



Summary Plan Description

Vision Care Plan

Savannah River Nuclear Solutions, LLC

Amended and Restated Effective January 1, 2024

Savannah River Nuclear Solutions, LLC Summary Plan Description

Vision Care Plan

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Vision Care is a comprehensive eye care benefit plan designed to help cover your expenses for eye examinations.

Savannah River Nuclear Solutions, LLC (SRNS) maintain vision benefits under the Vision Plan ("Plan").

EyeMed Vision Care, LLC has been contracted by SRNS to manage the benefits under this plan under a fully insured arrangement underwritten by Fidelity Security Life Insurance Company. The plan is funded 100% by employee premium contributions.

SRNS is also referred to as the "Employer" or "Company" in this Summary Plan Description ("SPD"). This document, together with the administrative policies and procedures of EyeMed, LLC ("the Claims Administrator" or "EyeMed"), and insurance documents of Fidelity Security Life Insurance constitute the Plan Document. If there is a conflict between this Summary Plan Description and the insurance documents, the insurance documents will govern. This SPD describes the Plan as of January 1, 2024. Please read this summary carefully. The Employer, however, reserves the right to amend or terminate the Plan, at any time.

The Vision Care plan does not cover medical or surgical treatment of the eye. Refer to your Medical Care Summary Plan Description for information on coverage of medically necessary eye procedures.

The Company, through its Health and Welfare Benefit Committee delegated as its Plan Administrator (the "Plan Administrator"), is responsible for maintaining the enrollment, payroll and other records related to, and administration of, the Plan. You should contact the Company through the Service Center for questions about enrollment and eligibility in the Plan.

As the Claims Administrator, EyeMed 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 or law. Any decision by the Plan Administrator or Claims Administrator that does not constitute an abuse of discretion must be upheld by a court of law.

This document is merely a summary of the provisions of the Vision Plan. The Vision Plan Document consists of the administrative policies and procedures of EyeMed, LLC and, insurance documents of Fidelity Security Life Insurance and the SRNS Welfare Benefit Plan, referred to as a Wrap Plan together constitute the Plan Document. If there is a conflict between this document and the terms of the Vision Plan, the terms of the Vision Plan will control. While SRNS intends to continue the Vision Plan indefinitely it may amend or terminate the Vision Plan, for any reason, at its sole discretion. If there is a conflict between this SPD and the terms of the Vision Plan, the terms of the Vision Plan will control.

Questions?

Plan Eligibility and Enrollment

SRNS Service Center

Telephone 803.725.7772
or 800.368.7333

Email Service-Center@srs.gov

Mail SRNS Service Center
Building 730-1B
Aiken, SC 29808

Claims

EyeMed Vision Care Customer Service

Telephone 1.866.800.5457

Web www.eyemedvisioncare.com

Mail Claims Processing Center
P.O. Box 8504
Mason, OH 45040-7111

Hours of Operation

Monday–Saturday
7:30 a.m. to 11 p.m.

Sunday
11 a.m. to 7 p.m.

Vision benefits at a glance

| Service | Low Option <i>(Frequency: Once every calendar year)</i> | | High Option <i>(Frequency: Once every calendar year)</i> | |
|---|---|------------------------------|---|------------------------------|
| | | | | |
| Eye Exam with Dilation | \$15 copay | Up to \$35 | \$10 copay | Up to \$35 |
| Standard Contact Lens fit/follow-up | Up to \$55 | | Up to \$55 | |
| Premium Contact Lens fit/follow-up | 10% off retail price | | 10% off retail price | |
| Retinal Imaging | Up to \$39 | | Up to \$39 | |
| Standard Plastic Lenses | | | | |
| Standard Single, Bifocal, Trifocal Lenses | \$0 copay | Up to \$25, \$40, \$55, \$55 | \$0 copay | Up to \$25, \$40, \$55, \$55 |
| Premium Progressive Tier 1-3 | \$20-45 copay | up to \$55 | \$20-45 copay | up to \$55 |
| Premium Progressive Tier 4 | \$0 copay plus 80% of charge, less \$120 allowance | up to \$55 | \$0 copay plus 80% of charge, less \$120 allowance | up to \$55 |
| Frames | \$0 copay to \$100 allowance for any frame; plus 20% balance over \$100 | up to \$50 | \$0 copay to \$160 allowance for any frame; plus 20% balance over \$160 | up to \$50 |
| Lens Options | | | | |
| UV Coating | \$15 | | \$0 | Up to \$5 |
| Tint (Solid and Gradient) | \$0 | Up to \$5 | \$0 | Up to \$5 |
| Standard Scratch Resistant | \$0 | Up to \$5 | \$0 | Up to \$5 |
| Standard Polycarbonate | \$40 | | \$0 | Up to \$5 |
| Standard Anti-Reflective | \$45 | | \$45 | |
| Premium Anti-Reflective Tier 1-2 | \$57-\$68 | | \$57-\$68 | |
| Premium Anti-Reflective Tier 3 | 20% discount | | 20% discount | |
| Photochromatic/Transitions Plastic | Up to \$75 | | Up to \$75 | |
| Other Add-ons and Services | 20% discount | | 20% discount | |

Vision benefits at a glance (continued)

| Service | Low Option <i>(Frequency: Once every calendar year)</i> | | High Option <i>(Frequency: Once every calendar year)</i> | |
|--------------------------------|--|-------------|---|-------------|
| Contact Lenses | | | | |
| Conventional | \$0 copay, 15% discount off balances over \$145 | up to \$116 | \$0 copay, 15% discount off balances over \$160 | up to \$116 |
| Disposable | \$0 copay, 100% of balance over \$145 | up to \$116 | \$0 copay, 100% discount off balances over \$160 | up to \$116 |
| Medically Necessary | \$0 copay | up to \$200 | \$0 copay | up to \$200 |
| Laser Vision Correction | 15% off retail price or 5% off promotional price | | 15% off retail price or 5% off promotional price | |

**You are responsible to pay the out-of-network provider in full at time of service and then submit an out-of-network claim for reimbursement. You will be reimbursed up to the amount shown on the chart. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.*

Participating in the Plan

Eligibility

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

You are not eligible to participate in this Plan if you:

- are 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 or any federal, state or local agency),
- perform services under an agreement between the Employer and a leasing organization,
- are a union employee of the Employer whose benefits are the subject of good faith bargaining, and the collective bargaining agreement does not provide for you to participate in this Plan,
- are a high school/post-secondary student participating in School-to-Work programs.

Quick Look: Coverage eligibility

| Your status | Eligibility |
|---|--|
| Full Service Employees <i>(excluding Craft Option B Union workers)</i> | Yes, eligible. <i>(also, you can't be covered both as an employee and a dependent.)</i> |
| Retiree rehires and dependents | No, not eligible |
| Retirees | No, not eligible |

See **“Coverage Continuation in Special Situations”** at the end of this section for information on when coverage ends in the event of termination of employment for long term disability, retirement, and/or leaves of absences.

