Savannah River
NUCLEAR SOLUTIONS℠

Summary Plan Description

Flexible Spending Accounts

Savannah River Nuclear Solutions, LLC
Amended And Restated Effective January 1, 2025

Flexible Spending Accounts

These flexible spending plans give you a way to set aside part of your pay on a pre-tax basis to pay for eligible health and dependent day care service expenses. HSA Bank is the claims administrator for Flexible Spending Accounts. Contact HSA Bank at askus@hsabank.com , or phone 866.471.5946.

Savannah River Nuclear Solutions, LLC (SRNS) maintains flexible spending benefits under the Health Care Account and Dependent Care Account (the "Plan"). These flexible spending plans give you a way to set aside part of your pay on a pre-tax basis to pay for eligible health and dependent day care service expenses. You avoid paying federal and state (in most states) income taxes and Social Security contributions on the money you set aside in a Flexible Spending Account (FSA).

The General-Purpose Health Care FSA gives you a way to pay for eligible medical, dental and vision expenses for you and your dependents—expenses that are not covered by the SRNS Health Choice options or any other benefit plan.

The Limited Health Care FSA gives you a way to pay for eligible dental and vision expenses for you and your dependents—when you are enrolled in the SRNS Health Savings Account (HSA) along with the Basic Choice High Deductible Health Plan.

The Dependent Care Account allows you to use pre-tax money to pay for job-related day care services (such as babysitters) for your dependents—children or adults—so that you (and your spouse if you are married) can work or seek work.

SRNS is also referred to as the "Employer" or "Company" in this Summary Plan Description (SPD).

This SPD describes the Plan as of Jan. 1, 2025. 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 HSA Bank. The Company, through its Health and Welfare Benefit Committee delegated as the Plan Administrator (the "Plan Administrator"), is responsible for maintaining the enrollment, and other records related to the 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 service provider for the SRNS Plan. However, you can also contact SRNS Workforce Services with any questions you may have on the SRNS Plan.

As the Claims Administrator, HSA Bank 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.

The benefit(s) described in this summary plan description is also governed by the terms of the SRNS Welfare Benefits Plan General ERISA Information and Wrap Summary Plan Description, referred to as a Wrap Plan and together constitute the Plan Document.

Questions?

Plan Eligibility and Enrollment

SRNS Service Center

Telephone 803.725.7772
or 800.368.7333

Email Service-Center@srs.gov

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

Claims

HSA Bank

HSA Bank HSA Bank is the claims administrator for Flexible Spending Accounts. HSA Bank

Web myaccounts.hsabank.com

Mail HSA Bank
P.O. Box 2744
Fargo, ND 58108-2744
Fax: 855.764.5689

Hours of Operation

Available 24 hours a day, 7 days a week

Phone:

English: 800.357.6246

Spanish: 866.357.6232

Email: askus@hsabank.com

FSA benefits at a glance

Traditional Health Care FSA

Pre-tax reimbursement for eligible health care (medical, dental and vision) expenses • Deductibles, co-pays and patient coinsurance • Expenses that exceed plan payment limits • IRS-approved expenses that are not covered by Medical, Dental and Vision Plans	Present maximum contribution of $3300 per calendar year (minimum of $96 per calendar year). The Internal Revenue Service (IRS) enacts limits and restrictions which may vary from year to year.	You will have 105 days from January 1 (run-out period) to file eligible claims against any prior year-end amount. Unclaimed, unapproved or unused money in your account will be forfeited at year end. However, you can roll over unused amounts of up to $640 from the previous year by re-enrolling in an FSA the following year. The roll-over amount (if any) will not be available for the following year until after the run-out period.

Dependent Care FSA

Pre-tax reimbursement for eligible nursery school, day care, baby sitting and home care expenses (as defined by the IRS) • Care required for an eligible dependent so that you (and your spouse if you are married) may work or seek work (as defined by the IRS) • Children under age 13 (as defined by the IRS) • Dependents of any age who are physically or mentally disabled (as defined by the IRS)	The IRS allows up to a maximum annual contribution of $5,000 per household. SRNS requires a minimum of $96 per calendar year to open a Dependent Care FSA account. The maximum contribution limits are determined by the IRS and may vary from year to year. Restrictions are based on federal tax filing status.	You will have 105 days from January 1 (run-out period) to file eligible claims against any prior year end amount. Unclaimed, unapproved or unused money in your account will be forfeited at year end. There is no roll-over provision for the Dependent Care FSA.

Limited Care FSA

Pre-tax reimbursement for eligible dental and vision expenses when the employee is enrolled in a High Deductible Medical Plan and is contributing to an HSA. All medical claims are excluded. Eligible pre-tax reimbursement for • Non-covered or non-reimbursed dental and vision expenses, • IRS-approved expenses that are not covered by the Dental and Vision Plans	Maximum contribution presently is $3300 per calendar year (minimum of $96 per calendar year) The IRS enacts limits and restrictions which may vary from year to year.	You will have 105 days from January 1 (run-out period) to file eligible claims against any prior year-end amount. Unclaimed, unapproved or unused money in your account will be forfeited at year end. However, you can roll over unused amounts of up to $640 from the previous year by re-enrolling in an FSA the following year. The roll-over amount (if any) will not be available for the following year until after the run-out period.

Participating in the Plan

Eligibility

If you are a Full-Service Employee Non-Craft or Option A Craft Full Service Employee, (regularly scheduled to work a minimum of 20 hours per week) you are eligible to enroll for FSA 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 labor 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; or
- are a high school/post-secondary student participating in School-to-Work programs.

Quick Look: Coverage eligibility

Your status	Eligibility
Full Service Employees *(excluding Craft Option B Union workers*	Yes, eligible
Retirees	No, not eligible
See **"Coverage Continuation in Special Situations"** at the end of this section for information on when coverage ends in the event of termination of employment for long term disability, retirement, and/or leaves of absences.	

Enrolling for Coverage and Requesting Election Changes

During the Plan enrollment process, you will be asked to elect…	…whether you want to participate in the Traditional Health Care FSA, Limited Health Care FSA (when enrolled in the Basic Choice High Deductible Health Plan), and/or Dependent Care FSA
&	…the amount, if any, that you want to contribute annually, which will be deducted every pay period (monthly or weekly) for each account
!	The IRS requires that your FSA elections stay in effect throughout the full Plan year. Once made, you cannot change your election during the year unless you experience a "qualifying change in status."

