Savannah River
NUCLEAR SOLUTIONS℠

Summary Plan Description

Dental Care Plan

Savannah River Nuclear Solutions, LLC

Amended and Restated Effective January 1, 2026

22CC00088

Savannah River Nuclear Solutions, LLC Summary Plan Description

Dental Care Plan

The Dental Care Plan is designed to help you and your family maintain good oral health by assisting you with the cost of dental treatments.

Savannah River Nuclear Solutions LLC (SRNS) is also referred to as the Employer or the Company in this Summary Plan Description (SPD). This document, together with the administrative policies and procedures of Blue Cross Blue Shield of South Carolina (the Claims Administrator or BCBS), constitute the Plan Document.

This SPD describes the Plan as of Jan. 1, 2026, with subsequent amendments. Please read this summary carefully. Its purpose is to explain 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 Employer, however, reserves the right to amend or terminate the Plan, at any time.

The benefits described in this document are sponsored by the Company and administered by Blue Cross Blue Shield of South Carolina (BCBS-SC). The Company, through its Benefits Committee, delegated as the Plan Administrator (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 Service Center for questions about enrollment and eligibility in the Plan.

SRNS operates the Service Center as a contracted service for the SRNS Dental Plan; however, you can also contact SRNS Workforce Services with any questions you may have on the SRNS Dental Plan.

As the Claims Administrator, BCBS 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 the law.

This document is merely a summary of the provisions of the Dental Plan. The Dental Plan consists of the dental 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 Dental Plan indefinitely it may amend or terminate the Dental Plan, for any reason, at its sole discretion. If there is a conflict between this SPD and the terms of the Dental Plan, the terms of the Dental Plan will control.

Questions?

Claims and Pre-Authorization

Blue Cross Blue Shield of South Carolina

1.800.325.6596

www.southcarolinablues.com

Monday-Thursday 8 a.m.-6 p.m.
Friday 8 a.m.-4:30 p.m. EST

Claims Processing Center
P.O. Box 100300, Columbia, SC 29202

Plan Eligibility and Enrollment

SRNS Service Center

803.725.7772 or 800.368.7333

Service-Center@srs.gov

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

SRNS Workforce Services

803.952.5767

Bldg. 992-2W Savannah River Site, Aiken, SC 29808

COBRA Administrator

HealthEquity® (formerly WageWorks)
866.924.6937
P.O. Box 660212, Dallas, TX 75266-0212

Dental benefits at a glance

Prime Choice	Participating Provider	Non-Participating Provider
Preventative and Diagnostic	The Plan pays 100% of Allowable Charges	The Plan pays 100% of Allowable Charges. Member must pay balance of Provider's charge.
Basic Dental Benefits: **Minor Restorative** Fillings, oral surgery, simple extractions, root canals, periodontic treatments	The Plan pays 80% of Allowable Charges Member pays remaining 20% of Allowable Charge	The Plan pays 80% of Allowable Charges. Member must pay balance of Provider's charge.
Major Dental Benefits: **Major Restorative** Crowns, bridges, dentures, implants	The Plan pays 60% of Allowable Charges. Member pays remaining 40% of Allowable Charge.	The Plan pays 60% of Allowable Charges. Member must pay balance of Provider's charge.
Temporomandibular Joint Disorder (TMJ) and Temporomandibular Disorder (TMD) (maximum $500 per member per lifetime)	The Plan pays 50% of Allowable Charges up to the lifetime maximum Member pays remaining 50% of Allowable Charge	The Plan pays 50% of Allowable Charges up to the lifetime maximum Member must pay balance of Provider's charge.
Orthodontics Benefits (maximum $500 per member per lifetime)	The Plan pays 50% of Allowable Charges up to the lifetime maximum (child and adult) Member pays remaining 50% of Allowable Charge	The Plan pays 50% of Allowable Charges up to the lifetime maximum (child and adult) Member must pay balance of Provider's charge.
Annual Deductible	None	None
Maximum Annual Benefit*	$2,000 per person per benefit year	$2,000 per person per benefit year

**Preventive and Diagnostic, Basic Dental Benefits, and Major Dental Benefits are subject to a combined maximum of $2,000 per member per Benefit Year. This limit—the maximum annual benefit—is available each year. Payments for TMJ/TMD and orthodontics do not count toward the maximum annual benefit amount under the Prime Choice Dental option. However, there is a maximum lifetime benefit as indicated in the table above for TMJ/TMD and orthodontics.*

Dental benefits at a glance (continued)

Standard Choice	Participating Provider	Non-Participating Provider
Preventative and Diagnostic	The Plan pays 100% of Allowable Charges	The Plan pays 100% of Allowable Charges. Member must pay balance of Provider's charge.
Basic Dental Benefits: Minor Restorative Fillings, oral surgery, simple extractions, root canals, periodontic treatments	The Plan pays 50% of Allowable Charges after the Benefit Year Deductible Member pays remaining 50% of Allowable Charge after Benefit Year Deductible	The Plan pays 50% of Allowable Charges after the Benefit Year Deductible Member must pay balance of Provider's charge after the Benefit Year Deductible
Major Dental Benefits: Major Restorative Crowns, bridges, dentures, implants	The Plan pays 50% of Allowable Charges after the Benefit Year Deductible Member pays remaining 50% of Allowable Charge after the Benefit Year Deductible	The Plan pays 50% of Allowable Charges after the Benefit Year Deductible Member must pay balance of Provider's charge after the Benefit Year Deductible
Temporomandibular Joint Disorder (TMJ) and Temporomandibular Disorder (TMD) (maximum $500 per member per lifetime)	No coverage	No coverage
Orthodontics Benefits (maximum $500 per member per lifetime)	No coverage	No coverage
Annual Deductible	$50 per family with no one member meeting more than $25	$50 per family with no one member meeting more than $25
Maximum Annual Benefit*	$1,000 per person per benefit year	$1,000 per person per benefit year

**Preventive and Diagnostic, Basic Dental Benefits, and Major Dental Benefits are subject to a combined maximum of $1,000 per member per Benefit Year.*

Participating in the Plan

Eligibility

If you are a Full Service employee Non-Craft (regularly scheduled to work a minimum of 20 hours per week) you are eligible to enroll for Dental 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,
- are a Limited Service Employee
- are retired from DuPont Savannah River Plant, and were rehired by WSRC or BSRI on April 1, 1989, you are not eligible for participation in the Dental Plan as an Active employee or as a retiree.

If you are eligible for coverage as a Pre-65 retiree under a Dental Plan of SRNS, and you are currently an active SRNS employee, you will only be eligible for the Active employee Dental Benefit plan. You will continue to be ineligible for the SRNS Pre-65 Retiree Dental Plan until your employment with SRNS terminates. After your employment terminates you will be eligible for the same health benefits as similarity situated retirees. If you are a post-65 retiree you will be given the option to keep your post-65 retiree benefits or roll over to the active benefits.

