



2023 Open Enrollment Benefits Guide

For COBRA or displaced workers
medical benefit participants of Savannah River Nuclear
Solutions (SRNS) and Battelle Savannah River Alliance (BSRA)

COBRA for Pre-65 Plan eligible medical and dental participants
of SRNS, Savannah River Mission Completion (SRMC) and BSRA

Pre-65 Plan eligible medical and dental participants



Open Enrollment is November 7-18, 2022

Time to choose the right plan for you and your family!

**Enroll at any time
between November 7-18, 2022.**

2023 Open Enrollment Benefits Guide

For COBRA or displaced workers medical benefit participants



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While SRNS, SRMC and BSRA intend to continue providing comprehensive benefit programs, the companies reserve the right to modify or terminate any of the benefit plans at any time. SRNS, SRMC, and BSRA will provide advance notification of any future substantial and material benefit changes. This open enrollment communication is also intended to summarize and notify you of any material modifications to the Plan (“Summary of Material Modifications”).



Getting started on your enrollment

You are on file with HealthEquity for either COBRA or the Displaced Workers Medical Benefit (DWMB) Program. Your benefit options are listed below.

COBRA Healthcare Benefit Options for SRNS and BSRA

- Medical
- Dental
- Vision

SRNS Displaced Worker Healthcare Benefit Options

- Medical

Former Limited Service Employees Healthcare Benefit Options

- Basic Medical only

COBRA Healthcare Benefit Options for those who were covered under the Pre-65 Retiree Health Plan for SRNS, BSRA and Savannah River Mission Completion (SRMC)

- Pre-65 Retiree Medical Plan
- Pre-65 Dental Plan

Changes to your 2023 benefits

The election you make for 2023 will remain throughout 2023 for you and the dependents you elect to cover, unless:

- You have a qualifying life event as defined by the Plan and the IRS, in which case you would be allowed to change your dependent level of coverage but would not be allowed to change your plan option (Standard or Basic).
- Your eligibility to receive COBRA or DWMB benefits runs out.
- You discontinue your premium payments for coverage.
- Your covered dependent no longer meets the eligibility requirements.

If you make no changes, your 2023 Medical, Dental and Vision benefits and covered dependents will remain the same as in 2022 but at the 2023 contribution rate.

If you wish to change your coverage for 2023, your response is required.

For faster service, fax to 866-450-5641 or enroll online at <https://mybenefits.wageworks.com>.

Or mail completed form to: WageWorks, Inc. at P.O. Box 223684 Dallas, TX 75222-3684.

COBRA Eligibility The benefits described in this brochure are for former employees and/or their dependents of SRNS, SRMC, and BSRA who are eligible for continuation of the companies' Medical, Dental and Vision care benefits under COBRA (the Consolidated Omnibus Budget Reconciliation Act, as amended) or SRNS DWMB (Displaced Workers Medical Benefits). The Basic Medical Plan is the only benefit option for former Limited Service Employees and/or their dependents for continuation of the companies' Medical benefit under COBRA. DWMB does not impact your rights or eligibility to elect COBRA Medical, Dental or Vision coverage. You cannot elect Medical coverage under both COBRA and DWMB. If you have no changes to your coverage, you do not have to submit anything. The Pre-65 Retiree Health Plan and Retiree Dental Plan described in this brochure are for former Incumbent Retirees and/or their dependents of SRNS, SRMC and BSRA who are eligible for continuation of the companies' Pre-65 Retiree Medical and Retiree Dental plan benefits under COBRA (the Consolidated Omnibus Budget Reconciliation Act, as amended).

You may participate in this coverage as long as your COBRA eligibility period has not expired, and you continue with timely payment of COBRA premiums.

If you elected coverage under COBRA and later become covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary or Medicare, then your COBRA coverage must terminate. In this situation, you would be required to notify the COBRA administrator.

You may continue to have COBRA coverage under a option if your new group plan does not offer a similar benefit. For example, if a new group plan offers medical coverage, you may continue your Dental coverage throughout the duration of your COBRA eligibility period.

Billing and Premium Payments The COBRA Administrator (HealthEquity®/WageWorks) will send you a bill each month. Premium rates are subject to change. Any adjustments in premiums will be reflected on your next monthly statement.

