



## Summary Plan Description

# Medical Plan: Part Two

*Coordination of Benefits*

*Claims Filing and Appeal Procedure*

*COBRA Continuation Coverage*

*General Provisions*

*Subrogation and Reimbursement*

*Legal Notices*

*ERISA*

*Plan Information*

# Savannah River Nuclear Solutions, LLC Summary Plan Description

## Medical Plan: Part Two

### **Page 4: Contacts for questions and pre-authorizations**

### **Page 5: Coordination of Benefits**

Page 5: Applicability

Page 5: Coordination of Benefits with Auto Insurance

Page 5: Order of Determination Rules for Employee Members

Page 5: Additional Order of Determination Rules

Page 6: Effect on Benefits of This Plan of Benefits

Page 6: Right to Receive and Release Needed Information

Page 7: Payment

Page 7: Right of Recovery

### **Page 8: Claims filing and Appeal Procedure**

Page 8: Claims Filing Procedure

Page 8: Appeal Procedures for an Adverse Benefit Determination

*Page 10: Initial Appeal*

*Page 11: External Review Procedures*

*Page 12: Final Appeal*

### **Page 13: COBRA Continuation Coverage**

### **Page 17: HIPAA Certification**

### **Page 18: General Provisions**

Page 18: Administrative Services Only

Page 18: Amendment

Page 18: Authorized Representatives

Page 18: Clerical Errors

Page 18: Notice of Nondiscrimination

### **Page 20: Notice of Privacy Practices**

### **Page 22: Governing Law**

### **Page 22: Grandfathered Health Plan**

### **Page 22: Information and Records**

### **Page 22: Legal Actions**

### **Page 23: Membership Application**

### **Page 23: Negligence or Malpractice**

### **Page 23: No Waiver of Rights**

### **Page 23: Other Insurance**

### **Page 23: Physical Examination**

### **Page 23: Replacement Coverage**

### **Page 24: Subrogation and Reimbursement**

Page 24: Benefits Subject to This Provision

Page 24: Statement of Purpose

Page 24: Definitions

### **Page 27: Legal notices**

Page 27: No Surprise Act

*Page 27: Your Rights and Protections Against Surprise Medical Bills*

*Page 27: What is "balance billing" (sometimes called "surprise billing")?*

*Page 27: You are protected from balance billing for*

*Page 27: When balance billing isn't allowed, you also have the following protections*

Page 28: Women's Health and Cancer Rights Act

Page 28: Late Enrollment Notice

Page 29: Wellness Program Disclosure

Page 29: Newborn Act Disclosure

Page 29: Genetic Information Non-Discrimination Act

Page 29: Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

**Page 31: ERISA information**

Page 31: A. Plan Sponsor

Page 32: B. Plan Administrator

Page 32: C. Plan Numbers

Page 32: D. Plan Documents

Page 32: F. Future of the Plans

Page 32 ERISA Rights

Page 33: Plan Information

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

Savannah River Nuclear Solutions, LLC (SRNS) maintains medical benefits under the Medical Plan designed to protect you and your family from the high cost of medical treatment. SRNS is also referred to as the Employer or Company in this Summary Plan Description (SPD). BlueCross BlueShield of South Carolina (BlueCross, BCBS or BCBS-SC) provides administrative services for your Employer's Group Health Plan. BlueCross is also referred to as the Corporation.

This SPD describes the Plan as of January 1, 2026, with subsequent amendments. Please read this summary carefully. This document explains how the Plan works, how you qualify for and ultimately receive Plan benefits, what benefits are available to you, and what your rights are as a Plan participant. The 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 under a self-funded administrative service contract with BlueCross and BlueShield of South Carolina. The Company has designated the SRNS Health and Welfare Benefit Committee as the Plan Administrator for this Plan. The Plan Administrator is responsible for maintaining the enrollment and other records related to, and administration of, the Plan. You should contact the Company through the SRNS Service Center for questions about enrollment and eligibility in the Plan. As a Claims Administrator, BlueCross provides claims payment services. You should contact them with general questions about the Plan and specific questions about claim determinations and appeals and payment of your claims. The Plan Administrator and Claims Administrator have discretionary authority to decide all issues of fact.

To the fullest extent permitted by law, the Plan Administrator will have the exclusive discretion to determine all matters relating to the Plan, including but not limited to eligibility, coverage and benefit determinations under the Plan. The Plan Administrator will also have the exclusive discretion to determine all matters relating to interpretation and operation of the Plan. The Plan Administrator may delegate any of its duties and responsibilities to one or more persons or entities. Such delegations of authority must be in writing and must identify the delegate and the scope of the delegated responsibilities. Decisions by the Plan Administrator, or any authorized delegate, will be conclusive and legally binding on all parties.

This is a summary of the most important provisions of the Plan. While this summary should answer most of your questions, it does not provide all of the details of the Medical Plan. The Medical Plan ("Plan") consists of the medical plan document prepared by BCBS for SRNS as well as the SRNS Welfare Benefit Plan, referred to as a Wrap Plan. While SRNS intends to continue the Medical Plan indefinitely it may amend or terminate the Medical Plan, for any reason, at its sole discretion.

The official Plan document is always used in cases requiring a legal interpretation of the Medical Plan. If there is any difference between the official Plan document and this summary, your rights will be based on the provisions of the official Plan document (and any legal rules that require changes not yet written into the official Plan document). To request a copy of the official Plan document, please contact the SRNS Service Center.

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

## Contacts for questions and pre-authorizations

### Claims/Customer Service

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

### Hospital Preauthorization & Medical Case Management

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

### Imaging Preauthorization

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

### Mental Health & Substance Abuse Pre-authorization

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

### Employee Assistance Program

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

### Traveling Outside the U.S.:

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

### COBRA Administrator

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

### SRNS Service Center

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

### SRNS Workforce Services

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

### Pharmacy Benefit Manager

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

# Coordination of Benefits

## Applicability

The coordination of benefits rules are intended to prevent duplicate payments from different Plans that otherwise cover a Member for the same Covered Expenses. The rules determine which is the Primary Plan and which is the Secondary Plan.

Generally, unless a specific rule applies, where a claim is submitted for payment under the BlueCross Schedule of Benefits and one or more other Plans, this Plan of Benefits is the Secondary Plan. Additionally, special rules for the coordination of benefits with Medicare may also apply.

## Coordination of Benefits with Auto Insurance

This is a self-funded ERISA Plan which does not provide benefits for claims which are paid or payable under automobile insurance coverage. Automobile insurance coverage shall include, but is not limited to, no-fault, personal injury protection, medical payments, liability, uninsured and underinsured coverage, umbrella or any other insurance coverage which may be paid or payable for the injury or illness.

Although benefits for claims which are paid or payable under automobile insurance coverage are not covered by this Plan of Benefits, the Plan/BlueCross may, in its sole discretion, agree to extend Benefits to a Member for the injury or illness. In this instance, if a Member has automobile no-fault, personal injury protection or medical payments coverage, or if such coverage is extended to the Member through a group or their own automobile insurance carrier, that coverage is primary to the Plan. The Plan will always be secondary to automobile no-fault, personal injury protection or medical payments coverage plans and the Plan will coordinate benefits for claims which are payable under those automobile policies.

If the Member resides in a state where automobile no-fault, personal injury protection or medical payments coverage is mandatory and the Member does not have the state mandated automobile coverage, the Plan will deny Benefits up to the amount of the state mandated automobile coverage.

This coordination of benefits provision applies whether the Member submits a claim under the automobile no-fault, personal injury protection or medical payments coverage.

As a condition of receiving Benefits the Member must:

1. Immediately notify the Plan/BlueCross of an injury or illness for which automobile insurance coverage may be liable, legally responsible, or otherwise makes a payment relating to the injuries or illness;
2. Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;
3. Deliver to the Employer's Plan/BlueCross a copy of your Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;
4. Deliver to the Plan/BlueCross a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within ninety (90) days of being requested to do so; and,
5. Cooperate fully with the Plan/BlueCross in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan/BlueCross.

Failure to cooperate with the Plan as required under this section will entitle the Plan/BlueCross to invoke the Auto Accident Exclusion and deny payment for all claims relating to the injury or illness up to the amount of available or state mandated coverage.

## Order of Determination Rules for Employee Members

When a Member's claim is submitted under this Plan and another Plan, this Plan is a Secondary Plan unless:

1. The other Plan has rules coordinating its benefits with those of this Plan;
2. There is a statutory requirement establishing that this Plan is the Primary Plan and such statutory requirement is not pre-empted by ERISA; or,
3. Both the other Plan's rules and this Plan's rules require that benefits be determined under this Plan before those of the other Plan.