During new hire orientation, you will be asked to enroll in any of the Plans. You will have two weeks from your date of hire to make any corrections to your elections and return your enrollment form to SRNS Workforce Services or the Service Center. If you enroll within two weeks of being hired, your account(s) will be effective as of the first day of the month following your employment as a full-service employee. If you fail to make an election during the first two weeks, you will not have any FSA accounts until Jan. 1 of the following year (that is, if you chose to enroll during the next annual enrollment period) unless you have a Change in Status as described below.

During the annual open enrollment period, you should login to eApplications and review your current Health Care, Limited and/or Dependent Care FSA election(s) and contribution amount(s). Your Health Care and/or Dependent Care FSA participation and contribution will be set to "Waive" with no annual contribution election unless you provide specific instructions to change your FSA contribution amount. Your FSA contribution amount(s) from the previous year will rollover to the new calendar year unless you provide specific instructions to change you FSA contribution amount. If you enroll in the SRNS Basic Choice High Deductible Health Plan during Open Enrollment, you cannot elect both an HSA and a Traditional Health FSA. If you elect an HSA, you can enroll in the Limited (Vision/Dental) Health FSA.

You can make an FSA election and change annual FSA amounts during the annual open enrollment period, to be effective at the beginning of the next calendar (Plan) year.

Any amount over $640 contributed to a Traditional Health Care FSA or a Limited Health Care FSA in one FSA Plan Year that is not reimbursed to you cannot "roll" or be added to contributions made in the next Plan Year. You may "roll" any amount of $640 or less of your current contributions into the next Plan Year by re-enrolling in either

a Traditional Health Care FSA or Limited Health Care FSA. If you enroll in the SRNS Basic Choice Medical Plan during Open Enrollment, your Health Care FSA account balance of $640 or less will be converted to a Limited FSA effective January 1 (you must enroll in the Limited FSA in order for the amount to "roll") and will only be available for dental and vision expenses incurred in the new plan year. The roll over will be completed following the run-out period (the run-out period begins January 1 and concludes in 105 days). You cannot "rollover" any unused Dependent Care FSA funds. Any Dependent Care FSA funds not utilized for eligible expenses will be forfeited.

During new hire orientation, you will be asked to enroll in any of the Plans. You will have two weeks from your date of hire to make any corrections to your elections and return your enrollment form to SRNS Workforce Services or the Service Center. If you enroll within two weeks of being hired, your account(s) will be effective as of the first day of the month following your employment as a full-service employee. If you fail to make an election during the first two weeks, you will not have any FSA accounts until Jan. 1 of the following year (that is, if you chose to enroll during the next annual enrollment period) unless you have a Change in Status as described below.

During the annual open enrollment period, you should login to eApplications and review your current Health Care, Limited and/or Dependent Care FSA election(s) and contribution amount(s). Your Health Care and/or Dependent Care FSA participation and contribution will be set to "Waive" with no annual contribution election unless you provide specific instructions to change your FSA contribution amount. Your FSA contribution amount(s) from the previous year will rollover to the new calendar year unless you provide specific instructions to change you FSA contribution amount. If you enroll in the SRNS Basic Choice High Deductible Health Plan during Open Enrollment, you cannot elect both an HSA and a Traditional Health FSA. If you elect an HSA, you can enroll in the Limited (Vision/Dental) Health FSA.

You can make an FSA election and change annual FSA amounts during the annual open enrollment period, to be effective at the beginning of the next calendar (Plan) year.

Any amount over $640 contributed to a Traditional Health Care FSA or a Limited Health Care FSA in one FSA Plan Year that is not reimbursed to you cannot "roll" or be added to contributions made in the next Plan Year. You may "roll" any amount of $640 or less of your current contributions into the next Plan Year by re-enrolling in either a Traditional Health Care FSA or Limited Health Care FSA. If you enroll in the SRNS Basic Choice Medical Plan during Open Enrollment, your Health Care FSA account balance of $640 or less will be converted to a Limited FSA effective January 1 (you must enroll in the Limited FSA in order for the amount to "roll") and will only be available for dental and vision expenses incurred in the new plan year. The roll over will be completed following the run-out period (the run-out period begins January 1 and concludes in 105 days). You cannot "rollover" any unused Dependent Care FSA funds. Any Dependent Care FSA funds not utilized for eligible expenses will be forfeited.

Money contributed in one FSA Plan Year for your Dependent Care FSA that is not reimbursed to you cannot "roll" or be added to contributions made in the next Plan Year, even if you allow your Dependent Care FSA election(s) to continue. The contributions made in each Plan Year are available only for reimbursement of eligible expenses incurred during that Plan Year.

If you, your spouse or dependent child experiences an event that qualifies as a Change in Status (see the section titled "Change in Status") and you wish to change your FSA elections, you must submit a written request of the benefit election change to the Service Center within 60 days after the event occurs.

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.

Change in Status

Generally, you are permitted to make Plan election changes only during the annual open enrollment period, which will be effective beginning Jan. 1 of the following year, and your FSA Plan elections will stay in effect for the full calendar year (also known as the Plan Year). You cannot change your benefit elections during the calendar year unless you have an event that qualifies as a Change in Status for benefit coverage purposes. Certain rules specify the events under which you may change a benefit election during the year, effective with the date of the event through the remaining portion of the calendar year.

The benefit change you want to make must be consistent with the Qualifying Change in Status. That is, the event must result in the employee, spouse or dependent child gaining or losing eligibility for coverage under the Plan. If the change is consistent with the qualifying change in status, you may enroll, change or decrease FSA contributions or terminate participation in the FSA Plans.

To make Plan election changes due to a Qualifying Event, complete Form OSR 5-200 (available on In-Site and/or by contacting the Service Center). Submit the form and supporting documentation to the SRNS Service Center, Bldg. 730-1B, Aiken, SC 29808 within 60 days of the Qualifying Event. Any change you request to make under the Plan must be consistent with your Qualifying Event. Proof of the Qualifying Event will be required.

Changes due to a qualifying Change in Status and approved by Benefits Administration will take effect on the date of the event.

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

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

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

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

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

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

For Dependent Care: A change in daycare provider, a significant change in cost, a change in a parent's work schedule (causing a change to the number of hours dependent care is needed) or a child of divorced parents switching residences between parents (only expenses incurred by custodial parent qualify) may qualify as a change in status.