If you fail to return your full monthly premium payment by the specified due date (within 30 days from the beginning of each month), you will be dropped from all the plans you elected to continue under COBRA. You will not be allowed to re-enroll in the future. Mail your monthly premiums on time, so your coverage will not be cancelled.



Changes for 2023

Here's a quick summary of the changes in this year's benefits for 2023. All changes to the benefits plans take effect on January 1, 2023.

All Medical Plans premium increases

Your monthly premiums are increasing beginning January 1.

Blue CareOnDemand

BlueCross BlueShield of South Carolina has a solution that removes the traditional barriers between patient and doctor. Blue CareOnDemand uses web and mobile technology to help members get the care they need, when they need it. Choosing Blue CareOnDemand can save time and money.

Below are the plan copays that apply when you use the mobile visit.

Basic \$59 copay before deductible and \$10 copay after deductible

Standard \$10 copay

Registration is required prior to using Blue CareOnDemand.

Be proactive and register now, before the need arises.

My Health Toolkit App

You can always use the digital card provided on the BCBS My Health Toolkit app. The app also provides quick and easy access to your Explanation of Benefits (EOBs).

Pharmacy Mail Saver Program

Effective January 1, this program requires participants to have prescriptions for drugs that are considered "maintenance" filled through an OptumRx Mail pharmacy.

More details can be found in this booklet.

Frequently Asked Questions

How do I...

... **add or remove dependents?**

You can add or remove dependents during Open Enrollment without a qualifying life status change. Review your dependents carefully. If you missed an enrollment period earlier in the year, now is the time to add them. Even though proof of the life event is not required during Open Enrollment, the new dependent(s) must still meet the eligibility requirements of the plan (spouse, eligible dependent child under the age of 26, etc.).

Outside of the Open Enrollment period, there must be a Qualifying Life Status Change.

A few examples of qualified life status changes include:

- Marriage or divorce
- Birth, adoption or placement for adoption of a child
- A dependent losing eligibility for coverage (child reaches maximum age, or spouse loses coverage or retires from his or her company)
- Death of a spouse or dependent
- You or your spouse become eligible or ineligible for Medicare or Medicaid

If you experience a qualified life event change, contact WageWorks within 60 days of the event date to request your change.

Adding or deleting a dependent will require you to provide a copy of the official documents confirming your status change. Examples include birth and marriage certificates, divorce decrees or legal guardianship documentation. If you experience a qualified life status change, contact the COBRA Administrator (HealthEquity@WageWorks) to update your information.

Terms you really should know

What is a deductible? The amount you owe for health care services or supplies before the plan begins to share costs with you

What is coinsurance? The percentage you and the plan pay after reaching your deductible

What is a copay? A fee you pay for services such as office visits and prescription drugs

What is an out-of-pocket maximum? The maximum amount you will have to pay out of pocket before the plan pays 100% of allowable costs for the remainder of the plan year



Medical Plans: Basic and Standard

SRNS and BSRA offer a choice of medical plans and coverage levels so you can decide what is best for you and your family. Both plans are administered by BlueCross BlueShield (BlueCross).

Each plan works somewhat differently. However, there is one exception – under all plans, most in-network preventive care is covered at 100%. Preventive care includes services you receive to prevent illness or injury, such as:

- Routine exams (such as well baby visits and annual physicals for children and adults)
- Health screenings, such as mammograms and colonoscopies
- Most immunizations

Basic

The Basic plan is a High Deductible Health Plan (HDHP).

- You pay less each month when you enroll in the Basic plan.

Plan Features

- You can choose to see in-network or out-of-network providers, but the plan pays more when you go in-network.
- When you need medical care other than in-network preventive care, you must pay for the full cost of your services until you reach your deductible.
- Office visits, prescriptions (see Page 9 for more information), treatments, procedures and labs go toward your deductible.
- Once you reach your deductible, the plan covers up to 80% of your health care costs (called “coinsurance”).
- You are protected by the out-of-pocket maximum.

Standard

The Standard plan is a Preferred Provider Organization (PPO).

- You have a choice each time you need care.
- You can receive care within the plan’s network or choose to visit an out-of-network provider.
- When you visit an in-network provider, the plan pays a higher portion of the cost of your care.
- When you need medical care other than preventive care, you are responsible for a portion of the cost, either a copay or coinsurance.
- Prescriptions, treatments, procedures, and labs go toward your deductible.
- You are protected by the out-of-pocket maximum.

