employee in the Basic Plan. However, if you are in the "Employee + One" and "Employee + Two or More" tiers of coverage, you must meet the entire family Out-Of-Pocket before the Plan begins to pay at 100% for covered services. **This is very different from the Standard Plan.** This means you will have to pay \$7,150 before the plan begins to pay at 100%.

Basic Plan: Annual Deductible

Individual (Employee Only)--\$2,000

Entire Family--\$4,000

Aggregate: Must meet this amount for all family members combined before claims are paid

Basic Plan: Deductibles

Under the Basic Plan, the deductible applies to all services except for preventive care (you pay for all services until the deductible is met). The amount of the deductible will be evaluated each year and announced during annual Open Enrollment.

The deductible in the Basic Plan works differently than the Standard Plan deductible. The Individual deductible of \$2,000 applies to Employee Only coverage. The deductible of \$2,000 is applied before you are reimbursed for most covered services. However, if you are enrolled in Employee + One, or Employee + Two or more, the entire family deductible of \$4,000 must be met before any reimbursement is made for most covered services. After you have paid your deductible, you will then pay

between 20% and 30% of the allowable charge (30% of the allowable charge when you use an emergency room for routine, non-emergency care). See the “Benefits at a Glance” page for specific coinsurance amounts.

Most expenses apply toward your deductible. This means you must pay 100% of these expenses before the coinsurance percentage applies (Example: 20% employee coinsurance/80% Plan paid). Note that preventive services performed at a non-network provider are not covered at all.

The chart below is not intended to be all inclusive but is intended to highlight a few of the major expenses.

<p>You will pay 100% of these charges UNTIL you meet your deductible</p>	<p>The Plan pays BEFORE you meet your deductible <i>(and so does not count toward deductible)</i></p>
<p>Covered services rendered by Network and non-Network providers</p> <p>Emergency Room Prescription drugs <i>(unless otherwise excluded; for example: brand name drug penalties and maintenance medication not purchased through the OptumRx Mail Order Pharmacy (Mandatory Mail Order Service Program)</i></p> <p>Chiropractic Non-Network office visit Blue CareOnDemand</p>	<p>Preventive care (100% at Network provider) ACA preventive drugs (Generics available at \$0) SRNS Expanded Preventive Drug List <i>(See “Prescription Drugs” section and Mandatory Mail Service Saver Program through OptumRx .)</i></p> <p>The Expanded Preventive Drug list applies to your deductible.</p>

Prescription Drugs

Covered prescription drugs count toward annual deductible. You will pay 100% of the allowable cost of the drug until you reach the deductible, then you will pay a coinsurance amount for generic, preferred brand, and non-preferred brand name drugs. See information regarding mail order and other pharmacy benefit requirements under the “Prescription Drugs” section. There are certain preventive medications that are paid for at 100% per the ACA. There is a list of these drugs on www.SouthCarolinaBlues.com or on InSite under Benefits.

In 2020, an expanded list of preventive drugs can be paid for before the deductible is met. See www.SouthCarolinaBlues.Com, or InSite > Human Resources > Benefits. These involve a maximum coinsurance amount. **This is another significant difference between the Standard and Basic Plan.** This list is not applicable to the Standard Plan.

Other Expenses

If you go to either a Network or a non-Network provider, for most other covered expenses you will pay between 20% and 30% of the allowable charge (Network allowed amount) after the deductible. If you go to a non-Network provider, they may “balance bill” you up to the amount above and beyond the BlueCross allowable charge.

Healthcare Limited Flexible Spending Account

When you are enrolled in the Basic Plan you can also use a Health Care Limited Flexible Spending Account (FSA) to reimburse yourself for your Out-Of-Pocket Medical expenses with pre-tax contributions. Refer to the FSA SPD for more information.

Health Savings Account

When you are enrolled in the Basic Plan, you may also enroll in an HSA, which will allow you to save pre-tax dollars for current and future health care expenses. See the HSA section of this Plan.

The BlueCross Medical Provider Network

The BlueCross Medical Network is available to you nationwide and in some foreign countries. You receive the maximum benefit when you use it.

In-Network Allowable Amounts: The Advantage

BlueCross has negotiated rates with the in-network providers. The provider has agreed to accept as payment-in-full the allowed amount (regardless of what is billed). The member's share is based on this allowed amount (which is lower than the billed amount)—this saves them money. Also, you can't be balance billed for this service. Balance billing is when a non-network provider expects you to pay the difference between the allowed and the billed amount.

Locating Network Providers

The providers in the Network may sometimes change. For the most current information on network status, check with your provider or check on-line by logging into your "My Health Toolkit" account on the BCBS South Carolina website at www.SouthCarolinaBlues.com. You may also call BlueCross at 1.800.325.6596.

For information on providers located outside of the United States, you should contact BlueCross BlueShield Global Core at 1.800.810.BLUE (2583) or call collect to 1.804.673.1177 or go to www.bcbsglobalcore.com.

Mental Health/Substance Abuse Services

For information on accessing mental health and/or substance abuse services available, you should contact Companion Benefit Alternatives (CBA), a BlueCross and BlueShield of South Carolina subsidiary, at 1.800.868.1032. Pre-authorization of mental health and substance abuse services is required for in-patient admissions, out-patient facility services and other admissions, such as residential treatment centers. Pre-authorization is through CBA, the BCBS-SC Mental Health and Substance Abuse Clinical Care Managers and is available 24 hours a day, seven days a week.