Quick Look: Coverage eligibility

Your status	Eligibility
Full Service Employees *(excluding Craft Option A and Option B Union workers)*	Yes, eligible unless noted in item 1 below *(also, you can't be covered both as an employee and a dependent.)*
Terminated Employees and Retirees *(see SRNS Pre-65 Retiree Health Plan Summary Plan Description)*	No, not eligible
Limited Service Employees	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 Dental plan include your lawful spouse and your children. (To add dependents, you must provide acceptable documentation to the Service Center.) Eligibility for spouses will be defined with validation of a state-recognized marriage certificate, including same sex marriage when recognized by state law through a valid marriage license. South Carolina common law will continue to have the same documentation requirements for attestation.

Note that if you are divorced, your ex-spouse is no longer eligible to be covered as your dependent under the Dental Plan as of the date of your divorce decree. You have an obligation to notify the Service Center of the effective date of the divorce. Dental claims for services provided to an ex-spouse after the date of the divorce are not eligible for reimbursement and may be recovered by the Dental Plan. Coverage continuation may be available through COBRA Continuation Coverage if you notify the Service Center within 60 days of the effective date of the divorce.

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 Glossary Section of this book 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 BCBS for evaluation. You will be requested to periodically provide proof of the disability to continue the child's eligibility under the Dental Plan.

The Dental 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 misrepresentation, without reimbursement of premiums and may invoke the right to seek reimbursement for claims paid on any ineligible dependent.

Special Rules for "Dual" Couples

If you and your spouse are both employees, and/or retirees, of the Company, you cannot be covered as both an employee/retiree and as a dependent.
A dependent child may not be covered by more than one 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 later choice in this example, you and your spouse may elect to be covered by different dental options.)

Enrolling for Coverage and Requesting Election Changes

Enrolling for Coverage

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

- Prime Choice, Standard Choice, or no dental coverage and
- 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 (2) weeks from your date of hire to make any changes to your elections and return your enrollment form to the Service Center. Your coverage will be effective on your first day of employment as a full-service employee. If you fail to make an election during the first two (2) weeks, you and your dependents will not have any dental 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, add, or remove eligible dependents from your coverage during the annual open enrollment period. The coverage will be effective at the beginning of the next calendar (Plan) year.

Requesting Election Changes and 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 Dental 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.

If you, your spouse or dependent child experiences an event that qualifies as a 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. You will only be able to add or delete a dependent and change your level of coverage (employee only, employee +1, employee +2 or more, or waive) under your dental elections. You will not be able to change the dental option (Prime Choice or Standard Choice) that you elected.

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 qualify as a "Change in Status" and you may be able to enroll yourself and/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.

To add or remove dependents from your coverage with a Change in Status, complete OSR Form 5-200 (available on In-Site and/or by contacting the Service Center). Submit the form and supporting documentation to Service Center, Bldg. 992-2W Savannah River Site, Aiken, SC 29808 within 60 days of the Qualifying Change in Status. The change must be consistent with your Qualifying Change in Status. You can only change the Plan option (Prime Choice or Standard Choice) during the Open Enrollment period (to be effective the following January 1).

Whenever you are adding new eligible dependents to your coverage, you must name the dependent to be covered, provide their date of birth, their Social Security number and acceptable documentation. The list of what is considered acceptable documentation can be accessed at Social Security number and acceptable documentation. The list of what is considered acceptable documentation can be accessed at https://www.srs.gov/general/jobs/benefits/documents/Acceptable_Dependent_Documentation.pdf 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. 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.

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.

Qualifying Change in Status

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, the acquisition of a stepchild, or as a result of a judgment, decree, or order including a qualified medical child support order;

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;

A special enrollment right for eligible persons this can arise due to a loss of eligibility for coverage under a group health plan, health insurance, or Medicaid or Medicare subsidy.

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.

Coverage Effective Date and Cost

Your coverage begins on 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 effective date of your Change in Status, whichever applies.

You and the Company share in the cost of the Dental Plan coverage. The amount of your premium contribution depends on the dental 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. Premium contributions are not pro-rated in accordance with your employment date or Change in Status date. Your premium will coincide with the Plan option 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.

As an active employee, if eligible, your premium contributions are deducted from your pay before FICA 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 or pension to cover your premiums.

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.

Identification Cards

If you are enrolled in the Company's Dental Plan, your BCBS identification card will provide information for your dental provider to use to verify your eligibility for dental coverage and to assist in filing a dental claim. If you should need additional cards, or a replacement card, contact the BCBS Claims Administrator at 1.800.325.6596 or at www.southcarolinablues.com through "My Health Toolkit."

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 may be eligible for coverage under a SRNS Retiree Health 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 Health Plan Summary Plan Description or the Post-65 SRNS Health Reimbursement Account Summary Plan Document. If survivor benefits do not apply, your dependents will be eligible to continue their coverage by electing COBRA continuation coverage.

If you are an "Incumbent" employee under the terms of the Pension Plan and you elect to retire and meet the Pension Plan eligibility for retirement provisions under the Normal, Early, Optional or Incapability Retirement provisions of the Pension Plan and you have a minimum of 15 years of Eligibility Service, you may be eligible

for participation in the Dental option of the Pre-65 Retiree Health Plan as a retiree unless otherwise excluded. See the Pre-65 Retiree Health Plan Summary plan description for eligibility requirements.

Rights to continuing dental coverage in retirement do not apply to employees with a vested deferred pension from the Pension Plan or to terminated "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 and/or retire, 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, 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 Dental 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 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 Dental 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 Dental 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 dental coverage during the period of time that you did not pay the required premium contributions. Dental 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 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 dental 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 military service, whichever is shorter.

An employee returning from military leave is guaranteed the right to reinstatement in the Dental 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 Dental 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 Dental 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. Dental claims incurred by you or your eligible dependents during that uncovered period of time will not be paid.

When Coverage Ends

Your coverage ends when you:

- no longer elect to be covered by one of the dental options
- no longer meet eligibility requirements
- fail to make the required premium contributions by their due date
- die

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 delete a dependent from dental coverage). You will be required to provide proof of the Change in Status to the Service Center within 60 days of the event
- your coverage ends.

Coverage for you and your dependents ends on the last day of your applicable pay period if you terminate employment unless noted otherwise.

If your premiums for dental 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 pay period in which you terminate employment.

In certain situations, you and your dependents may be eligible to continue coverage. (See the "COBRA" section on Page 18).

Dental Plan Choices

Prime Choice and Standard Choice give you the option of using a BCBS PPO Dental Network provider. The level of dental benefit payments from the Plan will be the same from dentist to dentist under the option you choose. However, when you use a network provider you will no longer be subject to being billed for the balance over the BCBS allowed amount.

Preventive care is covered at 100% of allowable charges under both options.

Prime Choice Dental offers higher coverage on restorative services; TMJ/TMD treatment and orthodontics are covered at 50% of allowable with no annual deductible.