Need an In-Network Provider?

Contact BlueCross Customer Service at (800) 325-6596 or www.southcarolinablues.com.

Medical Plans Comparison

Type	Basic		Standard	
	In-network	Out-of-network ²	In-network	Out-of-network ²
Deductible (Individual/Family)	\$1,500 / \$3,000 ¹	\$1,500 / \$3,000 ¹	\$600 / \$1,200	\$600 / \$1,200
Out-of-Pocket Maximum (Individual/Family)	\$4,500 / \$7,150	\$4,500 / \$7,150	\$2,000 / \$4,000	\$2,000 / \$4,000
Office Visit: Primary Office Visit: Specialist	20% after deductible	20% after deductible	\$20 copay \$30 copay	15% after deductible ²
Preventive Care	\$0	Not covered	\$0	Not covered
Chiropractic Treatment ³	20% after deductible	20% after deductible	15% after deductible	20% after deductible
Allergy/Hormone Injections	20% after deductible	20% after deductible	15% after deductible	15% after deductible ²
Physical and Occupational Therapy	20% after deductible	20% after deductible	15% after deductible	15% after deductible ²
Ambulance Services	20% after deductible	20% after deductible	15% after deductible	15% after deductible ²
Hospital and Surgical Services	20% after deductible	20% after deductible	15% after deductible	15% after deductible ²
Emergency Room: Life threatening Emergency Room: Non-emergency	20% after deductible 30% after deductible	20% after deductible ² 30% after deductible ²	15% after deductible 30% after deductible	15% after deductible ² 30% after deductible ²
Diagnostic Services ⁴	20% after deductible	20% after deductible	15% after deductible	15% after deductible
Home Health, Hospice and Durable Medical Equipment Services	20% after deductible	20% after deductible	15% after deductible	15% after deductible
Blue Care OnDemand	Cost varies by service. See Summary Plan Description for details	N/A	Cost varies by service. See Summary Plan Description for details	N/A

¹ All family members combined ² Based on allowable charge; you pay the balance after the provider's charge ³ Limited to \$750 total per person, per year ⁴ Pre-certification is required for major diagnostic services (MRI, MRA, CT scans, PET scans, etc.) Certain musculoskeletal non-emergent in-patient and out-patient surgeries and outpatient pain management services now require preauthorization.

Admissions, rehabilitation, behavioral health, and some outpatient services require precertification. If you do not receive a precertification before receiving services, your charges may be denied, and you will be responsible for the full cost. For more detailed information on your plan benefits, view the Summary Plan Description at www.srs.gov/general/jobs/benefits/index_e.htm or by contacting BlueCross Customer Service at (800) 325-6596 or <http://www.southcarolinablues.com>



Prescription Drug Plan

You automatically receive prescription drug coverage through BlueCross when you enroll in a medical plan. Your coinsurance begins after you reach your deductible. Visit www.southcarolinablues.com for more information and for prescription drug lists. The Basic plan Prescription Drug Plan is designed to help you save money by offering:

More low-cost medications available on the Preventive Drug List. Preventive drugs are used to prevent conditions such as high blood pressure, high cholesterol, heart attack, stroke, and prenatal nutrient deficiency.

Multiple levels of prescription options. The amount you pay depends on the level of medication that you choose or the brand that is available.

Preventive Drugs

Prescription drugs classified as preventive by Health Care Reform are covered at 100% and are not subject to the deductible under either plan.

This list is subject to change as the Patient Protection and Affordable Care Act guidelines are updated or modified. If you have questions, call (800) 325-6596.

An expanded Preventive Drug List is available for the Basic plan, making certain preventive and maintenance medications more accessible and affordable for members. These drugs will require copays but are not subject to the deductible. To determine if the drug you are taking is on the list, go to www.srs.gov/general/jobs/benefits/documents/Preventive_Drug_List.pdf

Pharmacy Administration

Your pharmacy benefit is administered by OptumRx, an independent company contracted by BlueCross BlueShield of South Carolina. Most plan members will see little or no effect. Changes include a new mail-service pharmacy, OptumRx Home Delivery and a new preferred specialty pharmacy, BriovaRx. Questions should be directed to BlueCross.