## Additional Order of Determination Rules

The Plan coordinates benefits using the first of the following rules that apply:

1. Dependent
  - a. The Plan that covers an individual as an Employee or Retiree is the Primary Plan.
2. Dependent Child – Parents not Separated or Divorced

When this Plan and another Plan cover the same Child as a Dependent, then benefits are determined in the following order:

  - a. The Plan of the parent whose birthday falls earlier in the year (month and date) is the Primary Plan.
  - b. If both parents have the same birthday, the Plan that has covered a parent longer is the Primary Plan

- c. If the other Plan does not have the rule described in (a) above but instead has a rule based upon the gender of the parent and if, as a result, the Plan and BlueCross do not agree on the order of benefits, the gender rule in the other Plan will apply. The “birthday rule” does not use the years of the parents’ birth in determining which has the earlier birthday.
3. Dependent Child – Separated or Divorced Parents: If two (2) or more Plans cover a person as a Dependent Child of divorced, separated or unmarried parents, benefits for the Child are determined in the following order:
    - a. First, the Plan of the parent with custody of the Child;
    - b. Second, the Plan of the parent’s Spouse with the custody of the Child;
    - c. Third, the Plan of the parent not having custody of the Child;
    - d. Fourth, the Plan of the parent’s Spouse not having custody of the Child.

Notwithstanding the foregoing, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses (or health insurance coverage) of the Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, that Plan is the Primary Plan. If the parent with responsibility for healthcare expenses has no health insurance coverage for the Dependent Child, but that parent’s Spouse does have coverage, the Spouse’s Plan is the Primary Plan. This paragraph does not apply with respect to any claim determination period or plan year during which any Benefits are paid or provided before the Plan has actual knowledge of the existence of an applicable court decree.

If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the healthcare expenses of the Child (or if the order provides that both parents are responsible), the Plans covering the Child shall follow the order of determination rules outlined in this section under Additional Order of Determination Rules.

4. Active and Inactive Employees: The Plan that covers a person as an Employee who is neither laid off nor retired or as that Employee’s dependent is the Primary Plan. If the Secondary Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Covered Expenses, this rule does not apply.
5. Medicare: This Plan is a Primary Plan except where federal law mandates that the Employer’s Group Health Plan is the Secondary Plan. Any claims where Medicare is primary must be filed by the Member after Medicare payment is made.

NOTE: Coordination of benefits for retirees over age 65 who have Medicare Part A and B benefits are determined by calculating the liability of the Employer’s Group Health Plan in the absence of Medicare and “carving-out” or subtracting Medicare’s payment.

When Medicare is primary and this Plan is secondary and the person did not elect coverage under Part B, Benefits may be reduced by the amount that would have been paid by Medicare Part B, had the person elected such coverage. For more information about how Medicare works with other insurance visit <https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance>

6. Longer or Shorter Length of Coverage: If none of the above rules determines the order of benefits, the Plan that has covered the Member longer is the Primary Plan.
7. COBRA: COBRA allows coverage to begin to continue under certain circumstances if the Member already has or obtains coverage under a Group Health Plan. In these situations, two policies may cover the Member, and the Plan providing COBRA coverage will be the Secondary Plan.

## Effect on Benefits of This Plan of Benefits

1. The Employer’s Group Health Plan as Primary Plan: When the Employer’s Group Health Plan is the Primary Plan, the Benefits shall be determined without consideration of the benefits of any other Plan.
2. The Employer’s Group Health Plan as Secondary Plan: When the Employer’s Group Health Plans a Secondary Plan, the Benefits will be reduced when the sum of the following exceeds the Covered Expenses in a Benefit Year:
  - a. The Covered Expenses in the absence of this coordination of benefits provision; plus
  - b. The expenses that would be payable under the other Plan in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not a claim is made.

When the sum of these two amounts exceeds the maximum amount payable for Covered Expenses in a Benefit Year, the Covered Expenses will be reduced so that they and the Benefits payable under the Primary Plan do not total more than the Covered Expenses. When the Covered Expenses of the Plan are reduced in this manner, each Benefit is reduced in proportion and then charged against any applicable limit of the Employer’s Group Health Plan.

3. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered for purposes of determining the appropriate level of coverage available.
4. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not a Covered Expense unless the Member’s Admission in a private Hospital room is Medically Necessary. When benefits are reduced under a Primary Plan because a Member does not comply with the Primary Plan’s requirements, the amount of such reduction in benefits will not be a Covered Expense.

## Right to Receive and Release Needed Information

The Plan (including through BlueCross) is entitled to such information as it deems reasonably necessary to apply these coordination of benefit provisions and the Member and the Employer must provide any such information as reasonably requested.

## **Payment**

A payment made under another Plan may include an amount that should have been paid under the Plan. In such a case, the Plan may pay that amount to the organization that made such payment. That amount will then be treated as though it had been paid under the Employer's Group Health Plan. The term "payment" includes providing Benefits in the form of services, in which case "payment" means the reasonable cash value of the Benefits provided in the form of services.

## **Right of Recovery**

If the amount of the payments made by the Plan is more than the Plan should have paid under this Coordination of Benefits section, the Plan may recover the excess or overpayment from the Member on whose behalf it has made payments, from a Provider, from any group insurer, Plan, or any other person or organization contractually obligated to such Member with respect to such overpayments.

# Claims filing and Appeal Procedure

## Claims Filing Procedure

1. Where a Participating Provider renders services, generally the Participating Provider should either file the claim on a Member's behalf or provide an electronic means for the Member to file a claim while the Member is in the Participating Provider's office. However, the Member is responsible for ensuring that the claim is filed.
2. Written notice of receipt of services on which a claim is based must be furnished to BlueCross, at its address listed at the beginning of this booklet, within twenty (20) days of the beginning of services, or as soon thereafter as is reasonably possible. Failure to give notice within the time does not invalidate nor reduce any claim if the Member can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, BlueCross will furnish or cause a claim form to be furnished to the Member. If the claim form is not furnished within fifteen (15) days after BCBS receives the notice, the Member will be deemed to have complied with the requirements of this Plan as to proof of loss. The Member must submit written proof covering the character and extent of the services within the time fixed for filing proof of loss.
3. For Benefits not provided by a Participating Provider, the Member is responsible for filing claims with BCBS. When filing the claims, the Member will need the following:
  - a) A claim form for each Member. Members can get claim forms from a member services representative at the telephone number indicated on the Identification Card or via BCBS's website, [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).
  - b) Itemized bills from the Provider(s). These bills should contain all the following:
    - i. Provider's name and address;
    - ii. Member's name and date of birth;
    - iii. Member's Identification Card number;
    - iv. Description and cost of each service;
    - v. Date that each service took place; and
    - vi. Description of the illness or injury and diagnosis.
  - c) Members must complete each claim form and attach the itemized bill(s) to it. If a Member has other insurance that already paid on the claim(s), the Member should also attach a copy of the other Plan's EOB notice.
  - d) Members should make copies of all claim forms and itemized bills for the Member's records since they will not be returned. Claims should be mailed to the BlueCross address listed on the claim form.
4. BCBS must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Member shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than fifteen (15) months following the date services were received.
5. Receipt of a claim by BCBS will be deemed written proof of loss and will serve as written authorization from the Member to BCBS to obtain any medical or financial records and documents useful to BCBS. BCBS, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only based on the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to BCBS in support of a Member's claim will be deemed to be acting as the agent of the Member. If the Member desires to appoint an Authorized Representative in connection with such Member's claims, the Member should contact the BlueCross for an Authorized Representative form.
6. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims and Concurrent Care Claims. The Plan will decide for each type of claim within the following time periods:
  - a) Pre-Service Claim
    - i. A determination will be provided in writing or in electronic form within a reasonable period, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.
    - ii. If a Pre-service Claim is improperly filed or otherwise does not follow applicable procedures, the Member will be sent notification within five (5) days of receipt of the claim.
    - iii. An extension of fifteen (15) days is permitted if BlueCross (on behalf of the Plan) determines that, for reasons beyond the control of BlueCross, an extension is necessary. If an extension is necessary BlueCross will notify the Member within the initial fifteen (15) daytime period that an extension is necessary, the circumstances requiring the extension, and the date BlueCross expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If BlueCross does not receive the required information within the forty-five (45) daytime period, the claim will be denied. BlueCross will make its determination within fifteen (15) days of receipt of the requested information or, if earlier, the deadline to submit the information. If BlueCross receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal. Reference Section 10, B for details regarding appeals.
  - b) Urgent Care Claim

- i. A determination will be sent to the Member in writing or in electronic form as soon as possible considering the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.
  - ii. If the Member's Urgent Care Claim is determined to be incomplete, the Member will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Member will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.
  - iii. If the Member requests an extension of urgent care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Member will be notified within twenty-four (24) hours of receipt of the request for an extension.
- c) Post-Service Claim
- i. A determination will be sent within a reasonable time, but no later than thirty (30) days from receipt of the claim.
  - ii. An extension of fifteen (15) days may be necessary if BCBS (on behalf of the Plan) determines that, for reasons beyond the control of BlueCross, an extension is necessary. If an extension is necessary, BlueCross will notify the Member within the initial thirty (30) daytime that an extension is necessary, the circumstances requiring the extension and the date BlueCross expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If BlueCross does not receive the required information within the forty-five (45) daytime period, the claim will be denied. BlueCross will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If BlueCross receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal. Reference Section 10.B for details regarding the appeals process.
- d) Concurrent Care Claim
- i. The Member will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Member time to appeal the decision before the Benefits are reduced or terminated.