Standard Choice Dental offers a lower coverage level on restorative services; no coverage for TMJ/TMD treatment or orthodontics; an annual deductible applies to non-preventive care services.

Implants are covered under Major Restorative Services for both Prime Choice and Standard Choice options, as of Jan. 1, 2011.

Temporomandibular Joint (TMJ) and Other Temporomandibular Disorders (TMD)

Under Prime Choice Dental, benefits for treatment of TMJ and TMD are paid at 50% of the BCBS allowable charge up to a maximum lifetime benefit of $500 for each covered person. Temporomandibular Disorders are diseases or conditions that result in pain and dysfunction of the jaws. Prime Choice Dental provides coverage for non-surgical treatment for problems specifically related to the treatment of the Temporomandibular disorders and is limited to: Dental splints to prevent clinching and/or grinding of the teeth, removal of occlusal appliances, bio-feedback therapy, and physical therapy based on BlueCross BlueShield TMD Treatment Guidelines.

Orthodontics

Prime Choice dental covers both adult and child orthodontics. The benefit level is 50% of the BCBS allowable charge but not more than $2,000 for each covered person in a lifetime. The lifetime maximum of $2,000 is applied even if you change coverage from Prime Choice dental to Standard Choice and then return to the Prime Choice Dental option. To be covered, services must be incurred (actually rendered by the dentist) during the same year that you are enrolled in the Prime Choice Dental option.

Deductible: Standard Choice Dental

Both Prime Choice and Standard Choice dental options reimburse 100% of the BCBS allowable charge amount of covered Preventive care. Under Standard Dental, all other covered services are paid at 50% of the BCBS allowable charge level for covered charges after you've met a $25 individual/$50 family yearly deductible.

Under the Standard Choice Dental Plan, the Individual Deductible is the amount that must be paid by one person each calendar year on covered non-preventive services. The Family Deductible is twice the individual deductible with no one member satisfying more than $25.

There is no carryover of unsatisfied deductible amounts from one year to the next. Your deductible amount starts over each January.

Maximum Annual Benefit

Prime Choice

The maximum Plan benefit (the most the option will pay) in any calendar year for each person covered under the Prime Choice dental option is **$2,000** per member per Benefit Year for Preventive and Diagnostic, Basic Dental Benefits, and Major Dental Benefits, combined. However, payments that were made by the Plan for TMJ/TMD and orthodontics do not count toward the maximum annual Benefit amount.

Standard Choice

The maximum Plan benefit for preventive and minor and major restorative services combined under the Standard Choice dental is **$1,000** per member per Benefit Year for Preventive and Diagnostic, Basic Dental Benefits, and Major Dental Benefits.

Your Share of Expenses

Regardless of which dental option you elect, there are certain expenses that you are responsible for:

- The deductible (for non-preventive services under the Standard Choice Dental option only) and coinsurance (for non-preventive services under both the Prime Choice and Standard Choice Dental options),
- Any expenses above the BCBS allowable charge when using a Non-network provider,
- Expenses not covered by the option you elect,
- Charges that exceed the maximum annual benefit,
- Charges that exceed the lifetime maximum benefit (TMJ/TMD and orthodontics), and

- Any charges for procedures that exceed or differ from widely accepted dental practice (refer to “Alternate Course of Treatment” below).

Pre-Treatment Estimate

A pre-treatment estimate, also called predetermination of benefits, is not mandatory but it is strongly advised. Both dental options pay based on the level of treatment that BCBS determines is “adequate and necessary” according to widely accepted dental practices. Since dental care can be expensive, it’s a good idea to find out in advance how much will be paid because benefits are limited to the course of treatment which Blue Cross Blue Shield, upon review, determines is appropriate. By getting a pre-treatment estimate, you’ll know whether the services are covered under BCBS’s dental treatment guidelines. You’ll also know how much of the dentist’s charges BCBS will pay. Therefore, you can avoid misunderstandings about your coverage.

If your dentist recommends a procedure that differs from widely accepted dental practice, then you will be required to pay the difference between your dentist’s bill and the amount covered by Prime Choice or Standard Choice.

Requesting a Pre-Treatment Estimate

Except in an emergency, you should discuss fees with your dentist before treatment begins. If you or a covered member of your family need dental treatment that the dentist estimates will cost $300 or more, you should ask that predetermination of Benefits be filed with BCBS-SC. By doing this, both you and the dentist will know in advance how much your dental Plan will pay for the course of treatment recommended. Here is how predetermination works.

Your dentist should list on a claim form, the treatment planned and charges for that treatment and forward the form to the Dental Claims Processing Unit at BlueCross BlueShield. After determining the amount eligible for payment, the Dental Claims Processing Unit will let you and your dentist know the amount of money that can be paid under your coverage for the recommended treatment.

If treatment costs $300 or more and your dentist does not ask for predetermination of Benefits, your claim will be paid according to the information contained on the claim form.

Predetermination of Benefits is not necessary for treatment that costs less than $300 or for emergency care, routine oral examinations, x-rays, fluoride treatments, cleaning, scaling or polishing teeth.

In Case of Conflict

While you can go ahead with any course of treatment, even a more expensive one, recognize that the benefit payment will be based on what BCBS considers to be “necessary, appropriate and adequate” according to widely accepted standards of dental practice for your condition. Some examples of the types of dental treatment where reimbursement may be denied totally or in part, include the unnecessary removal of impacted wisdom teeth and the installation of crowns, inlays and onlays, when a less expensive alternative treatment would be as effective. Refer to “Alternate Course of Treatment” below for more information.

Alternate Course of Treatment

An alternate course of treatment applies when more than one dental service or supply can treat the same dental problem. Sometimes, for example, either a crown or a filling could work adequately well. All services must meet widely accepted dental practice standards.

If alternate services and supplies can be used that will equally treat your dental problems, both dental options will always pay benefits based on the less expensive alternate services or supplies. The standards developed by BCBS are based on the services and supplies that are customarily used by dentists throughout the United States, taking into account the current condition of the patient.

Covered Dental Services

Dental services are covered and allowable benefits under the Prime Choice and Standard Choice Dental options when:

- the services are based on accepted standards of dental practice;
- the services are rendered or the supplies furnished by a dentist or dental hygienist acting within the scope of their license and are not otherwise excluded from coverage;
- the services and supplies are billed by or on behalf of the dentist.

Preventive care services are covered at 100% of BCBS allowable charge under both Prime Choice and Standard Choice with no deductible required.

Preventive And Diagnostic Dental Benefits

- Oral examination, including treatment plan if necessary, limited to twice per benefit year;
- Prophylaxis, including cleaning, scaling and polishing, limited to twice per year;
- Space maintainer for prematurely lost deciduous teeth are provided for dependent children under age 20;
- Emergency palliative treatment for the relief of pain;
- Pulp vitality tests;
- Diagnostic casts; and
- Application of sealants on teeth without any fillings: For dependent children under age 20 once per tooth every 60 months.