Employee Assistance Program

The on-site Employee Assistance Program (EAP) is enhanced with support through First Sun Employee Assistance Program, the BCBS provider of EAP services. This enhanced EAP offers additional off-site resources which can be especially helpful to family members of employees for providing off-site counseling and assistance services. Three free calls to a counselor are available under the program. If you need assistance with the demands of work, family and personal concerns, contact the EAP coordinator at the Savannah River Site at 803.725.8255 or offsite through BCBS at 1.800.968.8143. Please be aware that all Fitness for Duties issues must be handled through the on-site EAP coordinator.

When You Visit a Network Physician's Office

When you visit a Network physician, make sure you show your ID card. Using information on your ID card, the Network provider will file a claim for services rendered to the BCBS organization that they contracted for Network services (provided the Medical Plan is the primary payer.)

If you visit a physician who is not in the Network, you should still present your ID card so the receptionist can check your eligibility and coverage. In many cases, you may have to pay a non-Network provider in full at the time of the visit; then, you are responsible for filing a claim for reimbursement with BCBS. If another medical insurance plan (such as your spouse's employer's plan) provides primary coverage on one or more of your dependents, certain Coordination of Benefits (COB) rules apply. Refer to the COB section in this booklet for more information.

When You Must Be Hospitalized or Need to See a Specialist

If your physician is in the Network and he/she refers you to another medical provider, ask your physician if you can be referred to a specialist or hospital in the Network so you receive maximum benefits. A referral is not required and is not a guarantee that the specialist or hospital you are referred to is in your Network. It is up to you to ensure your providers are participants in the Network and that you have followed preauthorization requirements of the Plan if you want to receive maximum benefits.

When You Are Away from Home

BlueCross BlueShield Global Core Program

The BlueCross BlueShield Global Core Program is an inter-plan arrangement with the Blue Cross and Blue Shield Association. Under this arrangement, when you access covered healthcare services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. Please call 1.800.810.2583 or collect at 1.804.673.1177, 24 hours a day, 7 days a week, when traveling outside the United States for assistance with locating an international provider, in translating foreign languages and submitting claims. For more details regarding the BlueCross BlueShield Global Core Program, please refer to the BlueCross BlueShield of South Carolina Plan of Benefits located on the SRNS InSite and on the www.SouthCarolinaBlues.com website.

If you are traveling outside the U.S. contact BlueCross BlueShield Global Core Customer Service to find out if there are Network providers in the country you'll be visiting. If you need non-emergency inpatient medical care, you must call the BlueCross BlueShield Global Core Service Center, who can help you access

hospitalization at a BlueCross BlueShield Global Core hospital. It is important that you call the BlueCross BlueShield Global Core Service Center in order to obtain access for inpatient care. You should pay the provider of service at the time you receive treatment and obtain appropriate documentation of services received including bills, receipts, letters and medical narrative. You should then complete an International Claim Form and send it to the BlueCross BlueShield Global Core Service Center. Assignments of benefits to foreign providers or facilities will not apply.

Emergencies and Preauthorization

Regardless of the medical option you choose, the Medical Plan offers several programs designed to help you become a better consumer of health care services and to help keep costs of medical and pharmacy services down for both you and the Company.

As described in this section, your provider should call BlueCross to:

- Have each hospital admission preauthorized,
- Receive preauthorization for certain medical services (including diagnostic procedures),
- Access the services of a case manager when a catastrophic or long-term illness occurs,
- Receive authorization of mental health and substance abuse out-patient facility services and admissions (including admissions to residential treatment centers) through CBA.

Preauthorization: Required for Certain Services

Medical policies regarding preauthorization are available for review at www.SouthCarolinaBlues.com

> Insurance Basics

> Understanding Your Coverage

> Medical Policies.

You and your provider must follow certain procedures to avoid financial penalties. The Employer's Group Health Plan requires that all inpatient hospital stays and certain other medical services meet the applicable medical necessity requirements. While Network providers are familiar with pre-admission certification procedures and requirements (which means, there is less likelihood of a conflict in cooperation by a Network physician or facility), the member is responsible for making sure the appropriate preauthorization's have been obtained prior to receiving treatment.

IMPORTANT: Preauthorization is the approval of benefits based on medical necessity prior to the rendering of such benefits to a member. It is not a guarantee of payment. Preauthorization means only that the service is medically necessary. While preauthorization is not a guarantee of claims payment or verification of benefits, it does establish that the requested procedure(s) meets the criteria outlined in the BlueCross Medical Policy. Notwithstanding preauthorization, payment for benefits is subject to a member's eligibility and all other limitations and exclusions contained in this SPD. A member's entitlement to benefits is not determined until the member's claim is processed.

Investigational and/or experimental procedures are procedures, supplies, devices or drugs which, at the time provided, or sought to be provided, are in the judgement of BlueCross and not recognized as conforming to generally accepted medical or behavioral health practice in the U.S., or the procedure, drug or device:

- Has not received required final approval in the U.S. to market from appropriate government bodies;
- Is one about which the peer-reviewed medical literature in the U.S. does not permit conclusions concerning its effect on health outcomes;
- Is not demonstrated in the U.S. to be superior or as beneficial as established alternatives;
- Has not been demonstrated in the U.S. to improve net health outcomes; or,
- Is one in which the improvement claimed is not demonstrated in the U.S. to be obtainable outside the investigational or experimental setting.