### Notice of Determination

1. If the Member's claim is filed properly, and the claim is in part or wholly denied, the Member will receive notice of an Adverse Benefit Determination, in a culturally and linguistically appropriate manner, that will:
  - a) Include information sufficient to identify the claim involved (including date of service, healthcare Provider, claim amount (if applicable)) and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;
    - i. State the specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim;
    - ii. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Member's claim;
    - iii. Reference the specific Plan of Benefits provisions on which the determination is based;
    - iv. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;
    - v. Describe the claims review procedures and the Plan of Benefits and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;
    - vi. Disclose any internal rule, guideline or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request);
    - vii. If the reason for denial is based on a lack of Medical Necessity or Investigational or Experimental Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
    - viii. Disclose any internal rule, guideline or protocol relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);
    - ix. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals. For claims involving an urgent care claim, a description of the expedited internal and external review processes applicable to such claims;
    - x. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes; and,
    - xi. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA.
    - xii. The Member will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings, associated with the Adverse Benefit Determination.
    - xiii. No decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support the denial of Benefits.
    - xiv. The Member will also receive a notice if the claim is approved.

# Appeal Procedures for an Adverse Benefit Determination

## Initial Appeal

1. Member has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:
  - a. An appeal must be in writing;
  - b. An appeal must be sent (via U.S. mail) at the address below:

BlueCross BlueShield of South Carolina  
Claims Administrator  
Claims Service Center  
Post Office Box 100300  
Columbia, South Carolina 29202
  - c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,
  - d. An appeal must include the Member's name, address, identification number and any other information, documentation or materials that support the Member's appeal.
2. The Member may submit written comments, documents or other information in support of the appeal, and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.
3. The Member must raise all issues and grounds for appealing an Adverse Benefit Determination at every stage of the appeals process or such issues and grounds will be deemed permanently waived.
4. If the appealed claim involves an exercise of medical judgment, the Employer will consult with an appropriately qualified BCBS healthcare practitioner with training and experience in the relevant field of medicine. If a healthcare professional was consulted for the initial determination, a different healthcare professional will be consulted on the appeal.
5. The initial decision on an appeal will be made by the Claims Administrator (BlueCross BlueShield of SC) within the time periods specified below:
  - a. Pre-Service Claim: BlueCross (on behalf of the Plan) will decide the appeal within a reasonable period, considering the medical circumstances, but no later than thirty (30) days after receipt of the appeal.
  - b. Urgent Care Claim: The Member may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and BCBS (on behalf of the Plan) will communicate with the Member by telephone or facsimile. BCBS will decide the appeal within a reasonable period, considering the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.
  - c. Post-Service Claim: BlueCross (on behalf of the Plan) will decide the appeal within a reasonable period, but no later than sixty (60) days after receipt of the appeal.
  - d. Concurrent Care Claim: BlueCross will decide the appeal (on behalf of the Plan) of Concurrent Care Claims within the time frames set forth in Section 5, a-c, (BlueCross Article XI(B)(5)(a-c)) depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.
6. Notice of Appeals Determination by the Claims Administrator
  - a. If a Member's appeal is denied in whole or in part, the Member will receive notice of an Adverse Benefit Determination, in a culturally and linguistically appropriate manner, that will:
    - i. Include information sufficient to identify the claim involved (including date of service, healthcare Provider, claim amount (if applicable)) and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;
    - ii. State specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim and a discussion of the decision;
    - iii. Reference specific provision(s) of the Plan of Benefits on which the Benefit determination is based;
    - iv. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;
    - v. Describe any voluntary appeal procedures offered by BlueCross (on behalf of the Employer's Group Health Plan) and the Member's right to obtain such information;
    - vi. Disclose any internal rule, guideline or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request);
    - vii. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
    - viii. A description of any material or information necessary for the claim to be completed and an explanation of why such material or information is necessary;
    - ix. For a claims denial involving an urgent care claim, a description of the expedited external review processes applicable to such claims;

- x. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals;
  - xi. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act, to assist individuals with the internal claims and appeals and external review processes; and,
  - xii. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA.
- b. The Member will also receive, free of charge, any new or additional evidence considered, relied upon or generated regarding the claim. This evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination is received, to give the Member a reasonable opportunity to respond prior to that date.
  - c. If the Adverse Benefit Determination is based on a new or additional rationale, then the Member will be provided with the rationale, free of charge. The rationale will be provided as soon as possible and sufficiently in advance of the date of the Adverse Benefit Determination to give the Member a reasonable opportunity to respond prior to that date.
  - d. The Member will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings, associated with the Adverse Benefit Determination.
  - e. No decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support the denial of Benefits.
  - f. A Member's claim and appeals will be decided pursuant to a good faith interpretation of the Plan of Benefits, in the best interest of the Member, without considering either the amount of the Benefits that will be paid to the Member or the financial impact on the Plan.
  - g. The Member will also receive a notice if the claim on appeal is approved.
  - h. SRNS may retain BlueCross to assist the Employer in making the determination on appeal. Regardless of its assistance, BlueCross is only acting in an advisory capacity and is not acting in a fiduciary capacity. SRNS, at all times, retains the right to make the final determination.

## External Review Procedures

1. After a Member has completed the appeal process, a Member may be entitled to an additional, external review of the Member's claim at no cost to the Member. An external review may be used to reconsider the Member's claim if BlueCross has denied, either in whole or in part, the Member's claim. In order to qualify for external review, the claim must have been denied, reduced, or terminated because:
  - a. It does not meet the requirements for Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness; or,
  - b. It is an Investigational or Experimental Service and it involves a life-threatening or seriously disabling condition.
2. After a Member has completed the appeal process, (and an Adverse Benefit Determination has been made) such Member will be notified in writing of such Member's right to request an external review. The Member should file a request for external review within four (4) months of receiving the notice of BlueCross's decision on the Member's appeal. In order to receive an external review, the Member will be required to authorize the release of such Member's medical records (if needed in the review for the purpose of reaching a decision on Member's claim).
3. Within five (5) business days of the date of receipt of a Member's request for an external review, BlueCross will respond by either:
  - a. Assigning the Member's request for an external review to an independent review organization and forwarding the Member's records to such organization; or,
  - b. Notifying the Member in writing that the Member's request does not meet the requirements for an external review and the reasons for BlueCross's decision.
4. The external review organization will act on the Member's request for an external review within forty-five (45) days after it receives the request for external review from BlueCross.
 

The notice will include:

  - a. A general description of the reason for the request for external review, including the date or dates of service, the health care provider and the claim amount (if applicable),
  - b. The date the independent review organization (IRO) received the assignment to conduct the external review and the date of the IRO decision,
  - c. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision,
  - d. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision, and
  - e. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan, such as judicial review, and including current contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PHS Act Section 2793

Upon receipt of a notice of a final external review decision to reverse the adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or paying benefits) for the claim.
5. Expedited external reviews are available if the Member's Provider certifies that the Member has a Serious Medical Condition. A Serious Medical Condition, as used in this Section means one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place the Member's health in serious jeopardy. If the Member may be held financially responsible for the treatment, a Member may request an

expedited review of BlueCross's decision if BlueCross's denial of Benefits involves Emergency Services and the Member has not been discharged from the treating Hospital. The independent review organization must make its decision within seventy-two (72) hours after it receives the request for expedited review.