Basic Dental Benefits

Minor Restorative Services

- Oral surgery (but not periodontal surgery) including the following:
  Surgical extractions,
  Alveoplasty,
  Surgical excision of lesions and tumors,
  Removal of cysts and neoplasms,
  Excision of bone tissue,
  Biopsies of oral tissue,
  Treatment of oral fistula,
  Excision of hyperplastic tissue and
  Frenulectomy
- Fillings, consisting of amalgam and tooth-colored synthetic materials: Only the anterior teeth (the front 6 top teeth and front 6 bottom teeth) are covered for composite or tooth colored fillings. Amalgam fillings are covered elsewhere in the mouth;
- Simple extractions;
- Endodontics, consisting of pulpotomy, pulp capping and root canal treatment;
- Thirty minutes of IV sedation and general anesthesia if Medically Necessary and rendered in connection with covered oral or dental surgery, except as specified on the Schedule of Benefits;
- Apicoectomy (amputation of apex of a tooth root);
- Hemi-section;
- Periodontics: diagnosis and treatment of diseases of the tooth-supporting tissues, as follows:
  Surgical periodontic examination,
  Gingival curettage,
  Gingivectomy and gingivoplasty,
  Osseous surgery, including flap entry and closure,
  Management of acute infection and oral lesions;
- Periodontal cleanings (payable twice per year after the initial periodontal treatment is documented);
- Repair of removable dentures.

Major Dental Benefits

Restorative Services: The restoration and maintenance of oral function by the replacement of missing teeth and structures by artificial appliances as follows:

- Inlays (not part of a bridge);
- Permanent Crowns (not part of a bridge);
- Onlays (not part of a bridge);
- Removable dentures (complete and partial) and bridges (fixed and removable). Benefits for replacement will not be provided for (a) any denture replacement inlay, crown or onlays made less than five (5) years after a placement or replacement which was covered under this Plan or (b) any replacement made necessary by reason of loss or theft;
- Fixed bridge repairs;
- Relining or rebasing of removable dentures more than six months after the installation of an initial or replacement denture, then once every three (3) years:
- Crowns and/or bridges placed over implants.
- Dental Implants — placing artificial teeth or supports surgically into the jawbone.

Orthodontics (Braces): Prime Choice Only

Covered orthodontia is paid at 50% of the Allowable Charge under Prime Choice, up to a maximum lifetime benefit of $1,500 per person. Before undergoing treatment for Orthodontics, you must follow the pretreatment estimate procedures described earlier in this book.

The prevention or correction of irregularities in the alignment of the teeth and the prevention or the correction of dysfunctional malocclusion consisting of the following:

- Diagnosis, including models and radiographs,
- Active treatment, including necessary appliances, and
- Retention treatment following active treatment, limited to 10 visits in an 18-month period
- Benefits payable per patient are limited to the lifetime maximum of $1,500 and to services rendered within a period not to exceed 36 consecutive months;
- The initial payment will be equal to no more than 25% of the total liability/coverage limit of the Plan. The following payments will be payable no more frequently than once a month. If for any reason the orthodontic services are terminated before completion of the approved Treatment Plan, the responsibility of the Plan will end with payment through the month of termination; and
- The replacement of any appliances made necessary by reason of loss or theft is not covered.

As noted above, the Dental Plan's payment of orthodontic services is based on the assumption that a portion of the charge is incurred at the time the appliance is installed and that the balance is billed over the period of time the appliance is expected to remain in place. For this reason, the "set-up" fee is paid immediately and the balance of benefits available is paid on a monthly basis after services have been received.

Orthodontic benefits are based on the treatment plan and continue until the maximum benefit has been paid or the individual's coverage ceases, whichever occurs first. If coverage terminates after orthodontic treatment has begun but before treatment is complete, then no further benefits are available when coverage ceases, even though the orthodontic treatment may have begun prior to termination of coverage. You should follow the pre-treatment estimate procedure as described previously before beginning orthodontic treatment.

Temporomandibular Joint Disorder(TMJ) and Other Temporomandibular Disorders (TMD) — Prime Choice Only

Covered TMJ/TBD Services are paid at 50% of the Allowable Charge under Prime Choice, up to a maximum lifetime benefit of $ 500 per person. Before undergoing treatment for TMJ/TMD, you must follow the pretreatment estimate procedures described earlier in this book.

Non-surgical treatment(s) for problems specifically related to the treatment of the Temporomandibular Disorders are limited to:

- dental splints to prevent clinching and/or grinding of teeth,
- removable occlusal appliances,
- biofeedback therapy, and
- physical therapy based on BCBS's TMD Treatment Guidelines.

Cleft Lip and Palate

Covered Expenses are available for teeth capping, prosthodontics and orthodontics necessary for the care and treatment of congenital cleft lip and palate. The same Benefit Year Deductible and Coinsurance apply to these services as apply to other procedures covered by Plan. Benefits under this Plan related to these services are primary to any Benefits available for the patient under any individual or group accident Plan.

Dental Services Not Covered

You are not covered for the following dental expenses under Prime Choice nor Standard Choice Dental.