Always double check with BCBS Customer Service prior to undergoing any type of procedure and ask if it is investigational or experimental.

In an emergency...

In an emergency, get the care you need immediately.

Then, if you are admitted as a hospital inpatient, call the BlueCross Preauthorization number on the back of your ID card (1.800.327.3238 in South Carolina or 1.800.334.7287 outside of South Carolina) within one business day after your emergency admission.

Routine medical care provided by an emergency room will be reimbursed at a lower level than emergency medical care, regardless of the hospital or physician you use.

if you believe that a trip to the emergency room was for an emergency medical condition, but your Explanation of Benefits from BlueCross shows that the claim was processed as a "routine, non-emergency" visit, then contact BlueCross to discuss your situation.

If you are being admitted to a facility, it is your responsibility to obtain preauthorization for all elective admissions at least 48 hours prior to the admission, and in the case of emergency admissions, within one business day of the admission.

Network providers will often assist you with the preauthorization process. However, preauthorization is ultimately your responsibility.

Preauthorization certification

Preauthorization certification by BlueCross is required for any of the following services and apply to both the Standard and Basic Plan.

The following services/procedures require preauthorization.

Preauthorization Certification required	
Services/procedures	Payment/Penalty
In-Patient	
All admissions require preauthorization. If preauthorization is not obtained, room and board charges will be denied for participating providers. A \$200 penalty will apply when preauthorization is not obtained for non-participating providers.	\$200 penalty (does not count toward deductible or out-of-pocket)
Out-Patient	
Radiology management	
MRI: Payment will be denied without preauthorization	Not Allowed
MRA: Payment will be denied without preauthorization	Not Allowed
CAT scans: Payment will be denied without preauthorization	Not Allowed
Musculoskeletal care	
PET scans: Payment will be denied without preauthorization	Not Allowed
Radiation therapy: One time notification	
Cancer chemotherapy: One time notification	
Sclerotherapy: Benefits will be reduced by 50% of the Allowable Amount without preauthorization	50%
Septoplasty: Benefits will be reduced by 50% of the Allowable Amount without preauthorization	50%
Any surgical procedure that may be potentially cosmetic (i.e., blepharoplasty, reduction mammoplasty): Benefits will be reduced by 50% without preauthorization	50%
Hysterectomy	50%
Investigational or experimental procedures	Not Allowed
Mental health services and substance use disorder services	
Applied Behavioral Analysis (ABA) related to Autism Spectrum Disorder (preauthorization requests and treatment plans must be submitted to Companion Benefit Alternatives). Benefits will be reduced by 50% of the Allowable Amount without a preauthorization	50%
Facility-based inpatient services (no room and board; penalty for non-network)	\$200 per occurrence
Facility-based outpatient services (partial hospitalization, electroconvulsive therapy and intensive outpatient programs)	
Psychological testing	50%
Repetitive transcranial magnetic stimulation	50%
Residential treatment centers	Not Allowed

In addition, the following services/procedures may also require preauthorization.

- Ambulance
- Durable medical equipment, prosthetics and orthopedic devices, if purchase or rental is \$500 or more
- Home health care, including private duty nursing services
- Hospice care
- Oxygen
- Private duty nursing services
- Certain prescription drugs

- Cleft lip or palate (for service not covered under Dental Plan)
- Dental care for accidental injury
- Human organ and tissue transplants
- Obstetrical services outside the terms of the Newborn and Mother's Health Act of 1996
- Orthopedic devices
- Orthotic devices not available on an over-the-counter basis and not otherwise excluded.
- Rehabilitation following severe neurologic or physical impairment by a multidisciplinary team
- Clinical trials
- Pharmacy: Refer to www.SouthCarolinaBlues.com for complete information

What if You Don't Preauthorize Your Hospital Stay?

If preauthorization is not obtained, room and board charges will be denied for inpatient hospital stays at an in-network facility. For an in-patient hospital stay at out of network facilities, a \$200 copayment will be applied.

If you follow preauthorization procedures but your requested hospitalization is not certified and you go into the hospital anyway, no benefits will be paid for the duration of your stay.

If you stay in the hospital beyond the days certified by the Claims Administrator, benefits for the additional days may not be allowed.

These unpaid expenses will be your responsibility and will not count toward your deductible or your annual Out-of-Pocket Maximum.

Maternity Hospital Stay Limit

The Plan complies with the terms of the Newborns' and Mothers' Health Protection Act of 1996. The Plan covers the stay for mother and child in a covered hospital at the normal benefit level (subject to a coinsurance and/or deductible) for up to 48 hours for a vaginal delivery and up to 96 hours for a cesarean section. Medical complications may require longer stays. Preauthorization is required.

Second Surgical Opinions

If your physician recommends elective, non-emergency surgery, you may want to get a second board-certified surgeon's opinion. The opinion must be based on the surgeon's examination of the patient. The examination must be performed after another licensed medical doctor has proposed to perform surgery, but before the surgery is performed. The second licensed medical doctor must not be associated with the primary licensed medical doctor. Second opinions are not required.

You will be responsible for any applicable copay and/or coinsurance for second surgical opinions.

Transplants

If you or your covered dependent is considering any type of transplant, you or your physician should contact the BlueCross preauthorization number on the back of your ID card to discuss the care required. If the transplant is determined to be Medically Necessary by BlueCross, they will recommend a Blue Distinction Center best qualified to perform the specific transplant required. Human organ and tissue transplant services are only covered if provided at a Blue Distinction Center of Excellence or a transplant center approved by BCBS-SC in writing.