Eligible Dependents

Your dependents that are eligible for enrollment in the Vision plan include your lawful spouse (in accordance with state law in your state of residence) and your “children.”

You will be required to provide proof of eligibility for all covered dependents by submitting appropriate documentation. (See https://www.srs.gov/general/jobs/benefits/documents/acceptable_documents.pdf)

If you are divorced, your ex-spouse is no longer eligible to be covered as your dependent under the Vision Plan as of the date of your divorce decree. (Coverage continuation may be available through COBRA Continuation Coverage.)

Children include your own children, your legally adopted children (from the time they are legally placed with you), your stepchildren and children supported solely by you for whom you have been appointed legal guardian.

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. (See the Glossary for the definition and requirements of Medical Child Support Order.)

Your child must be under age 26, or satisfy the disabled/handicapped qualifications if over age 26 (see below). Your disabled/handicapped dependent child may continue coverage after attainment of age 26 if your child meets all of the following requirements:

- is incapable of sustaining employment by reason of a disabling mental handicap or physical handicap;
- is solely supported by the employee and claimed as dependent on your current federal income tax return; and
- the disability must have begun before age 26 and your child must remain continuously disabled beyond the age limit.

You must provide written proof of such dependency and incapability to EyeMed for evaluation. You will be requested to periodically provide proof of the disability to continue the child’s eligibility under the Vision Plan.

Special Rules for “Dual” Couples

If you and your spouse are both employees of the Company, you cannot be covered as both an employee and as a dependent. Additionally, employees and/or dependents cannot be covered under both SRNS Vision Plan, SRMC and/or BSRA Vision Plan.

A dependent child may not be covered by more than one SRNS employee. 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.

Enrolling for Coverage and Requesting Election Changes

During the Plan enrollment process, you will be asked to elect:

- Vision coverage or no Vision coverage
- Coverage for yourself only, you and one dependent, or you and two or more dependents.

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 your elections and return your enrollment form to the Service Center. Your coverage will be effective on your first day of the month following your hire date as a full-service employee.

If you fail to make an election during the first two weeks, you and your dependents will not have any vision coverage under the Plan until January 1 of the following year (that is, if you elect to cover them during the next annual enrollment period) unless you have a Change in Status as described below.

You can elect coverage, and add or remove eligible dependents from your coverage during the annual open enrollment period for the coverage to be effective at the beginning of the next calendar (Plan) year.

If you decline enrollment for yourself or your dependents (including your spouse) because of other vision insurance coverage and you subsequently lose such coverage, the event may qualify as a "Change in Status" (see section titled "Change in Status") 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.

If you, your spouse or dependent child experiences an event that qualifies as a Change in Status (see the section titled "Change in Status") 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.

To add or remove eligible dependents from your coverage with a Change in Status, complete OSR Form 5-200 (available on InSite and/or by contacting the Service Center). Submit the form and supporting documentation to: Service Center, Building 730-1B, Aiken, SC 29808 within 60 days of the Qualifying Change in Status. Any change you are able to make under the Plan must be consistent with your Qualifying Change in Status.

If a Qualifying Change in Status occurs during the Plan Year (calendar year), you will 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, or waiver) under your medical, dental and vision care elections.

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

Whenever you are adding or removing a dependent from coverage, you may be requested to supply a copy of an official document such as a birth certificate, marriage certificate, 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.

If you, your spouse or dependent child experiences an event that qualifies as a Change in Status (see section "Change in Status") but you do not need to change your coverage status, you should still immediately notify the Service Center. 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 Change in Status and eligibility for benefits, and will have the final decision making authority regarding any allowable changes.

Have a change?

Contact the Service Center at 803.725.7772 with information on a Qualifying Change in Status or an address change. Do not call the Claims Administrator.

If you, your spouse or dependent child experiences an event that qualifies as a Change in Status but you do not need to change your coverage status, you should still immediately notify the Service Center. Accurate records are important to ensure proper coverage for you and your dependents.

The benefit change you 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 Plan or the spouse's or dependent child's employer's plan.

Change in Status

Generally, you are permitted to make Plan election changes only during the annual enrollment period, which will be effective beginning January 1 of the following year, and your Vision Plan elections must stay in effect for the full calendar year (also known as the Plan Year). You cannot change your benefit elections during the calendar year unless you have an event that qualifies as a Change in Status 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.

The benefit change 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 Plan or the spouse's or dependent child's employer's plan.

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 shall constitute fraud or an intentional misrepresentation and will result in the retroactive rescission of coverage. The Plan will 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. In the event of a divorce, the "60-day clock" begins on the date of the final divorce decree. Submit Form OSR 5-200, "Health Care Enrollment/Change Form" to the Service Center to remove your dependents from the Plan.

What qualifies?

The following events may be considered a "Qualifying Change in Status" if they result in a change in eligibility for health care.

A change in legal marital status: An event that changes an employee's legal marital status, including marriage, death of spouse, divorce, legal separation or annulment.

A change in number of dependents: An event that changes an employee's number of dependent children, including birth, adoption, placement for adoption, death of a dependent child or the acquisition of a stepchild.

A change in employment status: The termination or commencement of employment by the employee, spouse or dependent child, or the commencement of or return from unpaid leave of absence.

A change in work schedule: The permanent reduction or increase in hours of employment by the employee, spouse or dependent child (including a switch between part-time and full-time), a strike or lockout, or the commencement or return from an unpaid leave of absence.

A change in which a dependent child satisfies or ceases to satisfy the Plan's eligibility requirements: An event that causes an employee's dependent child to satisfy or cease to satisfy the requirements for coverage due to attainment of maximum age under the plan or any similar circumstance under the plan that qualifies or disqualifies the child for coverage under the plan.

Identification Cards

If you are enrolled in the Vision Plan, your EyeMed identification card will provide information for your vision provider to use to verify your eligibility for vision coverage and to assist in filing a claim. If you do not have an identification card, you can self-identify yourself as an EyeMed participant when obtaining vision services. For replacement cards, contact EyeMed customer service, or you can print a replacement by creating an account at eyemed.com or downloading the EyeMed Members App through the App Store or Google Play to access a digital version.

Coverage Effective Date and Cost

Your coverage begins on the 1st day of the month following your hire date, unless you waive your coverage. If you waive coverage and enroll during the annual open enrollment or upon a Qualifying Change in Status, your coverage is effective as of the beginning of the Plan Year (calendar year), or on the effective date of your Change in Status, whichever applies. Coverage for your eligible dependents, if you elect to cover them, begins at the same time as your coverage, or on the first day of the month following your effective date of your Change in Status, whichever applies.