1. Any services or charges for services not Medically Necessary;
2. Dental services or supplies that are Investigational or Experimental;
3. Any charges for supplies or dental services rendered to the Member prior to the Member's Effective Date, the Employer's Effective Date or after the Member's coverage terminates
4. Dental services received from a dental or medical department maintained by or on behalf of the Employer, a mutual benefit association, labor union, trustee or similar person or group;
5. Dental services for which the Member incurs no charge;
6. Any service or charge for service to the extent a Member is entitled to receive payment or benefits relating to such service under any state or federal program that provides health care benefits, including Medicare, but only to the extent that benefits are paid or are payable under such programs. This exclusion includes but is not limited to, benefits provided by the Veterans Administration for care rendered for service-related disability, or any state or federal hospital services for which the Member is not legally obligated to pay;
7. Dental services or supplies primarily for cosmetic or aesthetic purposes, including personalization or characterization of dentures;
8. Dental services for which the Member would have no legal obligation to pay in the absence of Dental Coverage;
9. Appliances or restorations necessary to increase vertical dimensions or restore the occlusion, including management of TMJ disorders except as specified on the Schedule of Benefits;
10. Services rendered by a Provider beyond the scope of his or her license;
11. Dental services to the extent that charges for such services exceed the charge that would have been made and actually collected if no coverage hereunder;
12. Charges by a Provider for non-dental services such as broken appointments and completion of claim forms;
13. Charges for visits at home or in the hospital except in connection with emergency care;
14. Dental care or treatment not specifically listed under Dental Covered Expenses or specified on the Schedule of Benefits;
15. Any service or supply rendered by a member of the patient's immediate family or by the patient, including the dispensing of drugs. A member of the patient's family means the spouse, parent, grandparent, brother, sister, child or spouse's parent of the patient;
16. Illness contracted or injury sustained as a result of declared or undeclared war or any act of war, or while in the military service;
17. Services related to teeth missing prior to a Member's Effective Date of coverage under this Plan of Benefits are not eligible for payment of benefits, except as specified on the Schedule of Benefits;
18. Any service for the treatment of dysfunctions or derangements of the TMJ, including orthognathic surgery for the treatment of dysfunctions or derangements of the TMJ, except as specified on the Schedule of Benefits;
19. Any service related to the treatment of malposition's or deformities of the jawbone(s), dysfunction of the muscles of mastication, or orthognathic deformities, except as specified on the Schedule of Benefits;
20. Consultations;
21. Non-IV sedation (nitrous oxide and non-conscious sedation);
22. Replacement Prosthodontics made necessary by loss or theft except as specified in Article III or on the Schedule of Benefits;
23. Temporary crowns and partials;
24. Dental services for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member waives entitlement to workers' compensation benefits for which he/she is eligible; failed to timely file a claim for workers' compensation benefits; or, the Member sought treatment for the injury or illness from a Provider which is not authorized by the Member's Employer or Workers' Compensation Carrier. If the Plan pays Benefits for an injury or illness and the Plan determines the Member also received a recovery from the Employer or Employer's Workers' Compensation Carrier by means of a settlement, judgment, or other payment for the same injury or illness, the Plan shall have the right of recovery as outlined in Article IX of this Plan of Benefits;
25. Complications arising from a Member's receipt or use of either dental services or supplies or other treatment that are not Benefits, including complications arising from a Member's use of Discount Services;
26. Complications that occur because a Member did not follow the course of treatment prescribed by a Provider;
27. Any illness or injury received while committing or attempting to commit a crime, felony or misdemeanor or while engaging or attempting to engage in an illegal act or occupation;
28. Any dental service, supply or charge for an Incapacitated Dependent that is not enrolled by the maximum Dependent Child age listed on the Schedule of Benefits;

29. Any dental service, supplies, charges or losses resulting from a Member being Legally Intoxicated or under the influence of any drug or other substance, or taking some action the purpose, of which is to create a euphoric state or alter consciousness. The Member, or Member's representative, must provide any available test results showing blood alcohol and/or drug/substance levels upon request by the Corporation. If the Member refuses to provide these test results, no benefits will be provided;
30. Charges for a Member's appointment with a Provider that the Member did not attend;
31. Dental services or supplies received as the result of any intentionally self-inflicted injury that does not result from a medical condition or domestic violence;
32. Dental services or supplies or other items not specifically listed as a Benefit in Article III of this Plan of Benefits or on the Schedule of Benefits;
33. Orthodontics: If this Benefit is listed on the Schedule of Benefits as a Covered Expense, the following will apply:
    a. Benefits for these services will be limited to Members through the age set forth on the Schedule of Benefits, if any;
    b. Benefits payable per Member are limited to the maximum amount specified on the Schedule of Benefits and to services rendered within a period not to exceed thirty-six (36) consecutive months;
    c. The initial payment will be equal to no more than twenty-five percent (25%) of the total liability of the Employer, with the following sequential payments payable no more frequently than once a month, and if for any reason the orthodontic services are terminated before completion of the approved Treatment Plan, the responsibility of the Employer will cease with payment through the month of termination; and,
    d. The replacement of any appliances made necessary by reason of loss or theft is not covered by this Plan of Benefits.
34. Treatment of accidental injury to sound natural teeth within the first 12 consecutive months following the date of the accident, if coverage is provided under the health benefit plan;

35. Payment for dental services shall be limited as follows:
    a. In all cases involving covered services or supplies in which the Provider and Member selected a more expensive or personalized course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, payment under this agreement will be based on the charge allowed for the lesser procedure as determined by the Corporation;
    b. In the event a Member transfers from the care of one Provider to that of another Provider during the course of treatment, or if more than one Provider performs services for one dental procedure, the Employer's Group Health Plan shall be liable not more than the amount it would have been liable for had but one Provider performed the service; or,
    c. Any additional treatment that is necessitated by lack of Member cooperation with the Provider or non-compliance with prescribed dental care that results in additional liability will be the responsibility of the Member.

Coordination of Benefits

If you have dental coverage under another employer's group dental plan in addition to this one — through your spouse for example — the total benefits you are eligible to receive could be greater than your actual expenses. To help eliminate duplicate payments, your coverage under Prime Choice or Standard Choice is coordinated with payments from other group dental plans through which you have coverage. When the Health Choice Dental Plan is the secondary plan, it will pay up to the amount of Total Covered Charges as determined by BCBS, but the BCBS payment will not exceed the difference between the Total Covered Charges and the primary plan's payment. At no time will the Dental Plan, operating as a secondary plan, pay more that it would have if it had been the primary plan.

The SRNS Dental Plan will always be secondary payor to automobile no-fault, personal injury protection, or medical payment coverage plans and the Plan will coordinate benefits for claims which are payable under those automobile policies.

Please note that "other insurance" information must be updated on an annual basis with BCBS.

If you and your spouse (through another employer) both cover your children, the plan of the parent whose calendar birthday is first in the year will pay first.

Which Plan Pays First?

If you are an employee of SRNS, this plan will pay first.

If your child is covered by more than one plan, the plan which covers the parent whose birthday falls first in the year (month and day) pays for the dependent child before the plan covering the other parent. However, if you are separated or divorced, the plan of the parent who has custody of the child (provided that the parent hasn't remarried) will pay before the plan of the parent who doesn't have custody. If you're divorced, but have remarried and have custody of your child, your plan will pay before the child's stepparent's plan, and the stepparent's plan will pay before the plan of the children's non-custodial parent. If a court gives financial responsibility for the child's dental care expenses to one parent, then that parent's dental plan will pay before any other plan. When none of these situations apply, the plan under which you're covered the longest will pay first.

Other plans include any dental coverage available from:

- Group, fraternal, blanket or franchise insurance,
- Prepayment coverage,
- Coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefits organization plans, and
- Government programs, except Medicare.

Each employee is covered only as an employee or as a dependent. A child is regarded as a dependent of only one employee, not both. No coordination of benefits is applicable when only one dental plan is involved.

Claims Processing

All in-network (and most out-of-network) dental providers will electronically send your claims to BCBS.

If for some reason, your out-of-network dental provider did not electronically send your claim to BCBS, a Dental Services Claim Form may be obtained from the following sources: SRS Benefits home page (OSR 5-342), Service Center (803.725.7772), or BCBS of South Carolina Customer Service (1.800.325.6596).

If you believe your claim wasn't paid correctly, call BCBS Customer Service at 1.800.325.6596.

The Dental Plan Benefits Claim Form is OSR 5-342.

Complete your portion of the claim form and take it to your dentist. Your dentist may offer to file claims for you when you provide the necessary insurance information.