If BlueCross has pre-approved your transplant care at a Blue Distinction Center of Excellence and you decide to use the specified Blue Distinction Center, all hospital and physician charges for evaluation, transplant and post-operative care will be paid the same as any other covered Network service. You will also be reimbursed for limited travel and housing accommodation expenses for the transplant patient and one family member or companion* There is a \$10,000 limit on reimbursement for travel and housing. The Plan benefits include the following general travel reimbursement guidelines under the Blue Distinction Centers for Transplants:

- The cost of round-trip airline tickets (or personal vehicle travel expenses will be reimbursed at the mileage rate set by the Federal travel regulations at the time of the travel.) For the pre-transplant work-up, the actual transplant procedure and post-transplant care, for both the patient and a family member* or companion (airline ticket receipts are required, if flying),
- The actual cost of lodging (with a receipt, excluding any incidentals such as phone calls, etc.) up to \$100 per day (combined expenses for the patient and a family member* or companion), and
- The actual cost of meals (with a receipt, excluding any incidentals such as tips, etc.) up to \$40 per day per person for your family member* or companion, and up to \$40 per day for the patient when the patient is not hospitalized during the trip.

* Travel expenses for two family members are reimbursable when the patient is a dependent child.

Prescription Drugs

The Plan pays a percentage of the covered prescription drug charges after you have met your deductible. If you have not met your annual deductible, the covered charge will be applied to your deductible. If this Plan is secondary to another medical insurance plan (for example, your spouse's employer's medical plan), you still need to show your BlueCross ID card to ensure that you will receive maximum benefits.

When you present your BlueCross ID card, your pharmacist will recognize a code on the card and enter information into a computer. The pharmacist will then receive the discounted price electronically from the Pharmacy Benefit Manager system and will charge you the lower of the Pharmacy Benefit Manager program negotiated price or the regular retail price. If you use a network pharmacy, your pharmacy claim will be transmitted to BlueCross (Note: Pre-authorization from BlueCross is required for some drugs. You will be notified when the medication is dispensed if it requires pre-authorization.)

OptumRx is the Pharmacy Benefits Manager for BlueCross and in that role, administers the prescription drug program for this Plan. Contact OptumRx at 855.811.2218.

Mail Service Saver Program (Mandatory)

What Is the Mail Service Saver Program?

It's a program that requires you to have prescriptions for drugs which are considered "maintenance drugs" filled through an Optum Mail pharmacy. OptumRx is an independent company that provides pharmacy services on behalf of your health plan.

Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily or routine use of medicines. Examples of maintenance drugs are those used may include, but not be limited to treat high blood pressure, heart disease, asthma and diabetes.

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.

How Does the Program Work?

If you are not already getting 90-day supply maintenance medications through the mail-in pharmacy, you have a limited time to enroll before you will be required to fill at an Optum Mail Pharmacy.

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-in 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 (855) 811-2218.
- 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. Then OptumRx will call you to complete the initial mail order pharmacy setup or you can call OptumRx to complete the process.
- You can complete a mail service order form and send it to OptumRx Mail Service with your doctor's prescription (the form is attached).
- Active prescriptions can be electronically transferred to mail order via the My Health Toolkit App.

Not Covered

If you do not enroll in Mail Service, your maintenance prescriptions will not be covered by your pharmacy benefit once your grace period fills are exhausted.

Three Tier Drug Coverage

The SRNS Plan for prescription drugs has a three-tier design plus specialty drugs. The first tier is generic drugs. The second tier is preferred brand name drugs, and the third tier is comprised of non-preferred brand name drugs. The level of benefit paid by the Plan depends on whether the drug is generic, preferred brand (also called "formulary") or non-preferred brand.

The SRNS Plan for prescription drugs has a three-tier design plus specialty drugs. The first tier is generic drugs. The second tier is preferred brand name drugs, and the third tier is comprised of non-preferred brand name drugs. The level of benefit paid by the Plan depends on whether the drug is generic, preferred brand (also called "formulary") or non-preferred brand.

Three-Tier Standard and Basic Prescription Drug Coverage *(after deductible is met)*

Tier 1: Generic Drugs		
Standard Medical Plan	Basic (High Deductible Health Plan)	Mail Order Basic / In Network (High Deductible Health Plan)
You pay 10%, the company pays 90%	You pay \$10	You pay \$25 for a 90-day supply
For the lowest out-of-pocket expense, you should always consider Tier 1 generic drugs if you and your physician decide they are appropriate for you. Generic drugs can be dispensed at a retail pharmacy, with a maximum 90-day supply. Generic drugs have a chemical structure that has the same bioequivalence as a brand name drug but are not manufactured under a registered brand name, trademark or sold under a brand name. The Claims Administrator has the discretion to determine if a prescription drug is a generic drug.		

Tier 2: Preferred Brand Name Drugs		
Standard Medical Plan	Basic (High Deductible Health Plan)	Mail Order Basic / In Network (High Deductible Health Plan)
You pay 20%, when no generic equivalent is available	You pay 20%, maximum \$35	You pay 20%, maximum \$87.50
Preferred brand name drugs, also known as formulary drugs, are safe, effective brand name prescription drugs available at a lower cost than some competing brand name drugs. Consider a Tier 2 drug if no Tier 1 drug is available to treat your condition. Preferred brand name drugs can be dispensed at a retail pharmacy with a maximum 31-day supply. Note: When a generic equivalent is available but not used, in addition to paying Tier 2 co-payment, the Mandatory Generic Penalty described below will be applied.		