Need to declare a Qualifying Change in Status or an address change? Do not call the Claims Administrator. Instead, contact the Service Center at 803.725.7772.

Coverage Continuation in Special Situations

If you are laid off or terminate your employment, FSA enrollment for you and your dependents will end on the date of your termination. You may be able to continue your Health Care FSA for the remainder of the Plan year by electing FSA COBRA continuation coverage. Continuation of a Dependent Care FSA is not offered through COBRA.

If you die, FSA enrollment will end on the day after the date of your death. Claims may be filed for any eligible expense that were incurred while the FSA account was active until the runout period expires at which time any funds will be forfeited to the Company. The runout period ends April 15 (105 days following Dec. 31 of the year following the death of the FSA account holder).

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 Health Care FSA by electing COBRA continuation. Continuation of a Dependent Care FSA is not offered through COBRA.

If you are on a company-approved paid leave of absence (LOA), your FSA enrollment 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 FSA Health Plan. When you return as an active employee from Unpaid LOA, the FSA coverage that you had just prior to the Unpaid LOA will resume on a pre-tax deduction basis from your paycheck. Your FSA deduction amount will be recalculated based on the remaining pay periods in the year. If you have questions please contact the Service Center.

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 are enrolled in the FSA Plan and become absent from work due to military leave, you may have the right to elect to continue FSA coverage under the Plan. To be eligible for coverage during the period that you are absent from work on military leave, you must give reasonable notice to the Company of your military leave. If you have questions, please contact the Service Center.

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

An employee returning from military leave is guaranteed the right to reinstatement in the FSA Plan without any waiting period. When you return as an active employee from military leave, the FSA enrollment amounts that you had just prior to the military leave will resume on a pre-tax basis from your paycheck. Your FSA deduction amount will be recalculated based on the remaining pay periods in the year.

When Coverage Ends

Your FSA election will end on Dec. 31 of the current plan year unless you make an election during annual open enrollment. You will not be able to roll over unused Health Care FSA amounts of up to $640 from the previous year if you elect to not maintain your enrollment in the Plan during annual Open Enrollment. Your eligibility for the Flexible Spending Accounts—and your access to money in the FSAs—ends when you are no longer employed by SRNS. FSA claims may only be reimbursed for services that were incurred during the period of coverage. FSA participation ends on the day your employment terminates. For example, if you are a monthly-paid employee and your employment termination date is March 22, you cannot be reimbursed from your Health Care and/or Dependent Care FSA for any eligible services you or your dependents incurred after March 22.

If terminated, you may be eligible to continue to participate in the Health Care FSA by enrolling in COBRA continuation coverage. Continuation of a Dependent Care FSA is not offered through COBRA (see the "COBRA" section). If you terminate and elect COBRA FSA coverage, you will continue to use your current FSA Multi-purse Debit Card.

What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to benefits will be determined as follows:

- You will still be able to request reimbursement for qualifying dependent care expenses from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit claims within 105 days after termination.

- For health benefit coverage and Health FSA coverage on termination of employment, please see the "Continuation Coverage Rights Under COBRA" section. Upon your termination of employment, your participation in the Health FSA will cease and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health FSA have already been made. You will be allowed 105 days after the date of termination in which to file these claims. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

Health Care FSAs: Traditional and Limited

SRNS offers two types of health care--FSA: Traditional and Limited. The following explains the differences.

Traditional Health Care FSAs

The Traditional Health Care FSA allows you to reimburse yourself for eligible expenses not reimbursed by the SRNS Medical, Dental and Vision Plan options you elected, or by any other employer's plan, retiree plan or government-sponsored plan in which you or your eligible dependents participate including a Health Reimbursement Account.

Eligible expenses must be incurred by you or your dependents. You can claim amounts equal to your entire annual Traditional Health Care FSA at any time during the year.

Limited Health Care FSA

The Limited Health Care FSA gives you a way to pay
for eligible dental and vision expenses for you and your dependents.

You must be enrolled in the SRNS HSA along with Basic Choice High Deductible Health Plan.

Eligible Family Members for Traditional and Limited Health Care FSAs

The money deposited into the Health Care FSA is used to reimburse you for various expenses incurred during the Plan Year by you and your eligible family members. Your eligible dependents for the Health Care FSA are dependents as defined by the Internal Revenue Code of 1986 (IRC), as amended.

This means a person who depends on you for over 50% of his or her support. But you do not necessarily have to claim the individual as a dependent on your federal income tax return. The dependents for whom you file reimbursement claims under your Health Care FSA are not required to be covered under the SRNS medical, dental or vision options.

The difference between your dependents under the FSA and under your other Health Choice options (medical, dental and vision) is that the Health Care FSA allows you to submit the expenses of family members who qualify under federal income tax law as dependents for federal income tax purposes (as defined by the IRS).

For example, this could include your dependent parent, grandparent, brother or sister. These family members are not considered eligible dependents under the SRNS medical, dental and vision options.

Contributing to the Account

You can presently elect to deposit a maximum of $3050 a year (unless otherwise established by SRNS or the IRS in the future.) Federal income tax regulations require that you forfeit any unreimbursed monies left in your Account. This is commonly called the "use-it-or-lose-it" rule. However, you can roll over up to $640 if you make a Health FSA election in the following year. The minimum deposit to this Account is $96 a year. Estimate your contributions wisely and conservatively.

Your contributions are credited to your Health Care FSA in equal amounts each pay period (12 deductions per year for monthly-paid employees and 52 deductions per year for weekly-paid employees).

When you submit a claim for eligible expenses, you will be reimbursed from your Account (see "Submitting a Health Care FSA Claim") up to your annual elected amount, reduced by prior claims during the Plan Year. Expenses that are not properly submitted for reimbursement by the established deadline (April 15 of the following calendar year) and/or without proper documentation will also be forfeited.

The total amount you choose to contribute should reflect your best estimate of expected eligible out-of-pocket expenses for the next calendar year. Money in the Health Care FSA can only be used to reimburse you for certain health care expenses (medical, dental, vision and hearing); that is, expenses that would otherwise be eligible for a federal income tax deduction under the IRC of 1986, as amended.

Eligible expenses

The most important general principle in evaluating whether or not an item or service is an eligible expense: Is the item or service for the diagnosis, cure, mitigation, treatment, prevention of disease, or for affecting any structure or function of the body?