## **Final Appeal**

The final appeal request available to you is directly to the Plan Administrator. However, the final appeal is only available after you have exhausted all appeal opportunities through the Claims Administrator and completed an external review, if the member meets the requirements for an external review. The final appeal request to the Plan Administrator must be submitted within 30 days from the date of the notice of external review determination. Should the member not meet the requirements for an external review, then the member has 30 days from the date of the notice of determination of the appeal provided by the Claims Administrator to file their final appeal. Your appeal to the Plan Administrator must be in writing and include your name, the claimant's name, your address, identification number, and any other information, documentation, or materials that supports the appeal. In addition, your appeal must include all documents, records, questions or comments necessary for a complete review, including reference to the specific Plan provisions that you feel were misinterpreted, or inaccurately applied and copy of notice of determinations of the initial appeal provided by the claims administrator and notice of determination from the external review if available to the member and if not a copy of the notice to member stating the external review was not available to the member. The Plan Administrator will decide the appeal within a reasonable period of time, but no later than 60 days after receipt of the appeal. You will be notified if there are special circumstances that cause the review to take longer. Your appeal to the Plan should be sent to:

Savannah River Nuclear Solutions  
Attn: Plan Administrator  
992-2W Savannah River Site  
Aiken, SC 29808

In deciding an appeal regarding an adverse benefit determination that is based, in whole or in part, on a medical or dental judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate), the Plan will obtain an opinion from a health care professional who has the appropriate training and experience in the field involved in the medical or dental judgment. (The Plan Administrator may use the opinion obtained by the Claim Administrator from an independent peer review organization as part of any voluntary second level appeal you filed with the Claim's Administrator). The Plan Administrator has full discretion and authority to interpret Plan provisions, resolve any ambiguities and evaluate claims. The decision made by Plan Administrator is final and binding. If you fail to appeal an adverse benefit determination within the time frames set forth above, you will have waived your right to an appeal. The exhaustion of the claim and appeal procedure is mandatory for resolving any claim arising under this Plan. Federal law requires you to pursue all claim and appeal rights on a timely basis before seeking any other legal recourse regarding claims for benefits. As a participant in the Medical Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 as amended (ERISA). The official documents that govern the Plan dictate the actual operation of the Plan and the payment of benefits.

# COBRA Continuation Coverage

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

On May 4, 2020, in response to the National Emergency concerning the Novel Coronavirus Disease (COVID-19) Outbreak (National Emergency),<sup>5</sup> the Agencies published the Joint Notice, which extended certain timeframes otherwise applicable to group health plans, disability and other welfare plans, pension plans, and their participants and beneficiaries under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code of 1986 (Code). The Joint Notice extended these timeframes by requiring that plans subject to ERISA or the Code disregard the period for certain action from March 1, 2020, until 60 days after the announced end of the National Emergency or such other date announced by the Agencies in a future notification (the Outbreak Period), subject to a maximum disregarded period of one year.

The American Rescue Plan Act of 2021 (ARP) provides temporary premium assistance for COBRA continuation coverage and, where the employer elects to offer the option, an opportunity to switch to a different health plan option offered by your employer (see below for more information). Premium assistance is available to certain individuals who are eligible for COBRA continuation coverage due to a qualifying event that is a reduction in hours or an involuntary termination of employment. If you qualify for premium assistance, you do not need to pay any of the COBRA premium otherwise due to the plan for the months when you are eligible for premium assistance. This premium assistance is available from April 1, 2021 through September 30, 2021. If you choose to continue your COBRA continuation coverage beyond that date, you may have to pay the full COBRA premium amount due. However, when your premium assistance ends, you may qualify for a special enrollment period to enroll in coverage through the Health Insurance Marketplace.

When you become eligible for COBRA, you may also become eligible for other options that may cost less than COBRA continuation coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

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

## Continuation Coverage

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

## Disabled Members

1. To be eligible for up to twenty-nine (29) months of continuation of coverage due to disability, an Employee or Dependent
  - a. who is determined to be disabled under Title II or XVI of the Social Security Act,
  - b. With a disability onset date either before the COBRA event or within the first sixty (60) days of the COBRA continuation coverage must provide a copy of the notice of the determination of disability to the Employer within:
    - i. sixty (60) days of the determination of disability; and,
    - ii. before the end of the first eighteen (18) months of COBRA coverage.

Such Employee or Dependent must also notify the Employer within thirty (30) days of any determination that the Employee or Dependent is no longer disabled.

## Notice of Qualifying Event by the Member

Each Member is responsible for notifying the Employer within sixty (60) days of such Member's Qualifying Event due to divorce, legal separation or when a Dependent ceases dependency. If the Member does not give such notice, the Member is not entitled to continuation coverage.

## Notice by SRNS to the Member

SRNS must notify the COBRA Administrator no later than thirty (30) days after the date the Member loses coverage due to a COBRA event. The COBRA Administrator must send a COBRA election Notice to each Member no later than fourteen (14) days after receipt of the notice from the Employer. Notice to the Dependent Spouse is deemed notice to any Dependent of the Spouse.

## Election of Coverage

Continuation coverage is not automatic. The Member must elect continuation coverage within sixty (60) days of the later of:

1. The date the Member's coverage under the Employer's Group Health Plan ceases because of the Qualifying Event;
2. The date the Member is sent notice by the Employer of the right to elect continuation coverage; or,
3. The date the Member becomes an "eligible individual" (as that term is used in the Trade Act of 2002) provided that such election is made not later than six (6) months after the Qualifying Event that gives rise to eligibility under the Trade Act of 2002.

## Premium Required

The Member will be required to pay a Premium for the continuation coverage and shall have the option to make payment in monthly installments. The Member has forty-five (45) days from the date of election to pay the first Premium, which includes the period when coverage commenced, regardless of the date that the first Premium is due.

The Trade Act of 2002 (TAA) created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of a percentage of the Premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282. More information about the TAA is also available at [www.doleta.gov/tradeact/](http://www.doleta.gov/tradeact/).

## Length of COBRA Coverage

The maximum period for continuation coverage for a Qualifying Event involving termination of employment or a reduction in hours is generally eighteen (18) months. An Employee or Dependent who is determined to be disabled under Title II or XVI of the Social Security Act before the COBRA event or within the first sixty (60) days of COBRA continuation coverage is entitled to twenty-nine (29) months of continuation coverage, but only if such Employee or Dependent has provided notice of the determination of disability within sixty (60) days after determination is issued and before the end of eighteen (18) months of coverage. If a second Qualifying Event occurs within this period of continuation coverage, the coverage for any affected Dependent who was a Member under the Employer's Group Health Plan both at the time of the first and the second Qualifying Events may be extended up to thirty-six (36) months from the first Qualifying Event. For all other Qualifying Events, the maximum period of coverage is thirty-six (36) months. Below is a list of circumstances and the period of COBRA coverage for each circumstance.

1. Eighteen (18) months for Employees whose working hours are reduced, from full-time to part-time for instance and any Dependents who also lose coverage for this reason.
2. Eighteen (18) months for Employees who voluntarily quit work and any Dependents who also lose coverage for this reason.
3. Eighteen (18) months for Employees who are part of a layoff and any Dependents who also lose coverage for this reason.
4. Eighteen (18) months for Employees who are fired, unless the firing is due to gross misconduct, and any Dependents who also lose coverage for this reason.
5. Twenty-nine (29) months for Employees and all covered Dependents who are determined to be disabled under the Social Security Act during the first sixty (60) days after termination of employment or reduction of hours of employment. Notice of the Social Security Disability determination must be given to the COBRA Administrator within sixty (60) days of the determination of disability and before the end of the first eighteen (18) months of continuation of coverage.
6. Thirty-six (36) months for Employees' widows or widowers and their Dependent Children.
7. Thirty-six (36) months for legally separated or divorced husbands or wives and their Dependent Children.
8. Thirty-six (36) months for Dependent Children who lose coverage because they no longer meet the Plan's definition of a Dependent Child.
9. Generally, thirty-six (36) months for Dependents who are not eligible for Medicare when the Employee is eligible for Medicare and no longer has coverage with the Employer. This does not apply to any Employees or their Dependents if the Employee voluntarily quit work. See Section 8.G.2 (BlueCross Article VII(A)(1)(g)(ii)) for coverage for Employees who voluntarily quit. Refer to Continuation of Health Coverage (COBRA) | U.S. Department of Labor ([dol.gov](http://dol.gov)) at <https://www.dol.gov/general/topic/health-plans/cobra> for more information.
10. For Plans providing coverage for retired Employees and their Dependents, a special rule applies for such persons who would lose coverage due to the Employer filing for Title 11 Bankruptcy. (Loss of coverage includes a substantial reduction of coverage within a year before or after the bankruptcy filing.) Upon occurrence of such an event, retired Employees and their eligible Dependents may continue their coverage under the Plan until the date of death of the retiree. If a retiree dies while on this special continued coverage, surviving Dependents may elect to continue coverage for up to thirty-six (36) additional months.