The Plan is funded entirely by employee contributions. The amount of your premium contribution depends on whether you elect coverage for yourself only or for you and your dependents. Vision Premiums are not pro-rated. The amount of your premium will be for the entire month based on the Vision Plan selected and whether you elect coverage for yourself only or for you and your dependents. 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. Your premium will coincide with the level of coverage (employee only, employee +1, or employee +2 or more) that is in effect for the month.

As an active employee, if eligible, your premium contributions are deducted from your pay before Social Security and federal and state income taxes are computed and withheld. You will be billed separately on an after-tax basis if you do not have enough in your paycheck to cover your premiums. The monthly premium contribution is deducted from the first weekly payroll check of those paid weekly.

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 the Vision Plan,
- no longer meet eligibility requirements, or
- 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),
- they no longer meet the eligibility requirements,
- a Change in Status occurs (and as a result, you elect to eliminate a dependent from vision coverage). You will be required to provide proof of the Change in Status to the Service Center within 60 days of the event, or
- your coverage ends.

Coverage for you and your dependents ends on the last day of the month when you terminate employment.

If your premiums for vision coverage cannot be deducted from your payroll check and 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 month in which you terminate employment. The coverage ends on the last day of the month.

In certain situations, you and your dependents may be eligible to continue coverage. (See the "COBRA Continuation Coverage" section on Page 16).

Coverage Continuation in Special Situations

If you are laid off or 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 die, coverage for your dependents will end on the last day of the pay period in which you die. Your dependents will be eligible to continue their coverage by electing COBRA continuation coverage.

If you are approved for Long-Term Disability under the Disability Income Plan, 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.

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

If you are on a Company approved Unpaid Leave of Absence (Unpaid LOA) such as a Family and Medical Leave, you will be able to continue your Vision Plan coverage for yourself and your dependents, if you elected to cover them, as long as you pay the required monthly premium contribution by the beginning of the month, which will be on an after-tax basis, unless you decide to pre-pay on a pre-tax basis under the cafeteria plan. 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 Service Center for additional information and instructions on making the required premium contributions.

If, while on an 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 Vision 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 Vision 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 vision coverage during the period of time that you did not pay the required premium contributions. Vision claims incurred by you or your dependents during that uncovered period of time will not be paid.

If, you are absent 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 as the employee (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. In order 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 the Service Center for additional information and instructions on making the required premium contributions.

You will be entitled to COBRA-like rights with respect to your vision 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 Vision Plan without any waiting periods. If, while on a military leave of absence, 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 Vision 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 Vision 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 would have forfeited coverage during the period of time that you did not pay the required premium contributions. Vision claims incurred by you or your eligible dependents during that uncovered period of time will not be paid.

Vision Plan Benefits

Benefits are payable under the Vision Plan if you received covered services from any licensed ophthalmologist, optometrist or optician. You can locate EyeMed network providers, check eligibility for benefits, verify benefits, review Explanations of Benefits (EOBs) and order replacement ID cards on-line at www.eyemedvisioncare.com and choose the Access Network, or you can call the EyeMed Customer Service number: 1.866.800.5457. EyeMed's network of providers (subject to change) includes private practitioners, LensCrafters, Sears Optical, Target Optical, JCPenney Optical and most Pearle Vision locations.

Your Share of Expenses

Regardless of whether you go to a network provider, there are certain expenses that you are responsible for:

- Any expenses above copay and/or the scheduled benefit amount,
- Expenses not covered by the Plan, including upgrades,
- Expenses for the purchase of frames and/or lenses, when benefits for elective or medically necessary contact lenses have already been provided within the same Plan Year,
- Expenses for the purchase of elective or medically necessary contact lenses, when benefits for frames and/or lenses have already been provided within the same Plan Year,
- Applicable state and local sales tax.

Limitations

Benefits offered by the Vision Plan are available for eye care services incurred and eyewear purchased during the Plan Year (January 1 – December 31) in which you are enrolled for coverage. Vision Care benefits are limited to a routine eye exam and either lenses and/or frames or contact lenses, once every calendar year. In order to obtain benefits under this plan, you do not have to wait at least 12 months from receiving vision services in one Plan Year (calendar year) to receive services in the next Plan Year. For example, you could receive a benefit for vision services in November one year and July the next year (eight months apart in this example), as long as you are actively enrolled in the Vision Care plan. Eye care terms and their definitions may be found in the Glossary (Page 22).

Medical or surgical treatment of the eye is not covered under the Vision Care plan, but may be covered as medically necessary under the Health Choice Medical Options.

Benefits for elective or medically necessary contact lenses are provided only if you purchase contact lenses instead of eyeglasses. Benefits will not be provided for both lenses/frames and elective or medically necessary contact lenses purchased in the same calendar year.

Coordination of Benefits

If you have coverage under another employer's group vision or medical care plan — through your spouse, for example — your benefit payments under the Vision Plan will not be coordinated with benefit payments from any other group vision or medical care plan. In other words, you may or may not be eligible to receive the full amounts available under the Vision Plan. You should compare benefits under each vision program and use the one that provides the greatest level of coverage. Also, if the other group vision plan is with EyeMed Vision Care, you will be limited to benefit payments from only one group vision care plan.

What's covered (and what's not)

COVERED: These services and eyewear are covered under the High and Low Option Plans. You receive maximum benefits and pay preferred prices when services are provided by EyeMed Vision Care providers.

- A Routine Exam with Dilation is covered annually under both options with the High Option having a \$10 copay and the Low Option a \$15 copay with In-Network providers. The Out-of-Network reimbursement is up to \$35 under both options.
- Standard Single, Bifocal, Trifocal Lenses are covered with a \$0 copay using In-Network providers under the High and Low Option Vision plans once every calendar year. The Out-Of-Network reimbursement for the Standard Single lens is up to \$25, bifocal up to \$40, and Trifocal lenses up to \$55.
- Both Options provide coverage for Premium Progressive Tier 1-3 lenses with a \$20, \$30 and \$45 copay with In-Network providers and reimbursement up to \$55 when using an Out-Of-Network provider.
- Both Options provide coverage for Premium Progressive Tier 4 lenses with a \$0 copay plus 80% of charge, less \$120 allowance with In-Network Providers and up to \$55 reimbursement when using an Out-Of-Network provider.
- The Low Option has a \$0 copay with a \$100 allowance for any frames purchased once every 12 months while the High Option allows up to \$160 for any frame purchased once every 12 months and both providing a 20% percent discount of a balance over there maximum annual allowance. Both plan options provide up to \$50 reimbursement once per year for frames purchased from an Out-Of-Network provider.
- The High and Low option provide \$0 copay for conventional contact lenses with a 15% discount over the annual maximum of \$145 for the Low Option and \$160 for the High Option once every calendar year.
- Laser Vision Correction is covered In-Network only under both options providing 15% off retail price or 5% off the promotional price.