Tier 3: Non-preferred Brand Name Drugs		
Standard Medical Plan	Basic (High Deductible Health Plan)	Mail Order Basic / In Network (High Deductible Health Plan)
You pay 30%, when no generic equivalent is available	You pay 30%, maximum \$50	You pay 30%, maximum \$125
Non-preferred brand name drugs, also known as non-formulary drugs, are brand name drugs that have lower-cost alternatives available. Talk to your physician about Tier 1 and Tier 2 drugs that may be appropriate for you. Non-preferred drugs can be dispensed at a retail pharmacy with a maximum 31-day supply. Note: When a generic equivalent is available but not used, in addition to paying Tier 3 copayment, the Mandatory Generic Penalty described below will be applied.		

In addition, the Plan uses three BlueCross drug management programs: Mandatory Generic, Step Therapy and Quantity Management.

Drug lists for the three tiers and the drug management programs change periodically and updated information on these programs can be found by logging into My Health Toolkit (Benefits > Prescription Drugs > Drug Lists and Programs). You may also call BlueCross Customer Service at 800.325.6596.

Maintenance Medications must be purchased through the Mail Service Saver Program.

There are two additional categories of prescription drugs:

1. The ACA Preventive Drug list is applicable under both the Standard and Basic plans.
2. The Maintenance Preventive Drug list is applicable under the Basic Plan. These drugs may be purchased before you meet the deductible.

Mandatory Generic Prescriptions

The Mandatory Generic program can help you save money on the prescription drugs. When a generic equivalent is available for your brand-name drug, your pharmacist will ask if you want to take the generic instead. If your doctor indicated on the prescription that generic substitution is allowed and you approve, it, your pharmacist will fill your prescription with the generic medication. You'll pay the copayment (after you meet your deductible) for your prescription.

If you are prescribed a preferred or non-preferred brand name drug when a generic equivalent drug is available, you may pay more out of pocket. You must pay the preferred or non-preferred coinsurance after you meet your deductible, PLUS any difference in cost between the generic and the brand name drug. Even when your doctor requests that a brand drug be "Dispensed as Written," you will still be required to pay the cost difference. The cost difference does not count toward your deductible or out-of-pocket limits.

This same policy also applies if your doctor indicates that your prescription should be dispensed as written, with no substitutions. In this case, your prescription is filled according to doctor's orders. However, you still must pay the brand copayment, as well as the difference in cost between the generic and brand name drug. Speak to your doctor about the possibility of using generics instead of the more expensive brand name drugs.

Under the ACA, if your doctor prescribes a brand name drug when there is a generic available and your claim is denied, your physician may submit a "Generic Program Exception Request". For an exception to be granted, the following criteria must be met:

1. The generic has been ineffective in the treatment of the member's condition;
2. Based on sound clinical evidence, the known relevant physical or mental characteristics of the member and known characteristics of the drug regimen, the generic is likely to be ineffective or adversely affect patient compliance; or
3. The generic has caused or based on sound clinical evidence, is likely to cause an adverse reaction or other harm to the member.

The Generic Program Exception Request is available on My Health Toolkit (Benefits > Pharmacy > Drug Lists and Drug Management Program > Mandatory Generic Programs).

Generic Prescription vs. Preferred Brand	
Cost to Member for a Preferred Brand Drug When Generic is Available: Standard and Basic Plan	
Member Copayment on Preferred Drug (Cost \$80)	20% \$16
Plus, Preferred Brand Drug Cost	\$80
Less: Generic Drug Cost	-\$30
Brand less Generic Drug Cost	\$50
Member pays for preferred brand	\$66
Member generic cost	\$6

Step Therapy

Step Therapy is a quality and safety program that can help you lower your medication costs. Many medical conditions can be treated using a variety of medications. In some cases, there is a very large difference in cost among the medications, but only a little difference in the way the medications work. Step Therapy requires members to try cost-effective "first-choice" medications before trying (or "stepping up to") more expensive "second-choice" medications. Many people find the first-choice medications work just as well for them.

The Step Therapy program is based on Food and Drug Administration (FDA) and manufacturer dosing guidelines, medical literature, safety, accepted medical practice, appropriate use and benefit design. The program only affects the medications your benefit plan covers. You and your doctor should make the final decision about the medications that are right for you. The list of drugs that require you to try a first-choice alternative is updated periodically and can be found by logging into My Health Toolkit My Health Toolkit (Benefits > Prescription Drugs > Drug Lists and Programs). If your doctor prescribes a second-choice medication and the first-choice medications are not right for you, please have your doctor call the OptumRx Customer Service department at 855.811.2218.