## How can you elect COBRA continuation coverage?

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

The Plan's COBRA Administrator, WageWorks, will send you an election form in the mail to your address of record. To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent

children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. It is you or your dependent's responsibility to notify the Service Center within 60 days of the qualifying event.

## **Things to consider when electing COBRA**

### **Impacts to eligibility for SRNS retiree medical plans and COBRA**

If you or your dependents elect COBRA medical or dental coverage the electing individual – you or your dependents – will have waived the right to enroll in the SRNS Retiree Plans (Medical, Dental, and Retiree Reimbursement Account). However, you or your dependent(s) may elect COBRA vision and still participate in the SRNS retiree medical and dental plans. Conversely, if you elect to enroll in the SRNS Retiree Medical and Dental Plan, you cannot elect COBRA continuation coverage.

### **Impacts to eligibility for other group or individual medical plans**

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

### **How long will COBRA continuation coverage last?**

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

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

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

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

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

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

### **How can you extend the length of COBRA continuation coverage?**

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Administrator of a disability or a second qualifying event to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

### **Second Qualifying Event under COBRA**

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

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

### **Disability under COBRA**

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

You must notify the COBRA Administrator of your disability status within 60 days of the SSA determination and prior to the end of the 18-month period of continuation coverage. You will be required to submit a copy of the letter from the SSA notifying you of your disability status. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if they qualify. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the COBRA Administrator of the change within 30 days after SSA's determination.

### **How much does COBRA continuation coverage cost?**

- You pay 102% of the full cost of COBRA continuation coverage.
- You pay 150% of the premium during an 11-month disability extension.

### **When and how is payment made for COBRA 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 full payment for continuation coverage within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator with any questions you may have.

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

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

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan. You must make a payment even if you do not receive an invoice. An invoice is a courtesy provided by the COBRA administrator. Your first payment and all periodic payments for continuation coverage should be sent to the COBRA Administrator:

HealthEquity® (formerly WageWorks)  
P.O. Box 660212  
Dallas, TX 75266-0212  
Phone: 888.678.4872

### **Are there other coverage options besides COBRA Continuation Coverage?**

Yes, instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many options at [www.healthcare.gov](http://www.healthcare.gov).

### **For more information**

You should keep WageWorks, the COBRA Administrator, informed of any changes in your address and the addresses of family members. If you have any questions concerning the information or your rights to coverage, you should contact:

HealthEquity® (formerly WageWorks)  
P.O. Box 660212  
Dallas, TX 75266-0212  
Phone: 888.678.4872

# HIPAA Certification

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

## Privacy of Protected Health Information Certification of Compliance

Neither the Plan nor any third-party business associate servicing the Plan will disclose Plan Participants' Protected Health Information (PHI) to SRNS unless SRNS certifies that the Plan Document has been amended to comply with the privacy rules under HIPAA, and as set forth below and agrees to abide by the Privacy Rules.

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

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

## Purpose or Disclosure to SRNS

- The Plan and any third-party business associate servicing the Plan will disclose PHI obtained from the Plan to SRNS only to permit SRNS to carry out the administrative functions for the Plan not inconsistent with the requirements of the HIPAA. Any disclosure to and use by SRNS of PHI obtained from the Plan will be subject to and consistent with the provisions of this section.
- Neither the Plan nor any third-party business associate servicing the Plan will disclose PHI obtained from the Plan to SRNS unless the disclosures are explained in the Notice of Privacy Practices distributed to the plan participants.

## Adequate Separation Between the Company and The Plan

SRNS's Workforce Services, Business Services, Internal Audit and General Counsel employees may be given access to Plan participants' PHI received from the Medical Plan, health insurance issuer or business associate servicing the Medical Plan. Additionally, as previously stated, SRNS operates the Service Center as a service for the SRNS Medical 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 health insurance issuer or business associate servicing the Medical 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 Medical 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. SRNS will report such breach, violation or noncompliance to the Plan. SRNS will cooperate with the Medical Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action on each employee 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.

# General Provisions

**Administrative Services Only:** BCBS provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The Employer's Group Health Plan is a self-funded health Plan and the Employer assumes all financial risk and obligation with respect to claims.

**Amendment:** Upon thirty (30) days prior written notice, the Employer may unilaterally amend the Employer's Group Health Plan. Increases in the Benefits provided or decreases in the Premium are effective without such prior notice. The Corporation has no responsibility to provide individual notices to each Member when an amendment to the Employer's Group Health Plan has been made.

**Authorized Representatives:** A Provider may be considered a Member's authorized representative without a specific designation by the Member when the Preauthorization request is for Urgent Care Claims. A Provider may be a Member's authorized representative regarding non-Urgent Care Claims only when the Member gives BlueCross or the Provider a specific designation, in a format that is reasonably acceptable to the Plan to act as an authorized representative. If the Member has designated an authorized representative, all information and notifications will be directed to that representative unless the Member gives contrary directions.

**Clerical Errors:** Clerical errors by the Corporation or the Employer will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

**Notice of Nondiscrimination:** The SRNS Medical Plan does not discriminate or exclude participants based on race, color, national origin, sex, age, or disability. Any complaints, questions or concerns should be directed to the SRNS Plan Administrator, Bldg. 992-2W Savannah River Site., Aiken, SC 29808 or by phone; 803-952-5767.

## Disclosure of Personal Health Information to Plan Sponsor

The Employer's Group Health Plan will disclose (or will require BlueCross to disclose) Member's Personal Health Information (PHI) to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Employer's Group Health Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Plan Sponsor will be subject to and consistent with the provisions of paragraphs A and B of this section.

1. Restrictions on Plan Sponsor's Use and Disclosure of PHI.
  - a. The Plan Sponsor will neither use nor further disclose Member's PHI, except as permitted or required by the Plan Documents, as amended, or required by law.
  - b. The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Member PHI agrees to the restrictions and conditions of the Plan of Benefits, with respect to Member's PHI.
  - c. The Plan Sponsor will not use or disclose Member PHI for employment-related actions or decisions or relating to any other benefit or Employee Benefit Plan of the Plan Sponsor.
  - d. The Plan Sponsor will report to Employer's Group Health Plan any use or disclosure of Member PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
  - e. The Plan Sponsor will make PHI available to the Member who is the subject of the information in accordance with HIPAA.
  - f. The Plan Sponsor will make Member PHI available for amendment, and will on notice amend Member PHI, in accordance with HIPAA.
  - g. The Plan Sponsor will track disclosures it may make of Member PHI so that it can make available the information required for the Employer's Group Health Plan to provide an accounting of disclosures in accordance with HIPAA.
  - h. The Plan Sponsor will make its internal practices, books and records, relating to its use and disclosure of Member PHI, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.
  - i. The Plan Sponsor will, if feasible, return or destroy all Member PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the Employer's Group Health Plan, including all copies of and any data or compilations derived from and allowing identification of any Member who is the subject of the PHI, when the Member's PHI is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Plan Sponsor will limit the use or disclosure of any Member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.
  - j. The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that Plan Sponsor creates, receives, maintains or transmits on behalf of the Employer's Group Health Plan.
  - k. The Plan Sponsor will ensure that any agent, including a subcontractor, to whom Plan Sponsor provides ePHI (that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Employer's Group Health Plan), agrees to implement reasonable and appropriate security measures to protect this information.