NOT COVERED: These services and eyewear are not covered under the Vision Plan.

- Services or supplies covered by the Health Choice Medical Options, including the medical or surgical treatment of the eye, drugs or medication (An example of a surgical treatment covered under the Medical Options is the removal of cataracts.)
- Any amount exceeding the allowance available under this plan. (This would include applicable sales tax and the cost of non-covered expenses.)
- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes or supporting structures
- Any vision examination or any corrective eyewear required by a Policyholder as a condition of employment, such as safety eyewear
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
- Plano (non-prescription) lenses
- Non-prescription sunglasses
- Two pair of glasses in lieu of bifocals
- Services or materials provided by any other group benefit plan providing vision care
- Services rendered after the date an insured person ceases to be covered under the Policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order
- Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when vision materials would next become available.

Benefits by Category

Routine Eye Exam (once per year)

A routine eye exam is a general examination of the operation of the eye and includes a comprehensive vision analysis (including dilation if deemed necessary by the doctor). Note: Additional procedures such as diagnostic lens evaluation, vision field analysis, vision perception training, etc., are not covered by the routine eye exam, and you may be subject to an un-reimbursable charge for these additional procedures.

When your routine eye exam is performed by a Network Provider, you are entitled to a 100% paid-in-full benefit, after paying the \$10 copayment under the High Option and \$15 copayment under the Low Option. If your eye exam is received from a doctor who is not an In-Network Provider, then you will be reimbursed up to \$35.

Services provided by Network Provider may include the following:

- Medical and vision history
- Complete examination of eye structure including the glands that produce tears
- Refraction (measurement of how light bends in the eye in order to determine the prescription required to achieve near 20/20 vision)
- Evaluation of the movement capabilities of the eye muscles
- Glaucoma testing
- Color perception

Laser Vision Correction

EyeMed, in connection with the U.S. Laser Network, owned and operated by LCA Vision, offers discounts for LASIK and PRK. You receive a discount when using a network provider in the U.S. Laser Network. The U.S. Laser Network offers many locations nationwide. For additional information or to locate a network provider, visit www.eyemedlasik.com or call 1.877.5LASER6.

After you have located a U.S. Laser Network provider, you should contact the provider, identify yourself as an EyeMed member and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and schedule treatment, you must call the U.S. Laser Network again at 1.877.5LASER6 to activate the discount.

At the time treatment is scheduled, you will be responsible for an initial refundable deposit to the U.S. Laser Network. Upon receipt of the deposit, and prior to treatment, the U.S. Laser Network will issue an authorization number to your provider. Once you receive treatment, the deposit will be deducted from the total cost of the treatment. On the day of treatment, you must pay or arrange to pay the remaining balance of the fee. Should you decide against the treatment, the deposit will be refunded.

You are responsible for scheduling any required follow-up visits with the U.S. Laser network provider to ensure the best results from your laser vision correction procedure.

Retinal Imaging

Retinal imaging has been provided as a discount to your vision plan with using an In-Network provider. Retinal imaging is a diagnostic tool that provides high-resolution, permanent digital records of your inner eye. Please consult with your Provider to determine if you are a candidate for retinal imaging.

Benefits by Category (continued)

| Service | In Network | Out of Network |
|--|---|---|
| <p>Lenses <i>(One pair per year)</i></p> <p>The High and Low Option vision plans provide coverage for Standard, Bifocal, Trifocal, and Premium Progressive lenses 1-4</p> | <ul style="list-style-type: none"> Standard (non-premium) single vision, bifocal, trifocal, lenticular or standard progressive lenses (all powers) have a \$0 copay required under the High and Low Vision plans. Premium Progressive Tiers 1, 2, 3 have a copay of \$20, \$30, and \$45. Premium Progressive Tier 4 lenses have a \$0 copay plus 80% of the charge, less \$120 allowance. | <ul style="list-style-type: none"> Reimbursement for the Standard Single, Bifocal, Trifocal and Standard Progressive will be reimbursed up to \$25, \$40, \$55, \$55 respectively. Reimbursement for the Premium Progressive Tiers 1,2,3 up to \$55. Reimbursement for the Premium Progress Tier 4 up to \$55 |
| <p>Standard Lens Options</p> <p>The High and Low Option vision plans offer a variety of Standard Lens options.</p> | <ul style="list-style-type: none"> Both plans offer coverage for UV Coating with a \$0 copay under the High Option and \$15 under the Low Option. Both plans offer coverage for tint (solid and gradient) with a \$0 copay. Both plans offer coverage for standard scratch resistance with a \$0 copay. Both plans offer coverage for standard polycarbonate with a \$40 copay under the Low Option and \$0 copay under the High Option. Both plans offer coverage for standard anti-reflective coating with a \$45 copay. Both plans offer coverage for premium anti-reflective coating for Tiers 1 and 2 with a copay of \$57 (Tier 1) and \$68 (Tier 2). Both plans offer coverage for premium anti-reflective coating for Tier 3 with a 20% discount of the retail price. Both plans offer coverage for polarized with a 20% discount off the retail price. Both plans offer coverage for photochromatic/Transitions plastic, with the member paying up to \$75 dollars. Both plans offer a 20% discount of the retail price on other add-ons and services. | <ul style="list-style-type: none"> UV coating is offered under the High Option only up to a \$5 reimbursement. Tint (solid and gradient) is covered under both plans up to \$5 reimbursement. Standard scratch resistant is covered under both plans up to a \$5 reimbursement. Standard polycarbonate is covered under the High Option only up to a \$5 reimbursement. |
| <p>Frames <i>(One pair per year)</i></p> <p>The High and Low Options both provide coverage for the purchase of any frame.</p> | <ul style="list-style-type: none"> The Low Option has a \$0 copay plus 80% of the balance over your annual allowance of \$100. The High Option has a \$0 copay plus 80% of the balance over your annual allowance of \$160. | <ul style="list-style-type: none"> The Low Option has a \$0 copay plus 80% of the balance over your annual allowance of \$100. The High Option has a \$0 copay plus 80% of the balance over your annual allowance of \$160. |
| <p>Contact Lenses Conventional (non-disposable) and disposable contact lenses <i>(one purchase per year, in lieu of the frame and eyeglass lenses benefit)</i></p> | <ul style="list-style-type: none"> Both plans provide coverage for conventional contact lenses with a \$0 copay and 15% discount over the maximum allowance. The maximum annual allowance for the Low Option is \$145 and \$160 for the High Option. | <ul style="list-style-type: none"> Both plans provide coverage for conventional lenses with a reimbursement up to \$116. Both plans provide coverage for disposable lenses with a reimbursement up to \$116. Both plans provide coverage for medically necessary lenses with a reimbursement up to \$200. |