Eligible Traditional Health Care FSA Expenses

- Deductibles, copayments and coinsurance—the portion of covered expenses that you pay under the SRNS medical, dental or vision options
- Medically necessary medical care, dental, vision and hearing expenses not covered or reimbursed by any plan in which you are enrolled
- Expenses that exceed the maximum limits under the Health Choice medical, dental or vision options, including amounts that exceed allowable charge limitations
- Routine physical examination and preventive testing expenses not covered under the medical options
- Out-of-pocket expenses for prescription drugs that are prescribed by a doctor, even though they may not be covered by your medical plan (for example, drugs prescribed for impotency)
- Lasik surgery is an eligible expense; however, no reimbursement can be made until the surgery has been completed.
- "Over-the counter" (OTC) drugs and OTC supplies or supplements, that are covered under 502 IRS Code Section 213(d) and section 9003 of the Affordable Care Act are qualified as eligible expense. In addition, the items must be legally procured and generally fall within the category of medicines or drugs used to treat a condition.
- Health Care related transportation costs and other expenses, which are allowable by federal income tax regulations as "deductible" for federal income tax purposes.
- Dual purpose items or services typically serve a dual purpose —general health of the individual and/or to treat a specific medical condition. For more information on what qualifies as a dual purpose reimbursable item, contact HSA Bank at myaccounts.hsabank.com (you will need to register) under the Resources Library section.

Expenses must be incurred during the FSA Plan Year in which you participate and make contributions. The IRS determines which expenses are eligible for reimbursement. The preceding list of expenses is only a general guide to the type of expenses reimbursable from the Health Care FSA at the time this book was published. Federal income tax laws and regulations may change the items that qualify as eligible expenses.

Questions about eligible expenses? Call HSA Bank at 800.357.6246 or visit https://www.hsabank.com/hsabank/Learning-Center/Healthcare-Flexible-Spending-Accounts**.**

Eligible Limited Health Care FSA Expenses

- Deductibles, copayments and coinsurance—the portion of covered expenses that you pay under the SRNS dental or vision options
- Medically necessary dental and vision expenses not covered or reimbursed by any plan in which you are enrolled
- Expenses that exceed the maximum limits under the Health Choice dental or vision options, including amounts that exceed allowable charge limitations
- Lasik surgery is an eligible expense; however, no reimbursement can be made until the surgery has been completed.

Examples of Non-Reimbursable Expenses

A Health FSA can only reimburse expenses incurred for medical care as defined under IRC Section 213 (d). IRS Publication 502 can also be used as general guidance. Some examples of non-reimbursable expenses include:

- Deposits which are applied to eligible expenses for services that will be rendered during a subsequent FSA Plan Year or payments made during the year for services that were rendered in a previous FSA Plan Year
- Face lifts, hair transplants, hair removal, liposuction and generally most types of cosmetic surgery performed only to improve appearance. (However, in some situations, reconstructive surgery is allowable for reimbursement; see IRS Publication 502 for additional information.)
- Swimming lessons or health club dues
- Employee premium contributions for SRNS health benefits coverage or premiums paid for other health plan coverage, including premiums paid by your spouse or other dependents. (Note: Your SRNS premium contributions are deducted from your pay before taxes are withheld.)

Orthodontics for Limited and Traditional Health Care FSA Expenses

IRS regulations allow an FSA participant to be reimbursed for pre-paid orthodontia services, up to a participant's annual election amount, before services are provided.

- Orthodontic expense will be reimbursed only to the extent the expenses exceed any other type of reimbursement, such as orthodontic coverage under a dental insurance plan.
- Payments must have been made during the plan year in which you are participating in the FSA and must be claims against that year's FSA election.
- For a lump sum payment at the beginning of treatment, the IRS requires that the payment must be made prior to reimbursement from the FSA.

You should plan carefully when making your annual FSA election when orthodontic expenses will be involved. Reimbursement of your lump sum payment to the dentist may be ineligible if any of the orthodontic services (for which the lump sum payment is made) will be performed in a different Plan Year.

For examples of FSA orthodontics expenses, see the next page.

FSA + Orthodontia: Three Examples

Example One

Payment in full made on the first orthodontist visit.

Let's say you participate in an FSA in 2023. In October 2023, you sign an agreement with an orthodontist for your dependent.

During the first visit (November 2023), your dependent is X-rayed and fitted for braces.

On the second visit (December 2023), the braces are installed. During 15 more monthly visits, the braces are adjusted.

After 18 months, (if everything goes as planned), the braces are removed.

For these services, the orthodontist charged $2,600 and other insurance paid $1,000 dollars, leaving a balance of $1,600 dollars.

You can use your Multi-purse Debit Card to make lump sum payments.

Can I be reimbursed the full $1,600 from my 2024 Health Care FSA?

Yes, as long as you have at least $1,600 available in your FSA. Even though your dependent didn't receive all the care in 2023, the IRS regulations allow the health care FSA to reimburse you for the full $1,600 as a 2024 expense. (expense must occur within the applicable plan year)

What if I don't have the full $1,600 in my 2024 Health Care FSA?

If you paid the entire $1,600 and your FSA balance is $1,000, you can only be reimbursed for the amount available in your account ($1,000).

Example Two

My plan includes a run-out period and I'm "rolling over" funds from the previous year. How will my orthodontia payment be processed?

It depends on when you paid the lump sum orthodontia expense and how you submit for reimbursement. The IRS allows an exception for eligible orthodontia service allowing for lump sum payment considering future services as "incurred." However, the IRS requires that the lump sum payment be made prior to being reimbursed from the FSA account.

Let's say your orthodontia treatment started in October 2023 and the orthodontist balance after other insurance has paid is $2,600.

On January 15, 2024, you decide to pay the lump sum amount. You didn't use all your 2023 FSA contribution and have a current balance of $800. You re-enrolled in an FSA for 2024 and pledged an annual contribution of $2,000 The FSA Plan has a runout period that begins Jan. 1 and ending in 105 days.

The runout period allows you an opportunity to present incurred claims from the previous year (in this case, 2023) from the previous year's FSA balance (in this case, $800 in 2023). After the runout period you can "roll over" up to $640.

To use the 2023 FSA balance in the runout period you must submit a manual claim form to HSA Bank. You cannot use your Multi-purse Debit Card for the previous year's balance during the runout period.