- I. Plan Sponsor shall report any security incident of which it becomes aware to the Employer's Group Health Plan as provided below.
  - i. In determining how and how often Plan Sponsor shall report security incidents to Employer's Group Health Plan, both Plan Sponsor and Employer's Group Health Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both Plan Sponsor and Employer's Group Health Plan agree that this Agreement shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the Parties consider the following to be illustrative (but not exhaustive) of unsuccessful security incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of ePHI or interference with an information system:
    - aa. Pings on a Party's firewall;
    - bb. Port scans;
    - cc. Attempts to log on to a system or enter a database with an invalid password or username;
    - dd. Denial-of-service attacks that do not result in a server being taken offline; and,
    - ee. Malware (e.g., worms, viruses).
  - ii. Plan Sponsor shall, however, separately report to Employer's Group Health Plan (i) any successful unauthorized access, use, disclosure, modification or destruction of the Group Health Plan's ePHI of which Plan Sponsor becomes aware if such security incident either (a) results in a breach of confidentiality; (b) results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of Group Health Plan's ePHI; or (c) results in a breach of availability of Group Health Plan's ePHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after Plan Sponsor becomes aware of the impact of such security incident upon Group Health Plan's ePHI.
2. Adequate Separation between the Plan Sponsor and the Employer's Group Health Plan.
  - a. Only Employees or other workforce members under the control of the Plan Sponsor ("Employees") who, in the normal course of their duties, assist in the administration of Employee Benefits or the Employer's Group Health Plan or the Employer's Group Health Plan finances or other classes of Employees as designated in writing by the Plan Sponsor may be given access to Member PHI received from the Employer's Group Health Plan or business associate servicing the Employer's Group Health Plan.
  - b. These Employees will have access to Member PHI only to perform the Plan administration functions that the Plan Sponsor provides for the Employer's Group Health Plan.
  - c. These Employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Member PHI in breach or violation of or noncompliance with the provisions of this section to the Plan of Benefits. Plan Sponsor will promptly report such breach, violation or noncompliance to the Employer's Group Health Plan, and will cooperate with the Employer's Group Health Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each Employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Member, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.
  - d. The Plan Sponsor will ensure that the separation required by the above provisions will be supported by reasonable and appropriate security measures.
  - e. Plan Sponsor certifies that the Plan of Benefits contains and that the Plan Sponsor agrees to the provisions outlined above.

# Notice of Privacy Practices

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

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

## 1. Uses and Disclosures of Information that the Group Health Plan May Make Without Written

**Authorization.** The Group Health Plan may use or disclose protected health information for the following purposes without your written authorization as long as the legal requirements are met. The examples provided are not meant to be exhaustive.

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

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

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

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

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

**Abuse or Neglect.** The Group Health Plan may disclose protected health information to an appropriate government agency if it believes it is related to child abuse or neglect or in certain circumstances if it believes it is related to a victim of abuse, neglect or domestic violence. Health Oversight Activities. The Group Health Plan may disclose protected health information to governmental health oversight agencies for activities authorized by law, such as audits, investigations, and inspections. "Health oversight activity" does not include an investigation or other activity relating to you.

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

**Law Enforcement.** The Group Health Plan may disclose protected health information, subject to specific limitations, see Benefits Orientation Guide for New Full-Time Employees 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, then 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 Plan 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 Page 6 • Benefits Orientation Guide for New Full-Time 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 a 12-month period free of charge. 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, including protected health information created or received prior to making changes to the Notice. The new notice will be posted on the Group Health Plan's website.

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

- **Additional Information.** If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the below address. There will be no retaliation for filing a complaint.  
Office for Civil Rights  
Department of HHS  
Jacob Javits Federal Building  
26 Federal Plaza - Suite 3312  
New York, NY 10278  
Voice Phone (212) 264-3313  
FAX (212) 264-3039  
TDD (212) 264-2355

**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.

- **For Further Information.** If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the SRNS Privacy Officer by phone at (803) 952-8749 or at the following address: Bldgs. 992-2W Savannah River Site, Aiken, SC 29808. This Notice of Privacy Practices is also available on our SRNS web page at [https://www.srs.gov/general/jobs/benefits/index\\_e.htm](https://www.srs.gov/general/jobs/benefits/index_e.htm).

## Governing Law

The Employer's Group Health Plan (including the Schedule of Benefits) is governed by and subject to applicable federal law. If and to the extent that federal law does not apply, the Employer's Group Health Plan is governed by and subject to the laws of the State of South Carolina. If federal law conflicts with any state law, then such federal law shall govern. If any provision of the Employer's Group Health Plan conflicts with such law, the Employer's Group Health Plan shall automatically be amended solely as required to comply with such state or federal law.

## Grandfathered Health Plan

As of January 1, 2014, the SRNS Medical Plan is not considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("Act"). As permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Questions regarding health plan status can be directed to the Plan Administrator at 803.952.5749. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1.866.444.3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

## Identification Card

A Member must present his or her Identification Card prior to receiving Benefits. Identification Cards are for identification only. Having an Identification Card creates no right to Benefits or other services. To be entitled to Benefits, the cardholder must be a Member whose Premium has been paid. Any person receiving Covered Expenses to which the person is not entitled will be responsible for the charges.

## Information and Records

The Corporation and the Employer are entitled to obtain such medical and Hospital records as may reasonably be required from any Provider incident to the treatment, payment and healthcare operations for the administration of the Benefits hereunder and the attending Provider's certification as to the Medical Necessity for care or treatment.

## Legal Actions

No Member may bring an action at law or in equity to recover on the Employer's Group Health Plan until such Member has exhausted the appeal process as set forth in Section 7 (BlueCross Article XI). No such action may be brought after the expiration of any applicable period or Statute of Limitations as prescribed by applicable State or Federal law.

## Membership Application

BlueCross will only accept a Membership Application submitted by the SRNS on behalf of its Employees. BlueCross will not accept Membership Applications directly from Employees or Dependents.

## Negligence or Malpractice

BlueCross and SRNS do not practice medicine. Any medical treatment, service or Medical Supplies rendered to or supplied to any Member by a Provider is rendered or supplied by such Provider and not by the Corporation or the Employer. The Corporation and Employer are not liable for any improper or negligent act, inaction or act of malfeasance of any Provider in rendering such medical treatment, service, Medical Supply or medication.

## Notices

Except as otherwise provided in the Plan, any notice under the Plan may be given by United States registered or certified mail, postage paid, return receipt requested or nationally recognized carrier and addressed:

1. To BlueCross: BlueCross BlueShield of South Carolina, P.O. Box 100300, Columbia, South Carolina 29202
2. To a Member: To the last known name and address listed for the Employee related to such Member on the Membership Application. Members are responsible for notifying the Corporation of any name or address changes within thirty-one (31) days of the change.
3. To the Employer: To the name and address last given to BlueCross. The Employer is responsible for notifying BlueCross and Members of any name or address change within thirty-one (31) days of the change.

## No Waiver of Rights

On occasion, BlueCross (on behalf of the Plan) or SRNS may, at their discretion, choose not to enforce all the terms and conditions of the Plan. Such a decision does not mean the Plan or Employer waives or gives up any rights under the Employer's Group Health Plan in the future.

## Other Insurance

Each Member must provide the Plan (and its designee, including the Corporation) and Employer with information regarding all other health insurance coverage to which such Member is entitled.

## Payment of Claims

A Member is expressly prohibited from assigning any right to payment of Covered Expenses or any payment related to Benefits. The Plan may pay all Covered Expenses directly to the Member upon receipt of due proof of loss when a Non-Participating Provider renders services. When payment is made directly to the Member, the Member is responsible for any payment to the Provider. Where a Member has received Benefits from a Participating Provider, the Employer's Group Health Plan will pay Covered Expenses directly to such Participating Provider.

## Physical Examination

The Plan has the right to have examined, at their own expense, a Member whose injury or sickness is the basis of a claim (whether pre-service, post-service, concurrent or urgent care). Such physical examination may be made as often as the Plan (through its designee, including BlueCross) may reasonably require while such claim for Benefits or request for Preauthorization is pending.

## Replacement Coverage

If the Plan replaced the Employer's prior Plan, all eligible persons who were validly covered under that Plan on its termination date will be covered on the Plan of Benefits Effective Date of the Plan, provided such persons are enrolled for coverage as stated in Section 2.

## Right of Recovery

If the amount of the payments made by the Plan is more than the Plan should have paid under this Coordination of Benefits section, the Plan may recover the excess or overpayment from the Member on whose behalf it has made payments, from a Provider, from any group insurer, Plan, or any other person or organization contractually obligated to such Member with respect to such overpayments.

# Subrogation and Reimbursement

## Benefits Subject to This Provision

This provision shall apply to all Benefits provided under any section of the BlueCross Plan of Benefits. All Benefits under this Plan are being provided by a self-funded ERISA plan.

## Statement of Purpose

Subrogation and Reimbursement represent significant Plan assets and are vital to the financial stability of the Plan. Subrogation and Reimbursement recoveries are used to pay future claims by other Plan members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of the Plan. The Employer's Group Health Plan has a fiduciary obligation under ERISA to pursue and recover these Plan assets to the fullest extent possible.