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|---|--|--|
| <p>The High and Low Options both provide coverage for contact lenses.</p> | <ul style="list-style-type: none"> • Both plans provide coverage for disposable contact lenses with a \$0 copay and up to the maximum allowance. The maximum annual allowance for the Low Option is \$145 and \$160 for the High Option. The member is responsible for 100% of the cost over the maximum allowance. • Both plans provide coverage for Medically Necessary contact lenses, with a \$0 copay. • Both plans offer up to \$55 coverage for standard contact lens fit and follow-up. • Both plans offer a 10% discount on premium contact lens fit and follow-up. | |
|---|--|--|

Medically Necessary Contact Lenses

(one purchase per year, in lieu of the frame and eyeglass lenses benefit)

Medically necessary contact lenses are contact lenses that are required to treat a medical condition when one of the following exists:

- Keratoconus where the member’s vision is not correctable to 20/30 in either or both eyes using standard spectacle lenses,
- High ametropia exceeding –10 D or +10 D in spherical equivalent in either eye
- Anisometropia of 3D spherical or more or
- Vision improvement for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

The Plan provides a benefit for the purchase of medically necessary contact lenses if using an in-network provider, including diagnostic services necessary to prescribe the correct lenses, fitting and training the patient on the proper use and maintenance of the lenses, and professional follow-up.

The benefit may not be expanded for other eye conditions even if you or your provider deems contact lenses necessary for other eye conditions or visual improvement.

Online Purchases

Online Eyewear with Glasses.com

You can now apply your in-network benefit when purchasing glasses online through Glasses.com. For additional information, visit www.glasses.com.

Online Contact Lenses with ContactsDirect.com

You can now apply your in-network contact lens benefit at contactsdirect.com. Complete the online transaction form and the contacts will be delivered directly to your home.

Additional Purchases and Out-of-Pocket Discounts:

EyeMed provides an in-network discount on products and services once your in-network benefits for the applicable benefit period have been exhausted. These include:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the Plan at network providers

These discounts may not be combined with any other discounts or promotional offers. These discounts do not apply to the optometrist’s professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice.

Hearing Aids and Services

EyeMed has partnered with Amplifon—the world’s largest distributor of hearing aids and services—to add affordable hearing care to your EyeMed vision benefits package. Members receive a 40% discount off hearing exams and a low-price guarantee on discounted hearing aids. For additional information, call 877.203.0675.

Claims Processing

Network Providers

When you receive services from a participating network provider, you will not have to file a claim form. At the time services are rendered, you will have to pay the cost of any services or eyewear that exceeds the Plan allowances. You also will owe state and local sales tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

If you believe your claim wasn't paid correctly, contact EyeMed Customer Service at 1.866.800.5457.

Other Providers

When you want to use your Vision Plan benefits for services with a **non-participating provider**, you are responsible for payment of vision care services at the time of service. After you have paid for your services and/or eyewear in full, obtain an itemized bill from your eye doctor or optician and use it to file your claim to First American Administrators Inc. ("FAA"), a wholly owned subsidiary of EyeMed.

OnLine Step by Step:

How to file a claim online for non-participating providers

- Log in to www.eyemedvisioncare.com.
- Select Help and Resources.
- Go to "How Do I submit a claim" and select the highlighted words "claim form."
- Enter your valid email. EyeMed will send you a link that will allow you to complete the claim form online.
- Follow the prompts and upload the receipt.
- FAA will only accept itemized paid receipts that indicate the services provided and the amount charged for each service. The patient name and date of service must be included on the receipt. The services must be paid in full in order to receive benefits. Handwritten receipts must be on the provider's letterhead. Attach itemized paid receipts from your provider to the claim form. If the paid receipt is not in U.S. dollars, please identify the currency in which the receipt was paid.
- When you have completed the claim form and uploaded the receipt, you will be able to "Sign and Submit" the claim form online.

By Mail Step by Step:

How to file and mail a claim for non-participating providers

- Complete ALL sections of the FAA/EyeMed Out-of-Network Claim Form to ensure proper benefit allocation. You can obtain an Out-of-Network Claim form from InSite or by calling EyeMed Vision Care Customer Service at 1.866.800.5457.
- Have your eye doctor or optician give you an itemized bill. Handwritten receipts must be on provider letterhead. The itemized bill should include:
 - Date of service
 - Description of each service
 - Charge for each service
- Attach your itemized bill to your Out of Network claim form. Keep a copy of the bill for your records.
- Verify that the personal information listed on the form is correct.
- Promptly mail your claim form, along with the itemized bill from your eye doctor or optician to FAA/EyeMed Vision Care at the following address:

FAA/EyeMed Vision Care, LLC
Attn: Out of Network Claims Department, SRNS Plan
P.O. Box 8504
Mason, OH 45040-7111

FAA/EyeMed will process your claim and reimburse you up to the scheduled amount for the services rendered. You should receive reimbursement usually within 30 days after FAA/EyeMed receives your fully completed claim form.

If FAA/EyeMed needs additional time to decide a claim, they will send you a written notice explaining the information needed. You will have 45 days to provide the information to FAA. If the claim is denied, in whole or part, FAA will inform you of the denial in writing.

When your claim is paid, carefully review the Explanation of Benefits (EOB) statement to make certain you've received the correct benefits.

If your benefits don't appear to be paid correctly, contact EyeMed Vision Care Customer Service at 1.866.804.5457 and discuss the claim payment. Additional documentation may be required; if so, provide it promptly.

Time Frames for Processing Claims

FAA will decide claims within the time permitted by applicable state law, but generally no longer than 30 days after receipt. If FAA needs additional time to decide a claim, it will send you a written notice of the extension, which will not exceed 15 days. If FAA needs additional information from you in order to decide the claim, FAA will send you a written notice explaining the information needed. You will have 45 days to provide the information to FAA. If your claim is denied, in whole or in part, FAA will inform you of the denial in writing.

Appeals Process

If you need further explanation regarding the decision to deny or reduce the amount of your claim, or you have additional information that may change that decision, you should first contact EyeMed for further explanation of the denial.

If you are not satisfied with the EyeMed Vision Care response and still believe that the claim was incorrectly paid or denied, you should file a formal (ERISA) appeal within 180 days of your notice of denial. If you do not receive an EOB within 30 days of submission of your claim, you may submit a first-level appeal within 180 days after this 30-day period has expired. FAA will decide the claims.

Your written letter of appeal should include the following:

- The applicable claim number or a copy of the EyeMed Vision Care Explanation of Benefits
- The Vision Plan provision you feel was misinterpreted or inaccurately applied
- Additional information from your eye care provider that will assist FAA/EyeMed in completing their review of your appeal, such as documents, records, questions or comments.