Your dentist may give you an itemized bill. BCBS can accept an itemized bill without a completed claim form as long as the following information appears clearly on the bill:

- Employee's name and Social Security number,
- Patient's name and date of birth,
- Date of service,
- Diagnosis or reason for treatment,
- Type of treatment or name of each procedure performed,
- Charge for each service, and
- In the case of an accidental injury, description of the injury and the date of occurrence.

Always get a pre-treatment estimate whenever you are planning to have dental work that is expected to cost more than $300.

File claims promptly

File claims promptly so you don't lose track of expenses. Remember, if you do not file a claim within the specified time limit after you incurred a dental expense (that is, within 15 months from the date of service), it will not be covered and paid/reimbursed. You should "cluster" the bills for each individual family member onto a separate claim form, and then put the bills in order by type of service and date. If you are coordinating benefits with another plan that is primary (such as your spouse's employer's insurance plan that pays first), attach a copy of the other plan's Explanation of Benefits statement to the claim form. Keep a copy for your records — the claim form and all attachments — of the documents you send.

If your claim is denied or reduced, you will be notified of the reason for the denial. The Claims Administrator will send you notification called, an "Explanation of Benefits" (EOB) regarding the determination of your claim submission. The Claim Administrator's determinations will be in writing or in electronic form, within the following time periods from the claim receipt.

Urgent Care Claims

Initial benefit determination will be provided as soon as possible (taking into account the medical circumstances), but no later than 72 hours for pre-service urgent care claims. Urgent care claims include claims for health care that if processed under normal pre-service claim review timeframes could seriously jeopardize the claimant's life or health or jeopardize the claimant's ability to regain maximum function, or in the opinion of the physician, (with knowledge of the claimant's current medical condition) subject the claimant to severe pain which cannot be managed without the care that is the subject of the claim. A provider may be considered your authorized representative without your specific designation as such when the claim approval request is for urgent care claims.

Pre-Service Claims within 15 days: Pre-service claims include any claim for a benefit that, with respect to the terms of the Plan, conditions receipt of the benefit in whole, or in part, on approval of the benefit in advance of obtaining care. An approval means only that a service is Medically Necessary for treatment of a claimant's condition, but is not a guarantee or verification of benefits. Payment is subject to claimant's eligibility and all other Plan limits and exclusions. Actual benefit determination will be made when the Claims Administrator processes the post-service claim.

Post-Service Claims within 30 days: Most claims are considered post-service claims since they are usually filed after your health care Provider has already rendered services.

Pre-service and Post-service Claims: The Claims Administrator may use a 15 calendar day extension, if it is necessary for reasons beyond the control of the Plan to complete a benefits determination. If an extension is required, the Claims Administrator will notify you within the initial notification periods noted above.

If you are required to submit additional information for the Claims Administrator to make a determination, the initial notification deadlines noted above will be suspended from the time you are contacted for such additional information until you return the requested information. For Post-Service Claims and Pre-Service Claims, you must respond with the requested information within 60 days or the Claims Administrator may deny your claim. For an Urgent Care Claim, you should respond as soon as possible, no later than 48 hours, or the Claims Administrator may deny your claim.

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 BCBS for further explanation of the denial.

If you wish to file an appeal with the Claims Administrator (BCBS) you must send a letter to the Claims Administrator stating that an appeal has been requested. All pertinent information regarding the claim in question must also be included in your letter. The Claims Administrator will respond to you within the following time frames listed below, from the date when your appeal request is received. All of your appeal levels must be made within 180 days of the initial claim denial from the Claim Administrator (that they provided to you as an EOB in writing, or electronic form).

30 Days for Post-Service Claims: You can submit a second appeal to the Claims Administrator within 90 days after receiving the decision on your first appeal. The Claims Administrator will complete the second level appeal process within 30 calendar days after receiving your second appeal request.

15 days for Pre-Service Claims First Level Appeal: If you file a second appeal of a Pre-Service Claim, the Claims Administrator will complete the second level appeal process within 15 calendar days after receiving your second appeal request.

Urgent Care Claims: The Claims Administrator will respond as soon as possible taking into account medical circumstances that require action, but no later than 72 hours for Urgent Care Claims.

The final appeal request available to you is directly to the Plan Administrator and must be submitted within 30 days from the claim determination made by the Claims Administrator to file an appeal. Your appeal to the Plan Administrator must be in writing and include your name, the claimant's name, your address, identification number, and any other information, documentation, or materials that supports the appeal. In addition, your appeal must include all documents, records, questions or comments necessary for a complete review, including reference to the specific Plan provisions that you feel were misinterpreted, or inaccurately applied.

The Plan Administrator will decide the appeal within a reasonable period of time, but no later than 60 days after receipt of the appeal. You will be notified if there are special circumstances that cause the review to take longer.

Your appeal to the Plan should be sent to:

Savannah River Nuclear Solutions
Plan Administrator
Attn: SRNS Benefits Administration
Bldg. 992-2W Savannah River Site
Aiken, SC 29808

In deciding an appeal regarding an adverse benefit determination that is based in whole, or in part, on a medical or dental judgment, (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate), the Plan will obtain an opinion from a health care professional who has the appropriate training and experience in the appropriate field. The Plan Administrator has full discretion and authority to interpret Plan provisions, resolve any ambiguities and evaluate claims. The decision made by Plan Administrator is final and binding.

You have 180 days from the initial claim determination (Explanation of Benefits) made by the Claims Administrator to file a voluntary appeal to the Claims Administrator and/or to the Plan through the Plan Administrator. If you fail to appeal an adverse benefit determination within the time frames set forth above, you will have waived your right to an appeal.

The exhaustion of the claim and appeal procedure is mandatory for resolving any claim arising under this Plan. Applicable law requires you to pursue all claim and appeal rights on a timely basis before seeking any other legal recourse regarding claims for benefits.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 as amended (ERISA). The official documents that govern the Plan dictate the actual operation of the Plan and the payment of benefits.

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), if you or an eligible dependent loses coverage under the Dental Plan you may be entitled to continue dental 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 (or retired 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 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 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.

What to consider when electing COBRA

Impacts to eligibility for SRNS retiree medical plans and COBRA: If you or your dependents elect COBRA medical or dental coverage the electing individual – you or your dependents – will have waived the right to enroll in the SRNS Pre-65 Retiree Health Plan and the Health Reimbursement Account (HRA). Also, if you, as the employee, elect COBRA, you will be waiving you and your dependents right to enroll in the SRNS Pre-65 Retiree Health plans or HRA. If you or your dependents wish to have SRNS retiree health coverage, now or in the future, do not elect either COBRA medical or dental coverage. However, you or your dependent(s) may elect COBRA vision and still participate in the SRNS Retiree Health Plan or the HRA. Conversely, if you elect to enroll in the SRNS Pre-65 Retiree Health Plan, you cannot elect COBRA continuation coverage.