Retail Pharmacy (30 day supply)

Retail	Basic		Standard	
	After you meet the deductible, you pay...		After you meet the deductible, you pay...	
30 day supply	In-network	Out-of-network ^{1,2}	In-network	Out-of-network ^{1,2}
Generic	\$10 copay	\$10 copay	10% coinsurance	10% coinsurance
Preferred	20% coinsurance, up to \$35 max	20% coinsurance, up to \$35 max	20% coinsurance	20% coinsurance
Non-preferred brand	30% coinsurance, up to \$50 max	30% coinsurance, up to \$50 max	30% coinsurance	30% coinsurance
Specialty	30% coinsurance, up to \$50 max	Not covered	30% coinsurance	Not covered

¹Based on allowable charge; you pay the balance after the provider's charge. ²Prescription drug programs are subject to the BlueCross Mandatory Generic, Step Therapy and Quantity Management Programs.

Mail Order (90 day supply)

Mail	Basic		Standard	
	After you meet the deductible, you pay...		After you meet the deductible, you pay...	
90 day supply	In-network	Out-of-network	In-network	Out-of-network
Generic	\$25 copay	Not covered	10% coinsurance	Not covered
Preferred	20% coinsurance, up to \$87.50 max	Not covered	20% coinsurance	Not covered
Non-preferred brand	30% coinsurance, up to \$125 max	Not covered	30% coinsurance	Not covered
Specialty	30% coinsurance, up to \$125 max	Not covered	30% coinsurance	Not covered

Pharmacy Mail Service Program

Effective January 1, 2023, participants in the medical plans will be required to have prescriptions for drugs that are considered "maintenance" filled through an OptumRx Mail pharmacy. If you are not already getting your maintenance medications through the mail pharmacy, you will need a new prescription from your doctor written specifically for a 90-day supply. You can continue to get 30-day prescriptions for any acute (short-term) medications, such as antibiotics or pain medications, at any in-network retail pharmacy. Specialty drugs and controlled substances are not included in this program. The program only includes drugs that are taken to treat chronic conditions such as high blood pressure, asthma and high cholesterol, or drugs that are taken routinely, such as birth control pills. Additionally, this OptumRx will cover the cost of postage for this program and provide the benefit for the participant to pay for the 90 script in smaller payment options. **Please note:** If you do not enroll in Mail Service, your maintenance prescriptions will not be covered by your pharmacy benefit once your grace fills are used.

Grace fills

You can get up to two 30-day prescriptions for each maintenance drug you may be getting at any in-network retail pharmacy before the requirement to fill through the mail pharmacy goes into effect.

What Do I Need To Do?

Talk to your doctor about obtaining 90-day prescriptions for your maintenance medications. You can get started with mail service in several ways:

- Contact OptumRx Mail Service by phone at (855) 811-2218.
- Have your doctor's office call in a 90-day prescription to (800) 791-7658 or have your doctor e-prescribe to OptumRx Mail Service.
- You can complete a mail service order form and send it to OptumRx Mail Service with your doctor's prescription.



Dental Plans

For those previously enrolled in the Dental plan, you have two plans to choose from: Prime and Standard. Both plans are administered by BlueCross BlueShield of South Carolina.

Note: Craft Option A employees and Limited Service employees are not eligible.

Questions about the Dental Plan? Need an In-Network Dentist?

Contact BlueCross at (800) 325-6596 or www.southcarolinablues.com

Plan Benefits

When you take care of your teeth and gums, your whole-body benefits. Under the Plan, you are allowed two cleanings and checkups per year. Going to your checkups helps prevent and detect an early diagnosis for diabetes and heart disease. Claims rendered for services must be during the coverage period to be paid for by the plan.

Find an In-Network Dentist

Using in-network providers gives a larger discount to participants. Participants using out-of-network providers may be subject to balance billing and end up paying higher out-of-pocket costs.

What's balance billing? Balance billing is when a provider bills you for the difference between the provider's charge and the BlueCross allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. An in-network provider cannot balance bill you for covered services.