In this example, you would submit a manual claim form for reimbursement of the $800 from the 2023 balance and then you could submit a manual claim submission to your 2024 FSA Plan for the $1,800. In this scenario you have used all your 2023 FSA funds and have nothing to "roll over."

Note: The amount reimbursed can't exceed the amount paid to the orthodontist or the total amount of your 2023 and 2024 FSA balances.

Example Three

My orthodontia treatments will be provided over two Plan years.

What are my options?

When treatment is provided over two Plan years and you don't pay the full amount up front, you have two options:

You can pay the monthly payment amount directly to the orthodontist using your Multi-purse Debit Card, or if your provider doesn't accept the Multi-purse Debit Card, you can submit a claim each month for reimbursement. HSA Bank does offer a recurring claims form option. For more information you can call HSA Bank 800.357.6246 or access the form on Insite>Services>Workforce Services & Talent Management>Departments>Benefits>Active Employee Benefits>Flexible Spending Account (FSA)>FSA Forms>Recurring Orthodontia Claim Form

Dependent Care FSA

Contributing to the Account

The Dependent Care FSA works in much the same way as the Health Care FSA with one difference: You will be reimbursed up to the year-to-date amount you have contributed through your payroll deductions minus any previous disbursements from your Dependent Care FSA. Dependent Care FSA lets you reimburse yourself for eligible child and dependent care expenses with before-tax money to pay for job-related day care services (such as babysitters) for your dependents (children or adults) so that you can work or seek work. See the sections that follow on "Eligible Family Members," "Eligible Dependent Care Expenses" and "Special Provisions" to determine if you qualify to participate.

If you elect to contribute to the Dependent Care FSA:

- You can deposit a maximum of $5,000 annually.
- The minimum deposit to this Account is $96 annually.
- Your contributions are credited to your Dependent Care FSA in equal amounts each pay period (12 deductions for monthly-paid employees and 52 deductions for weekly-paid employees).
- When you submit a claim for eligible expenses, you will be reimbursed from your Account (see "Submitting a Dependent Care FSA Claim") up to avaible balance.
- To receive a reimbursement from your Dependent Care FSA, you must have accumulated sufficient contributions to cover the claim being made
- Contributions, including any from your employer, are excluded from your taxable gross income.
- Withdrawals are tax-free for eligible dependent care expenses.

NOTE: Dependent day care FSA expenses do not include medical expenses for your dependents. Health care expenses are only reimbursable through the Health Care FSA. As with the Health Care FSA, the total amount you choose to contribute should be based on your expected child and/or dependent day care expenses for the next calendar year. Amounts not reimbursed for eligible expenses incurred during the calendar year are forfeited under federal income tax regulations.

Special Limits on Your Contributions

If you are married and file a joint return, the amount you can contribute to the Dependent Care FSA cannot be greater than the annual earned income of you or your spouse, whoever earns less (but not more than $5,000 a year per household). If you are married and file separate federal income tax returns, the annual maximum is $2,500 per taxpayer. If your spouse is a full-time student in school at least five months a year, or is physically or mentally incapable of self-care, additional limits apply to your contributions. The IRS assumes your spouse has earned income of at least $250 a month (if you have one dependent) or $500 a month (if you have two or more dependents). These income levels are the maximum you can contribute monthly.

Contribution and eligible expense restrictions follow federal income tax regulations for use of the federal income tax credit. For information about the federal income tax credit, refer to IRS Publication 503, "Child and Dependent Care Expenses."

It is your responsibility to ensure your annual contributions, separately or combined with your spouse, do not exceed the maximum amount allowed by the IRS.

Eligible Family Members

The Dependent Care FSA allows you to be reimbursed for eligible child and/or dependent care services provided for certain family members.

Your eligible family members (as defined by the IRS) are:

- Your children under age 13; or
- A person of any age who spends at least eight hours a day in your home and is physically or mentally incapable of self-care.

To qualify as an eligible family member, the person must meet the IRC definition of a dependent for federal income tax purposes. Generally, this means you must provide more than 50% of the individual's financial support for the year. But you are not required to claim the individual as a dependent on your federal income tax return.

For more information on IRS rules pertaining to dependent care expenses, please refer to IRS Publication 503, "Child and Dependent Care Expenses." It is available at irs.gov/pub/irs-pdf/p503.pdf/.

Eligible Dependent Care Expenses

Generally, eligible dependent care expenses are those associated with the daycare provider to your eligible dependents while you (and your spouse if you are married) are either at work or looking for work, or so that your spouse can attend school full time.

Eligible dependent care expenses include:

- A sitter or nurse in or out of your home, provided the sitter is age 19 or older and not your dependent
- A day care center or other provider outside your home that complies with state and local licensing laws
- A day camp during school vacation (if not primarily for educational purposes)
- A licensed nursery school, even though the school provides lunch and educational services
- Cost of schooling below kindergarten if the cost of schooling cannot be separated from the cost of the child's care
- A housekeeper, maid or cook, only if at least part of their services are to provide day care for a person who qualifies as an eligible family member.

You are required to furnish the federal Taxpayer Identification number or Social Security number of your dependent day care provider, where applicable, on your federal income tax return and on your Dependent Care FSA Reimbursement Claim Form. Failure to do so will, in most cases, make you ineligible to receive a federal income tax credit or reimbursement from the Dependent Care FSA.

Federal Income Tax Credit

You can use the federal income tax credit currently available for dependent care expenses instead of the Dependent Care FSA. You also can use the federal income tax credit for expenses, which exceed the amount you contribute to the Dependent Care FSA. However, you cannot claim the same expense under both the Dependent Care FSA and the federal income tax credit. The amount of expenses eligible for the federal income tax credit is reduced dollar-for-dollar by the amount of eligible expenses reimbursed with your pre-tax dollars through your Dependent Care FSA.

The tax savings to you from the Dependent Care FSA versus the federal income tax credit will vary based on your total household income, the number of family members eligible for annual day care expenses and your tax filing status. Given the complexity of, and potential for, change to current tax laws, you should consult a tax advisor for advice on how to make the best use of both the federal income tax credit and the Dependent Care FSA.

IRS Forfeiture Rules

It is essential to estimate expenses carefully when deciding how much to contribute to your Dependent Care FSA. Federal income tax regulations require that the amount you contribute be fixed for the entire calendar year (unless you have a qualifying Change in Status). Any money in your FSA that is not used for eligible services incurred during the Plan Year must be forfeited. Any forfeitures shall revert to the Plan Sponsor.