When you go to the pharmacy, the pharmacist will enter your prescription into the computer system. If your prescription is a second-choice medication, the system will check your claims history. If you have filled prescriptions for first-choice medications, the pharmacist will fill your prescription for a second-choice medication. If you are required to try a first-choice medication, you have three options:

1. You or your pharmacist may call your doctor to change your prescription to a first-choice medication. You will pay the appropriate coinsurance amount after the deductible. The cost of the prescription will be applied to your deductible and Out-of-Pocket Maximum.
2. You can pay full price for your second-choice medication prescription and none of the cost goes toward the deductible or the Out-of-Pocket Maximum.
3. You or your pharmacist can ask your doctor to request a medical necessity exception. If the exception is approved, you will pay the appropriate coinsurance amount after the deductible and the cost of the prescription will be applied to your deductible. If the exception is denied, you will pay the full cost of the Second-choice prescription and none of the cost goes toward the deductible or the Out-of-Pocket Maximum.

If the BlueCross approves the request, it will cover your prescription. If your request is denied, you can still choose option 1 or 2.

If you submit your prescription to a mail-order pharmacy and do not meet the requirements for a second-choice medication, the pharmacy will not fill your prescription and will notify you by mail.

Quantity Management

The Quantity Management program is a quality and safety program that promotes the safe use of medications. The program limits the amount of some medications that are covered.

Quantity Management limits are based on FDA and manufacturer dosing guidelines, medical literature, safety, accepted medical practice, appropriate use and benefit design. The limits only affect the amount of medication the benefit plan covers. You and your doctor make the final decision about the amount of medication that is right for you.

The most recently updated list of medications is posted on the www.SouthCarolinaBlues.com website. Log into My Health Toolkit (Benefits > Prescription Drugs > Drug Lists and Programs). You should review the list of medications to determine if quantity limits apply to you.

For most medications on the list, the Plan will only cover a set amount within a set timeframe. The Plan will cover higher amounts of some medications when medically necessary.

Certain drugs on the list will be annotated to indicate that they are eligible for consideration for a medical necessity override for a larger amount. If you need more of these medications, please have your doctor call OptumRx Customer Service to make request at 855.811.2218.

When you go to the pharmacy the pharmacist will enter your prescription information into the computer system. If the drug has a limit on the covered amount, the pharmacist will fill your prescription as long as it does not exceed the limit. If your prescription exceeds the quantity limit, you have three choices.

1. Your pharmacist can reduce your prescription to the quantity your health plan covers.
2. You can pay full price for all your prescription or for the portion that exceeds the limit.
3. You or your pharmacist can ask your doctor to get a quantity override if one is available.

If the Plan approves the additional quantity, it will pay for it in accordance with drug reimbursement schedule. If the Plan does not approve it or the override is not available, you can still choose option 1 or 2.

If you submit your prescription to a mail service pharmacy and (1) you do not meet the requirements for an override for an additional quantity or (2) an override exception is not available for your drug, the pharmacy will not fill your prescription. It will return your prescription to you.

Prior Authorization

Prior Authorization is a quality and safety program that promotes the proper use of certain non-specialty medications. Note: there is a separate list for specialty drugs. If your doctor prescribes a medication that is included in the Prior Authorization program, you must get prior approval before your plan will cover your medication.

The Prior Authorization program is based on FDA and manufacturing guidelines, medical literature, safety, accepted medical practice, appropriate use and benefit design. This program only affects the medication your benefit plan covers. You and your doctor should make the final decision about the medication that is right for you.

The list of drugs that require Prior Authorization is posted on the www.SouthCarolinaBlues.com website. Log into My Health Toolkit (Benefits > Pharmacy > Drug Lists and Drug Management Programs). If your doctor prescribes a medication that needs Prior Authorization, have your doctor call OptumRx Customer Service to make request to 855.811.2218.

Specialty Pharmacy

Specialty drugs are prescription medications that are used to treat complex or chronic medical conditions like cancer, rheumatoid arthritis, multiple sclerosis and hepatitis, to name a few. These drugs are often self-injected and usually require patient-specific dosing and careful clinical monitoring. They may also require special handling and refrigeration.

The specialty drug prior authorization program is based on FDA and manufacturing guidelines, medical literature, safety, accepted medical practice, appropriate use and benefit design. This program only affects the medication your benefit plan covers. Optum Specialty Pharmacy is the Specialty Drug Benefit Manager and can be contacted at 877.259.9428.

Refills

The Medical Plan covers up to a 90-day supply of medication for generic drugs dispensed by retail pharmacies and for brand name drugs dispensed by mail order unless otherwise restricted under the Quantity Management program. The Plan covers up to a 31-day supply for brand name drugs dispensed at retail. Also, 75% of the days supplied on the prescription must have elapsed before a prescription refill will be considered a covered charge.

If you have special needs that require a longer supply, or you need a re-fill before the 75% rule is satisfied, contact BlueCross to discuss your individual situation. Prescription drug refills beyond one year from the original prescription date will not be covered. If you have other questions concerning the Prescription Drug discount program, you should contact OptumRx Customer Service at 855.811.2218.

Manual Claim Filing for Prescriptions

You will need to file your claim using a claim form if:

- You use a non-network pharmacy or
- You forget to show your BCBS-SC identification card or
- You are filing claims as the secondary payer (in which case you will also need to include the Explanation of Benefits from the primary payer).

The Prescription Drug Claim form can be obtained through OptumRx Customer Service by calling 855.211.2218. When completing a prescription drug claim form:

- Use a separate form for each family member
- Completely fill out Part One of the claim form
- Attach a drug receipt that includes:
 - Date the prescription was filled
 - Name/address of the pharmacy
 - Name of drug and strength
 - Quantity
 - How many days supply
 - National Drug Code
 - Prescription number
 - Amount paid

The prescription drug claim form should be mailed to OptumRx at the address noted at the beginning of this book.