Your appeal should be mailed to the following address:

FAA/EyeMed Vision Care, LLC
Attn: Quality Assurance Dept., SRNS Plan
4000 Luxottica Place
Mason, OH 45040-7111

FAA/EyeMed will review your appeal for benefits and notify you in writing within 30 days of their decision, as well as the reason for the decision, with reference to specific plan provisions. For more information on your rights and how to file a formal appeal under the Employee Retirement Income Security Act of 1974, as amended (ERISA), refer to the ERISA section of this booklet.

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), if you or an eligible dependent loses coverage under the Vision Plan you may be entitled to continue vision coverage for a limited period of time. This is called COBRA continuation coverage.

What is COBRA continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee covered under the group health plan, the covered employee’s spouse, and the dependent children of the covered employee.

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

How long will COBRA continuation coverage last?

In the case of a loss of coverage due to termination of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months.

In the case of loss of coverage due to an employee’s death, divorce, legal separation or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months.

When the qualifying event is the termination of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries’ other than the employee can continue up to 36 months after the date of Medicare entitlement.

How can you elect COBRA continuation coverage?

COBRA continuation coverage is available in the event you and/or your dependent’s coverage terminates due to certain qualifying events described below. The Company will provide you or your dependents with COBRA information for these qualifying events:

- Termination of your employment for any reason, including retirement, voluntary termination, etc., other than for gross misconduct,
- A reduction in your work hours causing ineligibility for coverage, or
- Your death.

It is your or your dependent’s responsibility to notify the Service Center within 60 days of the following qualifying events:

- Your dependent child no longer meets the eligibility requirements for coverage (Note: Children will automatically be removed from your SRNS Dental coverage on the last day of the birth month that the dependent turns 26.
- Your divorce or legal separation,
- You become entitled to Medicare benefits.

If you desire to exercise your right to continuation of coverage under COBRA, you must do so within 60 days following the date of the event that terminated your coverage. To remove a Dependent from your coverage you should complete an OSR 5-200 Health Care Enrollment Change form and submit it to the Service Center no later than 60 days from the date of the qualifying event or loss of coverage. You may be required to provide official documentation supporting your request such as a copy of your divorce decree.

The Plan’s COBRA Administrator, HealthEquity® (formerly WageWorks, Inc.), will send you an election form in the mail to your address of record. To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee’s spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children.

How much does COBRA continuation coverage cost?

You pay 102% of the full cost of COBRA continuation coverage. The premium includes actuarially calculated Plan costs, in addition to the cost of administering COBRA.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage: If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election. (This is the date the Election Notice is post-marked.) If you do not make your first payment for continuation coverage in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact HealthEquity® (formerly WageWorks, Inc.) with questions.

Periodic payments for continuation coverage: After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is provided to you during enrollment. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for periodic payments: Although periodic payments are due on the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you lose all rights to continuation coverage under the Plan. Your first payment and all periodic payments for continuation coverage should be sent to HealthEquity® (formerly WageWorks, Inc.), P.O. Box 660212 Dallas, TX 75266-0212.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid on time,
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify HealthEquity® (formerly WageWorks) of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Second Qualifying Event

An 18-month extension of coverage is available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan.

These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify HealthEquity® (formerly WageWorks) within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

You must notify HealthEquity® (formerly WageWorks) of your disability status within 60 days of the SSA determination and prior to the end of the 18 month period of continuation coverage. You will be required to submit a copy of the letter from the SSA notifying you of your disability status. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of him or her qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify HealthEquity® (formerly WageWorks) of that fact within 30 days after SSA's determination.

Questions about COBRA coverage?

If you have any questions concerning COBRA coverage or your rights to coverage, contact:

COBRA Administrator

HealthEquity (formerly WageWorks, Inc.)

P.O. Box 660212, Dallas, TX 75266-0212

By Phone HealthEquity® (formerly WageWorks)
COBRA Member Customer Service
888.678.4872

Website cobrabenefits.wageworks.com

HIPAA Certification

The options under this Plan do not deny coverage to participants because of pre-existing conditions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employers to provide certification showing evidence of your health coverage. You are entitled to receive a certificate (automatically provided to you with the COBRA information sent to you by the Plan) that will show evidence of your prior health coverage under the Plan, including the beginning and ending dates of your medical, dental and vision coverage. You should provide this certificate to your new employer. If you buy health insurance other than through an employer group plan, the certificate of prior coverage may help you obtain coverage without a pre-existing condition clause.

Privacy of Protected Health Information Certification or Compliance

Neither the Plan nor any third-party business associate servicing the Plan will disclose Plan Participants' Protected Health Information (PHI) to the Company unless the Company certifies that the Plan Document has been amended to comply with the privacy rules under HIPAA, as set forth in 45 Code of Federal Regulations Section 164.504(f)(2) (the "Privacy Rules") and as set forth in this "HIPAA Certification" section and agrees to abide by the Privacy Rules.

- SRNS will neither use nor further disclose PHI received from the Plan, except as permitted or required by the Plan documents, as amended, or required by law.
- SRNS will ensure that any agent, including any subcontractor, to whom it provides PHI obtained from the Plan, agrees to the restrictions and conditions of the Plan documents, including this section.
- SRNS will not use or disclose a participants' PHI obtained from the Plan for employment-related actions or decisions or in connection with any other non-group health benefit or employee benefit plan of SRNS.
- SRNS will report to the Plan any use or disclosure of PHI obtained from the Plan that is inconsistent with the uses and disclosures allowed under this section upon learning of such inconsistent use or disclosure.
- SRNS will make PHI obtained from the Plan available to the plan Participant.
- SRNS will track disclosures it may make of PHI obtained from the Plan so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with applicable law or regulation.
- SRNS will make its internal practices, Summary Plan Descriptions, and records, relating to its use and disclosure of PHI obtained from the Plan to the Plan and to the Secretary of Health and Human Services for audit purposes.

SRNS will, if feasible, return or destroy all PHI received from the Plan that SRNS maintains in whatever form and including copies of any such information, when the plan participant's PHI is no longer needed for the plan administration functions for which the disclosure was made.

Purpose or Disclosure to SRNS

The Plan and any third-party business associate servicing the Plan will disclose PHI obtained from the Plan to SRNS only to permit SRNS to carry out the administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996. Any disclosure to and use by SRNS of PHI obtained from the Plan will be subject to and consistent with the provisions of this section.

Neither the Plan nor any third-party business associate servicing the Plan will disclose PHI obtained from the Plan to SRNS unless the disclosures are explained in the Notice of Privacy Practices distributed to the plan participants.

Adequate Separation between the Company and the Plan

Benefits Administration, Service Center, Payroll, Internal Audit, and General Counsel employees may be given access to Plan participants' PHI received from the Plan or a health insurance issuer or business associate servicing the Plan.

These employees will have access to Plan participants' PHI only to perform the Plan administration functions that the Company provides for the Plan.