You have until April 15 (postmark date) of the year following the FSA Plan Year to submit claims, including all required documentation for eligible expenses incurred during the Plan Year. FSA claims filed after this date or without the proper documentation will not be reimbursed and the remaining amounts in your Account will be forfeited.

Federal income tax regulations require that you specify how the money will be used (for health care or dependent care) as the Health Care FSA, Limited Health Care FSA and the Dependent Care FSA are totally separate accounts. You may, of course, contribute to one or two of these Accounts, but money in the Health Care FSA may only be used for IRS-approved medical, dental, vision and other eligible health care expenses. Money in a Limited Health Care FSA can only be used for IRS-approved dental and vision expenses. Money in the Dependent Care FSA may only be used for child and/or dependent care expenses. If you participate in a Health Care FSA and Dependent Care FSA the amount you contribute to one Account cannot be transferred to the other Account. However, an employee should never have more than two accounts at one time. You may have a Healthcare (Traditional or Limited) and/or a Dependent Care Account.

Social Security

The contributions you set aside in your FSA are not taxed for Social Security purposes (or federal and most state income taxes). The tax savings make FSAs financially attractive to use. If your annual salary is at or below the Social Security taxable wage base, your Social Security wages—and taxes—for the year will be lower. This could result in slightly lower Social Security benefits in the future. For most people, though, the tax savings will more than outweigh any reduction in future Social Security benefits. You should consult with a tax advisor to make the best use of the FSAs.

Other Benefits

Other salary-based benefits, such as disability and life insurance offered by SRNS, will not be affected by your participation. These benefits will continue to be based on your annual base salary before any contributions to the FSAs.

Special Provisions

These special provisions apply to the Dependent Care FSA:

- A dependent care expense is eligible only if it is incurred in order for you (and your spouse if you are married) to work or seek work.
- You cannot participate in the Dependent Care FSA if your spouse is unemployed and not actively seeking employment, or employed in a non-paying capacity, unless your spouse is disabled or a full-time student for at least five months during the year.
- You can count work-related expenses you pay to a relative who is not your dependent, even if he/she lives in your home. However, dependent care expenses cannot be reimbursed for fees paid to your child under age 19, or to anyone you could legally claim as a dependent for federal income tax purposes.
- If the expenses are for a childcare center and the childcare center provides care for more than six children, the facility must comply with all applicable state and local regulations.
- You will not receive benefits for any services provided for the care of a dependent outside your home unless the dependent meets the requirements for an eligible family member (is under age 13 or is an IRS-qualified dependent that regularly spends at least eight hours a day in your home). Nursing home expenses for a dependent with Alzheimer's can only be reimbursed when the dependent regularly spends at least 8 hours each day in your household.
- You must provide the correct name, address and Federal Taxpayer Identification number or Social Security number of the dependent care provider on IRS Form 2441 when filing for the Dependent Care Tax Credit or when claiming reimbursement under the Dependent Care FSA.

These guidelines provide general information about the types of expenses currently reimbursed from the Dependent Care FSA. Final determination on all deductions rests with the Internal Revenue Service. You may wish to refer to IRS Publication 503, "Child and Dependent Care Expenses," for more information.

Reimbursements from your FSA

Claims Processing

Once you have enrolled, your contributions will be deducted automatically from your paychecks throughout the year and deposited into your FSA. The Plan can only reimburse you for approved expenses not covered by another plan.

You will be issued a FSA Multi-purse Debit Card after your enrollment. All Flexible Spending Accounts (Traditional Health Care, Limited Health Care and Dependent Care) will be on one card. If you terminate and elect COBRA FSA, you will continue to use the same card.

HSA Bank provides a Multi-purse debit card, all of your plan elections are on one card.

How the card works: When you swipe your card the transaction is sent to HSA Bank and the Merchant Code from the provider determines the plan the product and/or service will be paid from.

For example: If you have an HSA and Limited Purpose FSA and swipe your card at a medical doctor's office the transaction will be paid from your HSA because a medical doctor is not an eligible provider under the Limited Purpose FSA. Only dental and vision providers are eligible to be paid from your Limited Purpose FSA. Once your Limited Purpose FSA is depleted for the year, future transactions will automatically be paid from your HSA.

If you have a Limited Purpose FSA with funds available and an HSA and want a dental or vision expense paid from your HSA instead of your Limited Purpose FSA, you will need to pay out of pocket and request a reimbursement from your HSA.

Use the FSA Multi-purse Debit Card at the point-of-service when paying for eligible expenses for you and your eligible dependents. (Review the "Orthodontics for Limited and Traditional Health Care FSA Expenses" section on making orthodontic lump sum payments.)

The FSA Multi-purse Debit Card works like a debit card, deducting the expense from your FSA balance automatically. You can use it to pay for eligible expenses right away and submit any required documentation later, if required. If you do not submit receipts within the requested timeframe to verify a charge made with your prepaid debit card, then your card may be suspended until receipts are received. You will be required to repay the amount charged. Your plan administrator will reactivate your card after you submit a receipt or repay the amount in question.

Since the prepaid debit card is a prepaid card and no "prepaid" selection is available, you should select "credit." You do not need a personal identification number (PIN) and cannot get cash with this card.

IRS regulations allow you to use your cards in participating pharmacies, mail order pharmacies, discount stores, department stores and supermarkets that can identify FSA-eligible items at checkout. Transactions at these merchants are fully substantiated and in most cases, no paper follow-up is needed. If pharmacies are not equipped to identify the eligible items at point of sale, but have certified that 90% of the merchandise they sell is FSA-eligible, you may use your card. However, since these pharmacies cannot identify the eligible items at the point of sale, another form of auto substantiation or paper follow-up will be required. Expenses are deducted from the account balance at the point of sale.

You cannot use your cards at discount stores and supermarkets that do not participate. You can continue to use your cards at freestanding pharmacies and health care providers, such as hospitals, doctors, dentists, etc.

You should always save itemized receipts for FSA purchases made with your card. You may be asked to submit receipts to verify that your expenses comply with IRS guidelines. Each receipt must show the merchant or provider name; the service received or the item purchased; the date; and the amount of the purchase.