Mail Order Prescriptions

The Plan covers mail order prescription refills through the Pharmacy Benefit Manager system. Prescription drugs will be delivered by mail directly to your home in plain, tamper-evident packaging. You can get up to a 90-day supply of prescription drugs through mail order. This option can be significantly less costly for many medications. Detailed information on the mail order program can be found on the BlueCross website.

Prescription Drug Exclusions: What's not covered

1. Prescription drugs that are specifically listed on the BlueCross website as excluded;
2. Prescription drugs that have not been prescribed by a provider acting within the scope of his or her license;
3. Drugs not approved by the FDA;
4. Prescription drugs for non-covered therapies, services or conditions;
5. Prescription drug refills more than the number specified on the provider's prescription order or refills dispensed more than one year after the original prescription date;
6. More than a 31-day supply for prescription drugs (90-day supply for prescription drugs obtained through a mail service pharmacy), except as specified on the Schedule of Benefits or unless the quantity is limited by a Quantity versus Time program;
7. Any type of service or handling fee (except for the dispensing fee charged by the pharmacist for filling a prescription) for prescription drugs, including fees for the administration or injection of a prescription drug.
8. Dosages that exceed the recommended daily dosage of any prescription drug as determined by the Corporation based on the following guidelines as described in the current:
 - a. United States Pharmacopeia;
 - b. Facts and Comparisons;
 - c. Physicians' Desk Reference; and/or,
 - d. National Formulary
9. Prescription drugs used for or related to cosmetic purposes, including hair growth and skin wrinkles, except as specified on the BlueCross Schedule of Benefits;

10. Prescription drugs related to any treatment for infertility or impotence (except when prescribed for benign prostatic hypertrophy), including, but not limited to, fertility drugs, except as specified on the Schedule of Benefits;
11. Over-the-counter (OTC) drugs and over-the-counter supplies or supplements, except for OTC drugs that are designated by the Corporation as prescription drugs and are listed as covered on the Prescription Drug List (PDL) and are prescribed by a Provider;
12. Prescription drugs that are being prescribed for a specific medical condition that are not approved by the FDA for treatment of that condition (except for prescription drugs for a specific medical condition that have at least two formal clinical studies, or prescription drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one standard, universally accepted reference compendia or is found to be safe and effective in formal clinical studies, the results of which have been published in peer reviewed professional medical journals);
13. Prescription drugs that are not consistent with the diagnosis and treatment of a member's illness, injury or condition, or are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care or are not provided in compliance with any applicable place of service requirements;
14. Prescription drugs or services administered or dispensed when the required preauthorization is not obtained;
15. Prescription drugs for injury or disease that are paid by worker's compensation benefits (if a worker's compensation claim is settled, it will be considered paid by worker's compensation benefits);
16. Prescription drugs for obesity or weight control;
17. Prescription drugs that are not authorized when part of a Step Therapy program;
18. Prescription drugs which are new to the market and which are under clinical review by BlueCross shall be listed on the PDL as excluded until the clinical review has been completed and a final determination has been made as to whether the drug should be covered;
19. Prescription drugs, regardless of therapeutic class, that are determined to offer no clinical or cost-effective advantage over other comparable prescription drugs already covered under the PDL; and,
20. Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, except for prescription prenatal vitamins or prescription vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency
21. Maintenance Medications not purchased through the Mail Service Saver Program through OptumRx

Health Savings Account

In conjunction with the Basic Plan, SRNS offers the opportunity to participate in an HSA. Once you are enrolled in the Basic High Deductible Health Plan, you may be eligible to establish a tax-advantaged HSA to pay for eligible health care expenses.

An HSA is a tax-exempt trust or custodial account set up with a qualified trustee. The qualified trustee for SRNS is HSA Bank. You may access your account directly from HSA Bank or from links available on the BlueCross Web Site at www.SouthCarolinaBlues.com and My Health Tool Kit. SRNS will provide, with your authorization, HSA Bank with the initial information required to set up the HSA account.

The HSA offers you a triple tax advantage:

- Tax deductible contributions
- Tax-free while you are saving
- Taxes not deducted when used to pay for qualified medical expenses

HSAs are complex. This section provides general guidelines, but if your situation is complex (switching between Employee Only and Family, wanting an employee and the spouse have separate accounts, etc.) you should refer to the Internal Revenue Service (IRS) publication 969 at www.irs.gov/pub/irs-pdf/p969.pdf or you may call HSA Bank at 866.471.5946 or visit their website at www.hsabank.com.

To be eligible to contribute to an HSA:

- You must be enrolled in the SRNS Basic Medical Plan
- You cannot be enrolled in Medicare (Part A or B)
- You cannot be claimed as a dependent on someone else's tax return
- You do not have other non-HSA compatible coverage such as a Health Care Traditional FSA or Health Reimbursement Arrangement (HRA)
- You cannot be covered under TRICARE or a former employer's plan, in addition to your coverage at SRNS
- You are not a veteran who has received medical treatment through the Veterans Health Administration.

The company may provide an employer contribution into an HSA with HSA Bank. For new hires, this employer contribution will be prorated based on your month of hire. This amount will be determined during Open Enrollment each year.

When can I open an account?