Impacts to eligibility for other group or individual plans: In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 62-day gap in health coverage, and election of continuation coverage may help eliminate or reduce the gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law.

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 for up to 18 months.

In the case of loss of coverage due to an employee's death, divorce, legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 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 for up to 36 months after the date of Medicare entitlement.

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

- any required premium is not paid on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for other reasons such as fraud.

How can you extend the length of COBRA continuation 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 the COBRA Administrator 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 the COBRA Administrator 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 I8-month period of continuation coverage.

You must notify COBRA Administrator 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 they qualify. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the HealthEquity® (formerly WageWorks) COBRA Administrator of the change within 30 days after SSA's determination.

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?

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 the COBRA Administrator with any questions you may have.

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

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 dental 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, and as set forth below 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 administrative functions for the Plan not inconsistent with the requirements of the HIPAA. 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

1. Only Employees or other workforce members under the control of Plan Sponsor ("Employees") who, in the normal course of their duties, assist in the administration of Employee Benefits or the Employer's Group Health Plan or the Employer's Group Health Plan finances or other classes of Employees as designated in writing by the Plan Sponsor may be given access to Member PHI received from the Employer's Group Health Plan or business associate servicing the Employer's Group Health Plan.
2. These Employees will have access to Member PHI only to perform the Plan administration functions that the Plan Sponsor provides for the Employer's Group Health Plan.
3. These Employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Member PHI in breach or violation of or noncompliance with the provisions of this section to the Plan of Benefits. Plan Sponsor will promptly report such breach, violation or noncompliance to the Employer's Group Health Plan, and will cooperate with the Employer's Group Health Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions 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 Member, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.
4. The Plan Sponsor shall ensure that the separation required by the above provisions will be supported by reasonable and appropriate security measures.

Plan Sponsor certifies that the Plan of Benefits contains and that the Plan Sponsor agrees to the provisions outlined above.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of privacy practices (this "Notice") applies to the health plans and programs (the "Group Health Plan") sponsored by Savannah River Nuclear Solutions, LLC (the "Company"). The Group Health Plan includes the following Company-sponsored plans and benefits that are subject to the administrative simplification section of the Health Insurance Portability and Accountability Act and its implementing regulations: the Active Medical Plan the Pre-65 Retiree Medical Plan, the Active Dental Plan, the Pre-65 Retiree Dental Plan, the Active Vision Plan, the Employee Assistance Program, and Flexible Spending Accounts (Traditional and Limited). This Notice of Privacy Practices summarizes the Group Health Plan's responsibilities and your rights concerning protected health information, which is information that identifies you and relates to your physical or mental health, treatment, and payment for health care services. The Group Health Plan is required to abide by the terms of this Notice, which is currently in effect.

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

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

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

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

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

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

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

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

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

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

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

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

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

Threat to Health or Safety. The Group Health Plan may use or disclose protected health information to avert or lessen a serious threat to your health or safety or the health and safety of others.

Military. If you are in the military or are a veteran, the Group Health Plan may disclose protected health information as required for military or veteran purposes.

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

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

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

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

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

Persons Involved in Your Health Care/Payment for Health Care. Unless you object, the Group Health Plan may disclose protected health information to a member of your family, relative, close friend, or other person identified by you who is involved in your health care or the payment for your health care. The Group Health Plan will limit the disclosure to the protected health information relevant to that person's involvement in your health care or payment.

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

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

4. Your Rights Concerning Protected Health Information.
Right to Request Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of protected health information for treatment, payment or health care operations. You must submit your request for additional restrictions in writing to the Privacy Contact identified below. In most cases, the Group Health Plan is not required to agree to a requested restriction. If the Employees Group Health Plan agrees to a restriction in writing, then it will comply with the restriction unless an emergency or the law prevents the Group Health Plan from complying with the restriction, or until the restriction is terminated. Except as otherwise required by law, the Group Health Plan will comply if you request that protected health information not be disclosed to a health plan for purposes of payment or health care operations (but not treatment) if the information pertains solely to a health care item or service for which you have paid for out of pocket, in full.

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

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

Right to Request Amendment to Record. You have a right to request that incomplete or inaccurate protected health information be amended. You may request the amendment by submitting a request in writing to the Privacy Contact identified below. The Group Health Plan may deny your request in writing in certain circumstances If the Group Health Plan denies your request, then you have a right to submit a statement of disagreement and to have the statement attached to the record. The Group Health Plan then has the right to add a rebuttal statement.

Right to an Accounting of Certain Disclosures. You have the right to request and receive an accounting of disclosures the Group Health Plan has made of protected health information about you for certain purposes within the last six years. An accounting will not include disclosures: made to you; for treatment, payment, or health care operations; to family members or others involved in your health care or payment; for notification purposes; for incidental disclosures; for national security or intelligence purposes; for certain correctional institution or law enforcement purposes; for information that is part of a limited data set; or pursuant to an

authorization. You have a right to receive the first accounting within a12-month period free of charge. In certain circumstances, the Group Health Plan may temporarily suspend your right to an accounting. The Group Health Plan may charge a reasonable cost-based fee for all requests made after your first request during that 12-month period. You may request an accounting by submitting a written request to the Privacy Contact identified below.

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

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

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

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

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

8. Privacy Contact. If you have any questions about this Notice, wish to exercise any of your rights or you believe that your privacy rights have been violated, then you may contact the Privacy Official for the Group Health Plan.

Plan Administrator: SRNS Health and Welfare
Benefits Committee

Savannah River Nuclear Solutions, LLC
SRNS Benefits Administration
Bldg. 992-2W Savannah River Site Aiken
Aiken, SC 29808
Phone: 803.952.5767

ERISA

The information contained in this section provides important legal and administrative information about how the Dental Plan is administered, your rights to benefits from this Plan and the process of attempting to resolve a problem you might have with any portion of this Plan.

The information in this section explains your rights under Employee Retirement Income Security Act of 1974, as amended (ERISA), how to contact the Plan Administrator and additional information on rights that you may have as a plan participant.

This Summary Plan Description 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: The ERISA-covered Dental Plan referred to in this Summary Plan Description (SPD) is 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 the Dental Plan. The Plan Administrator also has the 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. The Plan Administrator(s) is designated by the SRNS Benefits Committee. Correspondence to the Plan Administrator should be sent to the address noted for the Plan Administrator in the Plan Information section below.

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 Summary Plan Description, 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. The policies and procedures of BCBS along with 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 BCBS 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 self-insured and funded through Company contributions and participant premium contributions and is administered under a contract with Blue Cross and Blue Shield of South Carolina.