If you are unable to use your Multi-purse Debit Card for FSA-eligible expenses and pay with cash or by check, you will need to submit a claim form to HSA Bank , along with an Explanation of Benefits (EOB) statement or other appropriate documentation of the eligible expense.. Then HSA Bank will reimburse you by check or if you elect by direct deposit.

Your FSA claims must be for services received during the calendar year in which your contributions to the Account were made. The FSA Plan has a run-out period that begins January 1 and lasts 105 days. The run-out period allows you an opportunity to present incurred eligible expenses from the previous year for reimbursement from that calendar year's FSA balance. You must submit a manual claim form to HSA Bank. You cannot use your FSA Multi-purse Debit Card for the previous year's balance during the run-out period.

Your FSA claim(s)—complete with all appropriate attachments such as EOBs—must be submitted and postmarked by April 15 of the year following the Plan year. (See additional information in this book about forfeiture rules)

After the run-out period, the remaining balance up to $640 will "roll over" to your next year's FSA account, if you re-enrolled in an FSA account (The Dependent Care FSA balance does not roll over and is forfeited after the run-out period). If you did not re-enroll, the balance will be forfeited.

Claims with Two Insurance Plans

(Health Care FSA and Limited Health Care FSA Claims)

If you send a medical or dental claim to another insurance plan for coordination of benefits (such as to your spouse's employer's plan), wait until the second plan has processed the claim and provides you with an EOB. Then, you can submit both EOBs attached to a Health Care FSA reimbursement form. The Health Care FSA Reimbursement Claim form is used for reimbursement of eligible health care expenses that are not processed at the point of sale with the FSA Multi-purse Debit Card. This form, OSR 5-343, is available electronically on InSite. When filing a claim for reimbursement under your Health Care FSA, you will need to include:

- A signed FSA Reimbursement Claim Form
- An EOB if one is available
- When an explanation of benefits is not available, provide a receipt that includes: 1) name, address and telephone number of provider; 2) date of service; 3) explanation of services rendered; 4) amount paid; 5) statement documenting that this expense is not reimbursable from any other source.
- In order to obtain a reimbursement for an OTC drugs and over-the-counter supplies or supplements, you must provide the name of the dependent for whom the product was purchased, along with an itemized receipt for a purchase that states:
  - — Date of purchase (it helps to circle the date on the receipt)
  - — Name of the store where the item was purchased
  - — Circle item for reimbursement on receipt
  - — If the receipt does not identify the OTC by name, you can submit a copy of the box that shows the name of the drug and UPC code that matches the receipt.

Before claims for orthodontic work can be reimbursed, the FSA Claims Administrator will need a copy of the orthodontic contract to ensure that only services incurred during the plan year are being reimbursed. The orthodontic contract should include: 1) total cost of treatment; 2) portion the insurance will pay; 3) down payment required by the provider; 4) length of treatment (e.g., 18 months, 24 months); 5) required monthly payment.

Claims should be submitted to the HSA Bank P.O. 2744, Fargo, ND 58108-2744, You may also contact the Claims Administrator by phone at 800.357.6246 or email askus@hsabank.com.

How Health Care Reimbursements Are Made

Reimbursements made as eligible expenses are received and paid out up to your annual Health Care FSA contribution. You may contact HSA Bank at the toll-free Customer Service numbers, 800.357.6246.or assistance.

Summary of Activity in the FSA

You can view or print reimbursement history and balance information from the HSA Bank web portal at myaccounts.hsabank.com.

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 your making the repayment in a lump sum, or 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 an FSA reimbursement is issued to you that exceeds the benefit amount you were entitled to, 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 be refunded, or
- Reducing the amount of the overpayment from future benefit payments

Submitting a Dependent Care FSA Claim

If you elect to submit a claim form for dependent care expenses instead of using your Flexible Spending Card, you must submit a completed Dependent Care FSA Reimbursement Claim form. You can access and submit the claim form on the My Health toolkit at www.southcarolinablues.com. The claim form is available electronically on Insite, Form OSR 5-344.

The following information is required with the claim form. The original bill (including the provider's name and address, the dates of service and the provider's federal Taxpayer Identification number or Social Security number) must be attached to your claim form. Provider bills that include day care costs as a part of tuition for a child in kindergarten (or higher) are not acceptable unless the day care cost is shown as a separate item. However, for a child who has not reached kindergarten, a provider bill that combines pre-kindergarten (or kindergarten) tuition and daycare expenses will be acceptable for reimbursement.

If you are married, you will be asked to certify that each claim for dependent care reimbursement from your FSA, together with any prior dependent care claims made during the calendar year, will not exceed the lesser of your earned income or the earned income of your spouse.

How Dependent Care Reimbursements Are Made

Reimbursements from the Dependent Care FSA are made monthly. You will be reimbursed up to the year-to-date amount you have contributed through your payroll deductions minus any previous disbursements from your Dependent Care FSA. Contributions to your Dependent Care account are made monthly; reimbursements are based on amount available in the account at that time.

Appeals Process

If you believe your FSA claim wasn't reimbursed correctly, contact HSA Bank Customer Service at 800.357.6246. If you need further explanation regarding the decision to deny or reduce the amount of your reimbursement, or you have additional information that may change that decision, you should first contact HSA Bank (Claims Administrator) for further explanation of the denial.

If your claim is denied in whole or in part and you cannot resolve the issue to your satisfaction with the Claims Administrator, the final appeal request available to you is directly to the Plan Administrator (SRNS) and must be submitted within 30 days from the claim determination made by the Claims Administrator to file an appeal. The final appeal is only available after you have exhausted all applicable appeal opportunities through the Claims Administrator. 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.

Final Appeals should be mailed to the following address:
Savannah River Nuclear Solutions, Plan Administrator,
Attn: SRNS Benefits Administration, Building 730-1B, Aiken, SC 29808

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), if you lose coverage under the FSA Plan you may be entitled to continue FSA coverage for a limited period of time. This is called COBRA continuation coverage.

COBRA continuation coverage is available to employees who are enrolled in a Traditional Health Care FSA and Limited Health Care FSA at the time they terminate employment. The continuation coverage is available until the end of the plan year. There is a 2% administration fee added to the monthly premium election. COBRA continuation coverage is only available to employees who have under-spent their account (had more money deducted than they have been reimbursed for). COBRA coverage is not available for the FSA Dependent Care Plan.

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 FSA health coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan.

How long will this coverage last?