For new hires, according to the IRS, the account cannot be opened until the first of the month after your hire date. All other eligible active employees can open an account during Open Enrollment. If you decline enrolling in an HSA when you first sign up for the Basic Plan, you may be able to open an account during the year. SRNS will send enrollment data to HSA Bank on your behalf. You cannot open an account if a Post Office box is used as your address.

Contributions to the account

As an active employee, you may contribute to your HSA through pre-tax payroll deductions that you authorize. The 2025 IRS annual contribution limits into your HSA are as follows. You will be notified of any changes to these limits in the Health Plan annual Open Enrollment period each year.

Health Savings Account	2026 Annual Contributions*	Over 55 Limit
Employee Only	\$4,400	\$5,400
Employee + One or More As of Jan. 1, 2026	\$8,750	\$9,750

Health Savings Account	2025 Annual Contributions*	Over 55 Limit
Employee Only	\$4,300	\$5,300
Employee + One or More As of Jan. 1, 2025	\$8,550	\$9,550

To determine how much, you may contribute during the year, you should reduce the annual contribution by the amount the company contributes (see your annual Open Enrollment materials posted on InSite). You can change it any time during the year through PeopleSoft eApplications.

The sum of your contributions into your HSA can vary but the sum of your calendar year contributions cannot exceed the annual contribution limit. It is the employee's responsibility to ensure they do not exceed the annual contribution limit. There may be tax consequences if you exceed the annual contribution maximum.

If you change coverage levels within the Basic Plan during the year (between Employee Only and Employee Plus One or More), you will have to recalculate your annual contribution amount. You should refer to the instructions for IRS Form 8889 on how to calculate this new amount or contact HSA Bank.

Key Points of the Health Savings Account

- If you are 55 years of age or older, your annual contribution limit is increased by \$1,000.
- Your unused balance in your HSA rolls over from year to year allowing your account balance to grow tax-free.
- You are permitted to make payroll contribution changes at any time throughout the year without a Qualifying Event.
- You are the owner of your HSA and are responsible for maintaining records of your medical expenses that satisfy IRS requirements.
- You are no longer eligible to contribute to an HSA once you are enrolled in Medicare (Part A or B). Accordingly, if you attain age 65 and are no longer covered under this Plan, your dependent spouse and/or children will not be eligible to contribute to or receive Employer contributions towards the HSA account (though you may continue using your existing balance to pay for future unreimbursed medical expenses).
- Per IRS regulations, the account is an individual account, not a joint account. The account must be set up in the employee's name who is having the deductions taken from their paycheck.

Mid-Year Eligibility Changes

You, as the employee, are responsible for managing your HSA according to the applicable tax laws and regulations.

The following are some examples of changes that you may want to consider in the management of your HSA. Individuals who become HSA eligible, lose HSA eligibility, or change High Deductible Health Plan coverage levels mid-year are limited in the amount they can contribute to their HSAs.

In general, if you were eligible at the end of the year, and on the first day of every month during the year you were, or were considered, an eligible individual with the same coverage you may contribute up to the annual maximum amounts.

IRS Last Month Rule

If you are an eligible individual on the first day of the last month of your tax year (December 1 for most taxpayers), you are considered an eligible individual for the entire year. However, there is an IRS testing period. If contributions were made to your HSA based on you being an eligible individual for the entire year under the last-month rule, you must remain an eligible individual during the testing period. For the last month rule, the testing period begins with the last month of your tax year and ends on the last day of the 12th month following that month (for example, December 1, 2021 through December 31, 2022).

How to use your HSA

You 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.

If you have questions, contact HSA Bank at 866.471.5946 or www.hsabank.com.

Note

If there is a discrepancy between what is presented in this section and what is presented by HSA Bank and the IRS, IRS rules will be followed first, then HSA Bank rules.

Questions? Contact us

SRNS Service Center

Telephone 803.725.7772 or 800.368.7333

Email Service-Center@srs.gov

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

This Summary Plan Description does not create an express or implied contract of employment. Eligibility for benefits should not be viewed as a guarantee of employment. Also, while SRNS SRR, SRMC and BSRA intend to continue providing comprehensive benefits programs, the Companies reserve the right to modify or terminate any of the benefit plans at any time. The Companies will provide advance notification of any future benefit changes.

Acronyms

ACA Affordable Care Act

BCBS BlueCross BlueShield

BCBS-SC Blue Cross Blue Shield - South Carolina

BSRA Battelle Savannah River Alliance

CAT Computed tomography, also called CT

CBA Companion Benefit Alternatives

COB Coordination of Benefits

COBRA Consolidated Omnibus Budget Reconciliation Act

EAP Employee Assistance Program

FDA Food and Drug Administration

FSA Flexible Spending Account

HRA Health Reimbursement Arrangement

HSA Health Savings Account

ID identification

IRS Internal Revenue Service

LOA Leave of Absence

LSE Limited-Service Employee

LTD Long-Term Disability

MRA Magnetic resonance angiography

MRI Magnetic resonance imaging

NDC National Drug Code

OTC over-the-counter

PDL Prescription Drug List

PET Positron emission tomography

PPO Preferred Provide Option

POS Point of Service

SRMC Savannah River Mission Completion, LLC

(new successor contractor beginning early 2022)

SRNS Savannah River Nuclear Solutions

SRR Savannah River Nuclear Solutions

SRS Savannah River Site

USERRA Uniformed Services Employment and Reemployment Rights Act of 1994

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

**Savannah River Nuclear Solutions
Medical Plan: Part One**

Amended And Restated Effective January 1, 2026