These employees will be subject to disciplinary action, for any use or disclosure of Plan participants' PHI in breach or violation of or noncompliance with the provisions of this section to Plan documents. SRNS will report such breach, violation or noncompliance to the Plan and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any participant, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

ERISA

The information contained in this section provides important legal and administrative information about how the Employee Benefit Plans are administered, your rights to benefits from these plans and the process of attempting to resolve a problem you might have with any of the plans. The information in this section explains your rights under Employee Retirement Income Security Act of 1974, as amended (ERISA) and how to contact the Plan Administrator; and additional information on rights that you may have as a plan participant. This SPD does not constitute an implied or expressed contract or a guarantee of employment. You should read this material carefully and keep it for future reference.

Plan Sponsor

All ERISA-covered benefit plans referred to in this SPD are sponsored by Savannah River Nuclear Solutions, LLC (referred to in this document as SRNS or the Company).

Plan Administrator

The Plan Administrator is responsible for maintaining the records related to and administration of ERISA-covered benefit plans. The Plan Administrator also has sole discretion to decide all issues of fact or law. The Plan Administrator reserves the right to request, at any time, documents to determine eligibility for benefits and to resolve appeals. Correspondence to the Plan Administrator should be sent to the address noted for the Plan Administrator in the Plan Information section.

Plan Numbers

A Plan Number has been assigned to the Plan for identification purposes. The Plan Number is listed in the Plan Directory located at the end of this SPD, along with the formal name of the Plan. You should use the formal name of the Plan and the Plan Number in all correspondence relating to the Plan.

Plan Documents

This SPD summarizes the provisions of the Plan. Together with the policies and procedures of EyeMed, this SPD shall constitute the Plan document. If any question should arise which is not covered by the SPD the text of the policies and procedures of EyeMed will control how the question will be resolved. Copies of Plan documents, together with Plan annual reports and descriptions are available for review by any Plan participant. If you would like to review a copy of these documents, contact your Plan Administrator.

Plan Financing and Administration

The Plan is fully insured and funded through participant premium contributions and is administered under a contract with EyeMed, LLC. The EyeMed Vision Care Plan is insured by Fidelity Security Life Insurance Company of Kansas City, Missouri. The Fidelity Security Life Insurance Company policy is VC-19/VC-20, form number M-9083.

Future of the Plans

While the Company expects to continue the plans for an indefinite period of time, the Company, by action of its Board of Directors and/or the Company Benefits Committee, reserves the right at any time and from time to time to modify, amend or terminate in whole or in part any or all of the provisions of the Plan.

If the Plan is changed or terminated, any claim for benefits incurred by you, your eligible dependents or beneficiaries prior to the date of change or termination will be considered liabilities of the plans. Once any of these welfare plans is terminated, you have no further rights to benefits (other than payment of covered expenses incurred during the time you were covered). You are not vested in any of these plan benefits.

ERISA Rights

Although ERISA does not require that an employer provide benefits, it does set standards on how a plan is run, and requires that you be kept informed of your rights and benefits. As a participant or beneficiary in the Plan, you are entitled to certain rights and protection under ERISA. Federal regulations require that all Summary Plan Descriptions include the following statement:

ERISA provides that you may examine, without charge, at the Plan Administrator's office and at other specified locations such as your personnel office, all Plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, Employee Benefits Security Administration (formerly Pension and Welfare Benefits Administration), such as detailed annual reports and plan descriptions. You may obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefits Plans. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. The fiduciaries are given specific authority under the plan. The determination of matters under their authority will be final and binding.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your application for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your application.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request Plan documents from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have an application for benefits which you believe was improperly denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and/or fees. If you lose, the court may order you to pay these costs and/or fees (for example, if it finds your claim frivolous or without reasonable cause).

The addresses for the insurance companies, claims administrators and/or trustees can be found in the Plan Information section at the end of this booklet. The Plan Administrator's address is also shown in the Plan Information section.

General Provisions

Overpayments

If, for any reason, an overpayment is erroneously made under the Plan, you will be responsible for refunding the amount to the Plan. The repayment shall be made by the method established by the Plan Administrator. The methods of repayment may include, but are not limited to, repayment in a lump sum, installment payments, or by deductions taken through payroll. The Plan reserves the right to offset overpayments against future benefit payments until reimbursement is received. The Plan has the right to recover overpayments from your estate and to take any appropriate collection activity available to collect overpaid amounts.

If a benefit payment is issued, either to you or to your Provider, that exceeds the benefit amount you were entitled to under the Plan, the Claims Administrator and/or the Plan has the right to collect the overpayment from you or your Provider. The process the Claims Administrator will follow in collecting overpayments includes:

- Sending written request to you or the provider or
- Reducing the amount of the overpayment from future benefit payments.

Note: If an overpayment occurs because you conceal, misrepresent or give misleading information (for example regarding your employment, earnings, medical condition or receipt of Social Security Disability award) your benefit may be terminated and you must repay the amount of the overpayment.

Complaint Procedure

If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility or with EyeMed's Plan administration, you should first call EyeMed Customer Care Center at 1.866.800.5457 to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed's Quality Assurance Department at

FAA/EyeMed Vision Care, L.L.C.
Attn: Quality Assurance Dept., SRNS Plan
4000 Luxottica Place
Mason, OH 45040-7111

You may also include written comments or supporting documentation.

The EyeMed Quality Assurance Department will resolve your complaint within 30 days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than 120 days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

Plan information

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| Plan Year | January 1 - December 31 | |
| Type of Plan | An insured welfare plan that provides vision benefits. | |
| Plan Name | The Savannah River Nuclear Solutions LLC Vision Care Plan | |
| Plan Number | 525 | |
| Plan Sponsor | Savannah River Nuclear Solutions LLC | |
| Plan Sponsor Employer Identification Number | Savannah River Nuclear Solutions LLC: | 26-0240191 |
| Plan Administrator | SRNS Health and Welfare Benefits Committee | |
| | Savannah River Nuclear Solutions LLC Attention: SRNS Benefits Administration Savannah River Site, Bldg. 730-1B Aiken, SC 29808 Phone 803.725.7772 | |
| Plan Administrator Employer Identification Number | 27-0584392 | |
| Claims Administrator | EyeMed Vision Care, LLC / First American Administrators Inc. and Insurer: P.O. Box 8504 Mason, OH 45040-7111 Phone: 866.800.5457 | |
| Agent for Legal Process | Fluor Corporation SRNS Processing Service Representative 3 Polaris Way Aliso Viejo, CA 92698 | |

Acronyms

| | |
|---------------|---|
| COBRA | Consolidated Omnibus Budget Reconciliation Act |
| EOB | Explanation of Benefits |
| ERISA | Employee Retirement Income Security Act |
| HIPAA | Health Insurance Portability and Accountability Act |
| LOA | leave of absence |
| PHI | Protected Health Information |
| QMCSO | Qualified Medical Child Support Order |
| SPD | Summary Plan Description |
| SRNS | Savannah River Nuclear Solutions |
| SSA | Social Security Administration |
| USERRA | Uniformed Services Employment and Reemployment Rights Act |

Glossary of Helpful Terms

Allowable Charge

The charge payable by the Claims Administrator. The payment will not exceed the Maximum Payment.