Future of the Plans: While the Company expects to continue this Plan for an indefinite period of time, the Company, by action of its Board of Managers 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 Plan. If this Plan is terminated, you will have no further rights to benefits (other than payment of covered expenses incurred during the time you were covered). You are not vested in the Plan's 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 Human Resource 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 charge a reasonable amount 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 terminate your employment 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. For legal action, the name and address for the agent for service of process on the Plan Administrator is:

Fluor Corporation
SRNS Processing Service Representative
3 Polaris Way
Aliso Viejo, CA

You may also contract the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210, or the nearest office of the Employee Benefits Security Administration:

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

General Provisions

Right of Recovery

In the event benefits are provided to or on behalf of a beneficiary under the terms of this Plan, the beneficiary agrees, as a condition of receiving benefits under the Plan, to transfer to the Plan all rights to recover damages in full for such benefits when the injury or illness occurs through the act or omission of another person, firm, corporation, or organization. The Plan shall be subrogated, at its expense, to the rights of recovery of such Beneficiary against any such liable third party.

If, however, the beneficiary receives a settlement, judgment, or other payment relating to an injury or illness from another person, firm, corporation, organization or business entity for the injury or illness, the beneficiary agrees to reimburse the Plan in full, and in first priority, for benefits paid by the Plan relating to the injury or illness. The Plan's right of recovery is on a first dollar recovery basis and applies regardless of whether the recovery, or a portion thereof, is specifically designated as payment for, but not limited to, health care benefits, pain and suffering, lost wages, other specified damages, or whether the Beneficiary has been made whole or fully compensated for his/her injuries.

The Plan's right of full recovery may be from a third party, any liability or other insurance covering the third party, the insured's own uninsured and/or underinsured motorist insurance, any medical payments, no fault, personal injury protection, malpractice, or any other insurance coverage which are paid or payable.

The Plan will not pay attorney's fees, costs, or other expenses associated with a claim or lawsuit without the expressed written authorization the Claims Administrator.

The Beneficiary shall not do anything to hinder the Plan's right of subrogation and/or reimbursement. The Beneficiary shall cooperate with the Plan, execute all documents, and do all things necessary to protect and secure the Plan's right of subrogation and/or reimbursement, including assert a claim or lawsuit against the third party, or any insurance coverage to which the beneficiary may be entitled. Failure to cooperate with the Plan will entitle the Plan to withhold benefits due the beneficiary under the Plan. Failure to reimburse the Plan as required will entitle the Plan to deny future benefit payments for all beneficiaries under this policy until the subrogation/reimbursement amount has been paid
in full.

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.

Glossary of Helpful Terms

Allowable Charge The charge payable under the Plan by the Claims Administrator. The payment will not exceed the Maximum Payment.

Coinsurance The percentage you pay for covered services. Your coinsurance amounts for non-preventive dental services are either 20%, 40% or 50%, depending on the specific dental service and the Health Choice dental option you choose.

Experimental/Investigational Surgical or health care procedures, supplies, devices, or drugs, which at the time provided, or sought to be provided, are in the judgment of the Claims Administrator not recognized as conforming to accepted practice, or the procedure, drug, or device or either:

- has not received required final approval to market from appropriate government bodies;
- the peer-reviewed literature does not permit conclusions concerning its effect on health outcomes;
- is not demonstrated to be beneficial as established alternatives;
- has not been demonstrated to improve the net health outcomes; or
- the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Lifetime Maximum The maximum amount of benefits the Plan will pay for an individual during his or her lifetime.

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; or
- 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 the Blue Cross and Blue Shield Association; or
- An amount established by the Claims Administrator in its sole discretion. In determining the Maximum Payment, the Claims Administrator through its staff and/or consultants, determine the Maximum Payment based on a number of factors, including, for example, comparable or similar services or procedures.

Medically Necessary/Medical Necessity is a health care service that a Physician 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 the service, supply or equipment must, in the judgment of the Claims Administrator be:

- In accordance with generally accepted standards of practice; and
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, Physician, or other health care Provider, and not more costly 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.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Post-Service Claims Most claims are considered post-service claims since they are usually filed after your health care provider has already rendered services.

Pre-Authorized/Pre-Authorization The approval of benefits based on Medical Necessity prior to the rendering of such benefit. Pre-Authorization is not a guarantee of payment or a verification that benefits will be paid or are available to you. Payment for benefits is subject to the Eligibility and all other limitations and exclusions contained in this Plan. Your entitlement to benefits is not determined until the claim is processed.

Pre-Service Claims Any claim for a benefit which conditions receipt of the benefit in whole or in part, on approval of the benefit in advance of obtaining dental care. An approval means only that a service is Medically Necessary for treatment of a claimant's condition, but is not a guarantee or verification of benefits. Payment is subject to claimant's eligibility, Pre-existing Condition Limitations and all other Plan limits and exclusions. Actual benefit determination will be made when the Claims Administrator processes the post-service claim.

Primary Plan A Plan whose benefits must be determined without taking into consideration the existence of another Plan.

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 in the practice of dentistry or oral surgery.

Secondary Plan A Plan that is not a Primary Plan. When this Plan constitutes a Secondary Plan, availability of Benefits are determined after those of the other Plan and may be reduced because of benefits payable under the other Plan.

Treatment Plan A written report, including any necessary x-rays, showing the recommended treatment of any dental disease, defect or injury, prepared by a Dentist as a result of any examination made by the Dentist while coverage under this Plan is in effect.

Urgent Care Claims: Claims for treatment for an acute injury or illness that if processed under the normal pre-service claim review timeframes could seriously jeopardize the claimant's life or health, jeopardize the claimant's ability to regain maximum function, or in the opinion of the Physician (with knowledge of the claimant's current medical condition) subject the claimant to severe pain that cannot be managed without the care or treatment that is the subject of the claim.

Contacts

Claims and Pre-Authorization

Blue Cross Blue Shield of South Carolina

1.800.325.6596

www.southcarolinablues.com

Monday-Thursday 8 a.m.-6 p.m.
Friday 8 a.m.-4:30 p.m. EST

Claims Processing Center
P.O. Box 100300, Columbia, SC 29202

Plan Eligibility and Enrollment

SRNS Service Center

803.725.7772 or 800.368.7333

Service-Center@srs.gov

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

SRNS Workforce Services

803.952.5767

Bldg. 992-2W Savannah River Site Aiken, Aiken, SC 29808

COBRA

HealthEquity® (formerly WageWorks Inc.)

866.924.6937
P.O. Box 660212, Dallas, TX 75266-0212

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

Plan information

Plan Year	January 1 - December 31
Type of Plan	A self-insured welfare plan that provides dental benefits.
Plan Name	The Savannah River Nuclear Solutions LLC Dental 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 Bldg. 992-2W Savannah River Site Aiken, SC 29808 Phone 803.952.5767
Plan Administrator Employer Identification Number	27-0584392
Claims Administrator	Blue Cross and Blue Shield of South Carolina I-20 at Alpine Road Columbia, SC 29219
Agent for Legal Process	Fluor Corporation SRNS Processing Service Representative 3 Polaris Way Aliso Viejo, CA 92698

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

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Savannah River Nuclear Solutions
Dental Care Plan

Amended And Restated Effective January 1, 2026