## Definitions

**Another Party:** Another Party shall mean any individual or entity, other than this Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Member's injuries or illness.

Another Party shall include the party or parties who caused the injuries or illness; the liability insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Member's own insurance coverage, such as uninsured, underinsured, medical payments, no fault, homeowner's, renter's or any other insurer; a workers' compensation insurer or governmental entity; or, any other individual, corporation, association or entity that is liable or legally responsible for payment in connection with the injuries or illness.

**Member:** As it relates to the Subrogation and Reimbursement Provision, a Member shall mean any person, Dependent or representative, other than the Plan, who is bound by the terms of the Subrogation and Reimbursement Provision herein. A Member shall include but is not limited to any beneficiary, Dependent, spouse or person who has or will receive Benefits under the Plan, and any legal or personal representatives of that person, including parents, guardians, attorneys, trustees, administrators or executors of an estate of a Member, and heirs of the estate.

**Recovery:** Recovery shall mean any and all monies identified, paid or payable to the Member through or from Another Party by way of judgment, award, settlement, covenant, release or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. A Recovery exists as soon as any fund is identified as compensation for a Member from Another Party. Any recovery shall be deemed to apply, first for Reimbursement of the Plan's lien. The amount owed from the Recovery as Reimbursement of the Plan's lien is an asset of the Plan.

**Reimbursement:** Reimbursement shall mean repayment to the Plan of recovered medical or other Benefits that it has paid toward care and treatment of the injuries or illness for which there has been a Recovery.

**Subrogation:** Subrogation shall mean the Plan's right to pursue the Member's claims for medical or other charges paid by the Plan against Another Party.

**When this Provision Applies:** This provision applies when a Member incurs medical or other charges related to injuries or illness caused in part or in whole by the act or omission of the Member or another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness; or Another Party may otherwise make a payment without an admission of liability. If so, the Member may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Member agrees, as a condition of receiving Benefits from the Plan, to transfer to the Plan all rights to recover damages in full for such Benefits.

**Duties of the Member:** The Member will execute and deliver all required instruments and papers provided by the Plan/BlueCross, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other Benefits will be paid by the Plan for the injuries or illness. The Plan/BlueCross may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Plan will remain entitled to Subrogation and Reimbursement. In addition, the Member will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made whole and common fund doctrines. A Member who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the portion of the Recovery subject to the Plan's lien to the Plan under the terms of this provision.

A Member who receives any such Recovery and does not immediately tender the Plan's portion of the Recovery to the Plan will be deemed to hold the Plan's portion of the Recovery in constructive trust for the Plan, because the Member is not the rightful owner of the Plan's portion of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed. The portion of the Recovery owed by the Member for the Plan's lien is an asset of the Plan.

As a condition of receiving Benefits, the Member must:

- Immediately notify the Plan/BlueCross of an injury or illness for which Another Party may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;
- Execute and deliver an Accident Questionnaire within one hundred eighty (180) days of the Accident Questionnaire being mailed to the Member;
- Deliver to the Plan/BlueCross a copy of the Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;
- Deliver to the Plan/BlueCross a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within ninety (90) days of being requested to do so;
- Authorize the Plan to sue, compromise and settle in the Member's name to the extent of the amount of medical or other Benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Member's rights to Recovery when this provision applies;
- Include the Benefits paid by the Plan as a part of the damages sought against Another Party. Immediately reimburse the Plan, out of any Recovery made from Another Party, the amount of medical or other Benefits paid for the injuries or illness by the Plan up to the amount of the Recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;
- Immediately notify the Plan/BlueCross in writing of any proposed settlement and obtain the Plan/BlueCross written consent before signing any release or agreeing to any settlement; and,
- Cooperate fully with the Plan/BlueCross in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan/BlueCross

**First Priority Right of Subrogation and/or Reimbursement:** Any amounts recovered will be subject to Subrogation or Reimbursement. The Plan will be subrogated to all rights the Member may have against that other person or Another Party and will be entitled to first priority Reimbursement out of any Recovery to the extent of the Plan's payments. In addition, the Plan shall have a first priority equitable lien against any Recovery to the extent of Benefits paid and to be payable in the future. The Plan's first priority equitable lien supersedes any right that the Member may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Member procures or may be entitled to procure regardless of whether the Member has received full compensation for any of his or her damages or expenses, including attorneys' fees or costs and regardless of whether the Recovery is designated as payment for medical expenses or otherwise. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative or contributory negligence, limits of collectability or responsibility, characterization of Recovery as pain and suffering or otherwise. As a condition to receiving Benefits under the Plan, the Member agrees that acceptance of Benefits is constructive notice of this provision.

**When a Member Retains an Attorney:** An attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) for an injury or illness in which the Plan has paid or will pay Benefits, has an absolute obligation to immediately tender the portion of the Recovery subject to the Plan's equitable lien to the Plan under the terms of this provision. As a possessor of a portion of the Recovery, the Member's attorney holds the Recovery as a constructive trustee and fiduciary and is obligated to tender the Plan's portion of the Recovery immediately over to the Plan. A Member's attorney who receives any such Recovery and does not immediately tender the Plan's portion of the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because neither the Member nor the attorney is the rightful owner of the portion of the Recovery subject to the Plan's lien.

The portion of the Recovery owed for the Plan's lien is an asset of the Plan.

If the Member retains an attorney, the Member's attorney must recognize and consent to the fact that this provision precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine against the Plan in his or her pursuit of Recovery. The Plan will not pay the Member's attorneys' fees and costs associated with the recovery of funds, nor will it reduce its Reimbursement pro rata for the payment of the Member's attorneys' fees and costs, without the expressed written consent of the Plan Administrator.

**When the Member is a Minor or is Deceased or Incapacitated:** This Subrogation and Reimbursement Provision will apply with equal force to the parents, trustees, guardians, administrators, or other representatives of a minor, incapacitated, or deceased Member and to the heirs or personal and legal representatives, regardless of applicable law. No representative of a Member listed herein may allow proceeds from a Recovery to be allocated in a way that reduces or minimizes the Plan's claim by arranging for others to receive proceeds of any judgment, award, settlement, covenant, release or other payment or releasing any claim in whole or in part without full compensation therefore or without the prior written consent from Plan/BlueCross

**When a Member Does Not Comply:** When a Member does not comply with the provisions of this section, Plan/BlueCross shall have the authority, in its sole discretion, to deny payment of any claims for Benefits by the Member and to deny or reduce future Benefits payable (including payment of future Benefits for other injuries or illnesses) under the Plan by the amount due as satisfaction for the Reimbursement to the Plan. The Plan/BlueCross may also, in its sole discretion, deny or reduce future Benefits (including future Benefits for other injuries or illnesses) for the Member under any other group benefits plan maintained by the Employer. The reductions will equal the amount of the required Reimbursement; however, under no circumstances shall the Reimbursement, denial or reduction of Benefits exceed the amount of the Recovery. If the Plan must bring an action against a Member to enforce the provisions of this section, then the Member agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

**Prior Recoveries:** In certain circumstances, a Member may receive a Recovery that exceeds the amount of the Plan's payments for past and/or present expenses for treatment of the injuries or illness that is the subject of the Recovery. In other situations, based on the extent of the Member's injuries or illness, the Member may have received a prior Recovery for treatment of the injuries or illness that is the subject of a claim for Benefits under the Plan. In these situations, the Plan will not provide Benefits for any expenses related to the injuries or illness for which compensation was provided through a current or previous Recovery. The Member is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses.

To the extent a Member's Recovery exceeds the amount of the Plan's lien, the Plan is entitled to deny that amount as an offset against any claims for future Benefits relating to the injuries or illness. In those situations, the Member will be solely responsible for payment of medical bills related to the injuries or illness. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

The Plan/BlueCross has sole discretion to determine whether expenses are related to the injuries or illness to the extent this provision applies. Acceptance of Benefits under the Plan for injuries or illness which the Member has already received a Recovery may be considered fraud, and the Member will be subject to any sanctions determined by the Plan/BlueCross, in their sole discretion, to be appropriate, including denial of present or future Benefits under the Plan.

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

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

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

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

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

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

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

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

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

# Legal notices

## No Surprise Act

### *Your Rights and Protections Against Surprise Medical Bills*

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected by federal law from surprise billing or balance billing.

#### **What is “balance billing” (sometimes called “surprise billing”)?**

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

#### **You are protected from balance billing for:**

##### **Emergency services**

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as deductibles, copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

##### **Certain services at an in-network hospital or ambulatory surgical center**

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

**You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.**

#### **When balance billing isn't allowed, you also have the following protections:**

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

**If you believe you've been wrongly billed**, you may contact the Department of Labor or BCBS of South Carolina 800.325.6596.