Aniseikonic lenses

Lenses that correct a condition that causes the ocular image to be different in each eye.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 and any amendments thereto

Coinsurance

The percentage you pay for covered services.

Cornea

The clear part of the coating of the eyeball that covers the iris and pupil.

Disposable contact lenses

A disposable contact lens is considered a single-use medical device which must be discarded upon removal from the eye, according to the Federal Drug Administration, which approves contact lenses for patient use.

Full Service Employee

Any employee, designated by the Company as a full-time employee who is on the active payroll and who is scheduled to work 20 or more hours per week, and who is hired to fill a permanent job vacancy. There are two sub-categories of full service employees: Full time employees (works a minimum average of 40 hours per week) and part time employees (scheduled to work between 20 and 40 hours per week.)

You are not eligible to participate in this Plan if you:

- are 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 or any federal, state, or local agency),
- perform services under an agreement between the Employer and a leasing organization,
- are a union employee of the Employer whose benefits are the subject of good faith bargaining, and the collective bargaining agreement does not provide for you to participate in this Plan,
- are a high school/post-secondary student participating in School-to-Work programs,
- are currently eligible for coverage as a retiree under the Plan of Savannah River Nuclear Solutions, LLC (SRNS), you are not eligible to also be covered under the Plan as an active employee of the Company, or
- are retired with DuPont Savannah River Company, and were rehired by WSRC or BSRI on 4/1/1989, you are not eligible for participation in the Plan as an Active employee or as a retiree.

Glaucoma

Any disease of the eye that causes increased intraocular pressure which can result in blindness.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, and any amendments thereto

Maximum Payment

The maximum amount the Plan will pay (as determined by the Claims Administrator) for a particular Benefit. The Maximum Payment will be one of the following as determined by the Claims Administrator in its discretion:

- The actual charges made for similar services, supplies or equipment by Providers and filed with the Claims Administrator during the preceding calendar year;
- The Maximum Payment for the preceding year increased by an index based on national or local economic factors or indices; or
- The lowest rate at which any service, supply or equipment is generally available in the local service area when, in the judgment of the Claims Administrator, charges for such service, supply or equipment generally should not vary significantly from one Provider to another; or
- An amount that has been agreed upon by a Provider and the Claims Administrator or a member of EyeMed; or
- An amount established by the Claims Administrator in its sole discretion.

In determining the Maximum Payment, the Claims Administrator may, through its medical staff and/or consultants, determine the Maximum Payment based on a number of factors, including, for example, comparable or similar services or procedures.

Medical Child Support Order

Any judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction or a national medical support notice issued by the applicable state agency which:

- Provides child support with respect to a child or provides for health benefit coverage to a child, is made pursuant to a state domestic relations law (including a community property law), and relates to the Plan of Benefits;
- Enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Group Health Plan.
- A qualified Medical Child Support Order (“QMCSO”) is a state court order or an order of a state administrative agency that requires the Plan to cover a child of an employee who is eligible to receive health care benefits under the Plan. A Medical Child Support Order must meet certain requirements to be qualified. In order to be a QMCSO, a Medical Child Support Order must clearly specify:
 - The name and the last known mailing address (if any) of each participant Employee and the name and mailing address of each Alternate Recipient covered by the order; and,
 - A reasonable description of the type of coverage to be provided by the Plan to each such Alternate Recipient or the manner in which such type of coverage is to be determined; and,
 - The period to which such order applies; and,
 - Each Group Health Plan to which such order applies.
- If the Medical Child Support Order is a national medical support notice, the order must also include:
 - The name of the issuing agency; and,
 - The name and mailing address of an official or agency that has been substituted for the mailing address of any alternate recipient; and,
 - The identification of the underlying Medical Child Support Order.
- A Medical Child Support Order meets the requirement of this definition only if such order does not require a Group Health Plan to provide any type or form of the requirements of a law relating to medical child support not otherwise available under the Plan as described in Section 1908 of the Social Security Act (as added by section of 13822 of the Omnibus Budget Reconciliation Act of 1993).

Ophthalmologist

A licensed Medical Doctor or Doctor of Osteopathy who specializes in the branch of medicine dealing with the structure, functions and diseases of the eye.

Optician

A person who specializes in fitting eyeglasses

Optometrist

A licensed Doctor of Optometry specifically trained to determine the presence of visual problems and to prescribe necessary corrective lenses.

Orthoptics

Eye muscle exercises for correcting faulty eye coordination or other conditions involving the structure and functions of the eye, also called Visual Training

Plano Lenses

Lenses that do not require a prescription.

Premium Contributions

The amount you pay to purchase coverage (not what you pay when you use the coverage)

Provider

Any person or entity licensed by the appropriate state regulatory agency and legally engaged within the scope of such person or entity's license.

Retina

The membrane that lines the interior of the eyeball

Contacts

Plan Eligibility and Enrollment

SRNS Service Center

Telephone 803.725.7772
or 800.368.7333

Email Service-Center@srs.gov

Mail SRNS Service Center
Building 730-1B
Aiken, SC 29808

Claims

EyeMed Vision Care Customer Service

Telephone 1.866.800.5457

Web www.eyemedvisioncare.com

Mail Claims Processing Center
P.O. Box 8504
Mason, OH 45040-7111

Hours of Operation

Monday–Saturday
7:30 a.m. to 11 p.m.

Sunday
11 a.m. to 7 p.m.

Eligible Expenses, Reimbursements, Complaints

EyeMed Vision Care Customer Service

Telephone 1.866.800.5457

Appeals

Mail FAA/EyeMed Vision Care, L.L.C.
Attn: Quality Assurance Dept., SRNS Plan
4000 Luxottica Place
Mason, OH 45040-7111

COBRA

COBRA Administrator
HealthEquity® (formerly WageWorks, Inc.)
P.O. Box 660212
Dallas, TX 75266-0212

By Phone

HealthEquity® (formerly WageWorks)
COBRA Member Customer Service
888.678.4872

Website

cobrabenefits.wageworks.com

ERISA

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

U.S. Department of Labor
Employee Benefits Security Administration
61 Forsyth Street SW
Atlanta, GA 30323

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 intends to continue providing comprehensive benefits programs, the Company reserve the right to modify or terminate any of the benefit plans at any time. The Company will provide advance notification of any future benefit changes.

SRNS Service Center
Building 730-1B
Savannah River Site
Aiken, SC 29808

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Savannah River Nuclear Solutions Vision Care Plan

Amended And Restated Effective January 1, 2024