In the case of a loss of coverage due to termination of employment (including an employee's death) or reduction in hours of employment, coverage may be continued until the end of the Plan year for Health Care FSA.

How can you elect COBRA coverage?

COBRA continuation coverage is available in the event your 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 of work causing ineligibility for coverage
- Your death

If you desire to exercise your right to FSA continuation of coverage under COBRA, you must do so within 60 days following the date of the event that terminated your coverage. The Plan's COBRA Administrator—HealthEquity® (formerly WageWorks, Inc.)—will send you an election form in the mail to your address of record. To elect continuation coverage, you must complete the election form and furnish it according to the directions on the form.

How much does this coverage cost?

You pay 102% of the full cost of COBRA continuation coverage. The premium includes your monthly contribution plus the cost of administering COBRA.

When and how must payment be made?

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

Periodic payments for continuation coverage: After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period 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 reimbursement 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 must be sent to COBRA Administrator, HealthEquity® (formerly WageWorks, Inc.), P.O. Box 660212, Dallas, TX 75266-0212.

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

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

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

HIPAA Certification

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 (the Health Insurance Portability and Accountability Act of 1996), as set forth in 45 Code of Federal Regulations Section 164.504(f)(2) (the "Privacy Rules") and as set forth in this "HIPAA Certification" section and agrees to abide by the Privacy Rules.

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

Privacy of Protected Health Information Certification or Compliance

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- 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 available to the Plan and to the Secretary of Health and Human Services for audit purposes.

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

Purpose or Disclosure to SRNS

The Plan and any third-party business associate servicing the Plan will disclose PHI obtained from the Plan to SRNS only to permit SRNS to carry out the administration functions for the Plan not inconsistent with the requirements of the 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.

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
Savannah River Site, Bldg. 730-1B
Aiken, SC 29808
Phone: 803.725.7772

Adequate Separation Between The Company and The Plan

SRNS Workforce Services, Business Services, Internal Audit and General Counsel employees may be given access to Plan participants' PHI received from the Medical Plan or a health insurance issuer or business associate servicing the Plan. Additionally, as previously stated, SRNS operates the Service Center as a service for the SRNS plans, and SRNS employees in the SRNS Benefits Accounting, Benefits Administration, Service Center, and Payroll, organizations may be given access to Plan participants' PHI received from the Medical Plan or a health insurance issuer or business associate servicing the Plan.

These employees will have access to Plan participants' PHI only to support or perform the Plan administration functions that the Companies provide for the Plan.

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

ERISA

Plan Sponsor

ERISA stands for "Employee Retirement Income Security Act." All ERISA-covered benefit plans referred to in this Summary Plan Description (SPD) are sponsored by Savannah River Nuclear Solutions, LLC (referred to in this document as SRNS or the Company).

Plan Administrator

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

Plan Numbers

A Plan Number has been assigned to the Plan for identification purposes. The Plan Number is listed in the Plan Directory located at the end of this 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 Summary Plan Description summarizes the provisions of the Plan. This Summary Plan Description and the "Wrap Plan" shall constitute the Plan document. 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 participant premium contributions and is administered under a contract with HSA Bank..

Future of the Plans

While the Company expects to continue the plans for an indefinite period of time, the Company, by action of its Board of 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 plans. Once any of these welfare plans is terminated, you have no further rights to benefits (other than payment of covered expenses incurred during the time you were covered). You are not vested in any of these plan benefits.

ERISA Rights

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

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

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

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

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

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

The addresses for the insurance companies, claims administrators and/or trustees can be found in the Plan Information section at the end of this booklet. The Plan Administrator's address is also shown in the Plan Information section. For legal action, the name and address for the agent for service of process on the Plan Administrator is Corporation Services Company, 1703 Laurel Street, Columbia, SC 29201; Phone: 800.927.9800.

You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 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.

Acronyms

COBRA Consolidated Omnibus Budget Reconciliation Act

EOB Explanation of Benefits

ERISA Employee Retirement Income Security Act

FSA Flexible Spending Account

HIPAA Health Insurance Portability and Accountability Act

HSA Health Savings Account

IRS Internal Revenue Service

IRC Internal Revenue Code

LOA leave of absence

OTC over the counter

PHI Protected Health Information

PIN Personal Identification Number

SRNS Savannah River Nuclear Solutions

USERRA Uniformed Services Employment and Reemployment Rights Act

Plan information

Plan Year	January 1 - December 31
Type of Plan	Flexible Spending Account
Plan Name	The Savannah River Nuclear Solutions, LLC and Flexible Spending Dependent Care Plan Flexible Spending Health Plan
Plan Number	525 Health Care FSA 507 Dependent Care FSA
Plan Sponsor	Savannah River Nuclear Solutions, LLC
Plan Sponsor Employer Identification Number	26-0240191
Plan Administrator:	SRNS Health and Welfare Benefit Committee Savannah River Nuclear Solutions, LLC SRNS Benefits Administration Savannah River Site, Bldg. 730-1B Aiken, SC 29808 Phone: 803.725.7772
Plan Administrator Employer Identification Number	27-0584392
Claims Administrator	HSA Bank P.O. Box 2744 Fargo, ND 58108-2744 Phone: 800.357.6246, Fax: 855.764.5689
Agent for Legal Process	Corporation Services Company 1703 Laurel Street Columbia, SC 29201 Phone: 800.927.9800

Questions? Contact us

FSA Plan Eligibility and Enrollment

SRNS Service Center

Telephone 803.725.7772 or 800.368.7333

Email Service-Center@srs.gov

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

Claims

HSA Bank is the claims administrator for Flexible Spending Accounts.

HSA Bank

Telephone 800.357.6246

Web myaccounts.hsabank.com

Mail HSA Bank
P.O. Box 2744
Fargo, ND 58108-2744

Eligible Expenses and Reimbursements

HSA Bank

Telephone 800.357.6246

Appeals

SRNS Plan Administrator
Attn: SRNS Benefits Administration
Building 730-1B
Aiken, SC 29808

COBRA

COBRA Administrator

HealthEquity® (formerly WageWorks, Inc.)

P.O. Box 660212

Dallas, TX 75266-0212

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

Website cobrabenefits.wageworks.com

ERISA

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor

200 Constitution Avenue NW
Washington, DC 20210

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

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

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Savannah River Nuclear Solutions
Flex Spending Accounts Summary Plan Description

Amended And Restated Effective January 1, 2025