Individuals interested in obtaining information from the DOL concerning employment-based health coverage laws may call the Employee Benefits Security Administration (EBSA) Toll-Free Hotline at 1.866.444.EBSA (3272) or visit the DOL's website ([www.dol.gov/ebsa](http://www.dol.gov/ebsa)).

## Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires that you be specifically informed that you are covered by the Medical Plan for certain medical services following a mastectomy. The Medical options provide coverage for the following services subsequent to a mastectomy:

- Elective reconstructive surgery of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas. Such coverage is subject to normal plan rules (such as coinsurance provisions). Questions concerning breast reconstruction following a mastectomy should be directed to BlueCross.

## Late Enrollment Notice

**Loss of Eligibility for Other Medical Coverage:** If you are declining Plan enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage and you submitted any written verification that may have been requested from you as described below at the time coverage was declined, you may be able to enroll yourself and your dependents in the Plan or switch medical benefit options under this Plan, if you are otherwise eligible to enroll, if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents other non-COBRA coverage). However, you must request enrollment within 60 days after the date your or your dependents other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of eligibility for coverage includes:

- Loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Plan), death of an employee, termination of employment, reduction in the number of work hours of employment,
- In the case of coverage offered through an HMO or other arrangement loss of coverage because an individual no longer resides, lives or works in the service area (whether or not it was the individual's choice), and with respect to an HMO in the group market, no other benefit package is available to the individual,
- A situation in which a Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual, and
- In the case of an individual who has COBRA continuation coverage, at the time the COBRA continuation coverage is exhausted

However, loss of eligibility for other coverage does not include a loss of coverage due to:

- The failure of the employee or dependent to pay premiums on a timely basis,
- Voluntary disenrollment from a Plan, or
- Termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan)

If you enroll yourself, your spouse, your domestic partner, and/or your eligible dependent children in the plan, as applicable, due to a "loss of eligibility for coverage" event as described above, Medical, Prescription Drug, Dental, Vision and Health Care Spending Account programs coverage, as applicable, will begin prospectively, following the receipt and review of all required information. Your contribution rate will increase at the time the coverage begins.

**Gaining a New Dependent:** If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the plan, as applicable, or switch medical coverage options under this Plan. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you are not enrolled in the plan as an employee, as applicable, you also must enroll in the Plan when you enroll any of these dependents. And, if your spouse or domestic partner is not enrolled in the plan, you may enroll him or her in the Medical, Prescription Drug, Dental, and Vision programs, as applicable, when you enroll a child due to birth, adoption or placement for adoption. Written verification of the reason you or your spouse or domestic partner previously declined coverage under the plan is not required if a special enrollment period occurs under the "Gaining a New Dependent" section.

In the case of marriage or entry into a domestic partnership, coverage will be prospective following the receipt and review of all required information. In the case of birth, adoption or placement for adoption, coverage is retroactive to the date of birth, adoption or placement for adoption, but not before the effective date of your coverage under the Plan.

**Loss or Gain of Eligibility for a State Children's Health Insurance Program (CHIP) or Medicaid:** If you (the employee) are eligible for, but not enrolled in, the plan or your dependent is eligible for, but not enrolled in, plan you (and your dependent) may enroll in the plan, or switch medical benefit options under this Plan, if either of the following conditions is met:

- You or your dependent is covered under CHIP or Medicaid and such coverage is terminated as a result of loss of eligibility and you request coverage under the plan, as applicable, not later than 60 days after the date of termination of such CHIP or Medicaid coverage, or
- You or your dependent becomes eligible for CHIP or Medicaid premium assistance subsidy with respect to coverage under the plan, as applicable, if you request coverage under the plan programs, as applicable, not later than 60 days after the date you or your dependent is determined to be eligible for such premium assistance subsidy

If you enroll yourself, your spouse or domestic partner and/or your eligible dependent children in the plan, due to a loss or gain of eligibility for coverage event described above, coverage will begin prospectively following receipt and review of all required information. If, however, you become eligible for Medicaid or CHIP and apply for coverage through the Health Insurance Marketplace, then coverage would be retroactive back to the date you applied, or up to three months earlier in some states.

To request special enrollment or obtain more information, contact the SRNS Benefits Service Center at 803.725.7772.

## Wellness Program Disclosure

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

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

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at 803.952.5824 and we will work with you to develop another way to qualify for the reward.

If you decide to complete the American Heart Association survey, no individual information is shared with SRNS.

## Newborn Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## Genetic Information Non-Discrimination Act

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

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov). If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call 1-866-444-EBSA (3272). If you live in one of the states listed on the next page, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. You should contact your state for more information on eligibility.

# Medicaid/CHIP Premium Assistance Program

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

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

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

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

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
(877) 267 2323  
Menu Option 4, Ext. 61565

## ERISA information

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

Your rights under Employee Retirement Income Security Act of 1974, as amended (ERISA);

- How to contact the Plan Administrator; and
- Additional information on rights that you may have as a plan participant.

This Summary Plan Description does not constitute an implied or expressed contract or a guarantee of employment. You should read this material carefully and keep it for future reference.

### A. Plan Sponsor

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," the "Company" or "Plan Sponsor").

## **B. Plan Administrator**

The Plan Administrator is responsible for maintaining the records related to and administration of the medical Plan. The Plan Administrator also has the sole discretion to decide all issues of fact or law. The Plan Administrator reserves the right to request, at any time, documents to determine eligibility for benefits and to resolve appeals. The Plan Administrator(s) is designated by the SRNS Benefits Committee. Correspondence to the Plan Administrator should be sent to the address noted for the Plan Administrator in the Plan Information section.

## **C. 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.

## **D. Plan Documents**

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

## **E. Plan Financing and Administration**

The Medical Plan is self-insured and funded through Company contributions and participant premium contributions and is administered under a contract with BlueCross BlueShield of South Carolina.

## **F. Future of the Plans**

While the Company expects to continue this Plan for an indefinite period of time, the Company, by action of its Board of Managers and/or the Company Benefits Committee, reserves the right at any time and from time to time to modify, amend or terminate in whole or in part, any or all of the provisions of the Plan. The Company's rights include the right to obtain coverage and/or administrative services from additional or different insurance carriers, parties, HMOs, third party administrators, etc. at any time, and the right to revise the amount of employee contributions. Employees will be notified of any material modifications to the plan.

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

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

## **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 charge a reasonable amount for the copies.

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

No one, including your employer or any other person, may 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 claim 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 claim for benefits.

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 Service Company, 1703 Laurel Street, Columbia, SC 29201  
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 NW, 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

## Plan information

Eligibility for benefits should not be viewed as a guarantee of employment. While the Company intends to continue providing a comprehensive benefits program, the Company reserves the right to modify or terminate any of the benefit plans at any time.

This Summary Plan Description does not create an express or implied contract of employment.

Plan Year	January 1-December 31
Type of Plan	A self-funded welfare plan that provides Medical benefits
Plan Name	The Savannah River Nuclear Solutions, LLC Medical Care Plan
Plan Number	525
Plan Sponsor	Savannah River Nuclear Solutions, LLC
Plan Sponsor Employer Identification Number	26-0240191
Plan Administrator	SRNS Health and Welfare Benefit Committee Attn: Plan Administrator Savannah River Nuclear Solutions, LLC SRNS Workforce Services 992-2W Savannah River Site Aiken, SC 29808 Phone 803.952.5767
Plan Administrator Employer Identification Number	27-0584392
Claims Administrator	BlueCross and BlueShield of South Carolina

## Questions? Contact us

This Summary Plan Description does not create an express or implied contract of employment. Eligibility for benefits should not be viewed as a guarantee of employment. Also, while SRNS intend to continue providing comprehensive benefits programs, the Companies reserve the right to modify or terminate any of the benefit plans at any time. The Companies will provide advance notification of any future benefit changes. The Company cannot advise you regarding tax, investment or legal considerations related to the Plan. Therefore, if you have questions regarding benefit planning, you should seek advice from a personal advisor (e.g., legal counsel, tax advisor, investment advisor).

## SRNS Service Center

Telephone 803.725.7772 or 800.368.7333

Email [Service-Center@srs.gov](mailto:Service-Center@srs.gov)

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

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

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

SAVANNAH RIVER NUCLEAR SOLUTIONS, LLC  
AMENDED AND RESTATED EFFECTIVE JANUARY 1, 2026