Dental Plan	Prime	Standard
Deductible	None	\$25 per person / \$50 per family
Maximum Annual Benefit ¹	\$2,000 per person, per year	\$1,000 per person, per year
Preventive and Diagnostic ²	You pay \$0	You pay \$0
Minor Restorative Services Basic Dental Oral Surgery Periodontic Benefits	You pay 20%	You pay 50%
Major Restorative Services Prosthodontic Benefits Dental Implants	You pay 40%	You pay 50%
Temporomandibular Joint Disorders (TMJ and TMD) Coverage	You pay 50% (Lifetime Maximum: \$500)	None
Orthodontics	You pay 50% (Lifetime Maximum: \$2,000)	None

¹ Temporomandibular Joint Disorders (TMJ and TMD) and Orthodontics payments do not count toward the maximum annual benefit under Prime

² Unless you have reached your Maximum Annual Benefit



Vision Plans

SRNS/BSRA offer two vision plans through EyeMed Vision Care. You and your eligible dependents have access to a nationwide network of physicians, optometrists and opticians, both in private practices and in retail. You receive maximum benefits and pay preferred prices when services are provided by EyeMed Vision Care providers and provide out-of-network benefits for other eye doctors.

Vision plans comparison

	Low Option		High Option	
Type	In-network	Out-of-network reimbursement ¹	In-network	Out-of-network reimbursement ¹
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Eye Exam with Dilation Standard Contact Lens fit/follow-up Premium Contact Lens fit/follow-up	\$15 copay Up to \$40 10% off retail price	\$35 N/A N/A	\$10 copay Up to \$40 10% off retail price	\$35 N/A N/A
Standard Plastic Lenses Standard Single, Bifocal, Trifocal Lenses Premium Progressive Tier 1-3 Premium Progressive Tier 4	\$0 copay \$20-\$45 copay \$0 copay plus 20% off retail price, less \$120 allowance	\$25, \$40, \$55 \$55 \$55	\$0 copay \$20-\$45 copay \$0 copay plus 20% off retail price, less \$120 allowance	\$25, \$40, \$55 \$55 \$55
Frames	\$0 copay to \$100 allowance for any frame; plus 20% off balance over \$100	\$50	\$0 copay to \$160 allowance for any frame; plus 20% off balance over \$160	\$50
Lens Options				
UV Coating	\$15	N/A	\$0	\$5
Tint (Solid and Gradient)	\$0	\$5	\$0	\$5
Standard Scratch Resistant	\$0	\$5	\$0	\$5
Standard Polycarbonate	\$40	N/A	\$0	\$5
Standard Anti-Reflective	\$45	N/A	\$45	N/A
Premium Anti-Reflective Tier 1-2	\$57 - \$68	N/A	\$57 - \$68	N/A
Premium Anti-Reflective Tier 3	20% off retail price	N/A	20% off retail price	N/A
Photochromic	\$75	N/A	\$75	N/A
Other Add-ons and Services	20% discount	N/A	20% discount	N/A
Contact Lenses				
Conventional	\$0 copay, 15% off balances over \$145	\$116	\$0 copay, 15% off balances over \$160	\$116
Disposable	\$0 copay, 100% of balance over \$145	\$116	\$0 copay, 100% of balance over \$160	\$116
Medically Necessary	\$0 copay	\$200	\$0 copay	\$200
Laser Vision Correction	15% off retail price or 5% off promotional price	N/A	15% off retail price or 5% off promotional price	N/A

For more information, visit www.eyemed.com or view your Summary Plan Description under **InSite>Services>Workforce Service & Talent Management>Departments>Benefits>Active Employee Benefits>Vision** or from off-site at www.srs.gov/general/jobs/benefits/index_e.htm.
Note: Option A Craft employees are not eligible for this benefit.

¹reimbursed up to

SRNS, BSRA and SRMC Retiree Medical Plans Comparison

Type	Basic		Standard	
	In-network	Out-of-network ²	In-network	Out-of-network ²
Deductible (Individual/Family)	\$1,500 / \$3,000 ¹	\$1,500 / \$3,000 ¹	\$600 / \$1,200	\$600 / \$1,200
Out-of-Pocket Maximum (Individual/Family)	\$4,500 / \$7,150	\$4,500 / \$7,150	\$2,000 / \$4,000	\$2,000 / \$4,000
Office Visit: Primary Office Visit: Specialist	20% after deductible	20% after deductible	\$20 copay \$30 copay	15% after deductible ²
Preventive Care	\$0	Not covered	\$0	Not covered
Chiropractic Treatment ³	20% after deductible	20% after deductible	15% after deductible	20% after deductible
Allergy/Hormone Injections	20% after deductible	20% after deductible	15% after deductible	15% after deductible ²
Physical and Occupational Therapy	20% after deductible	20% after deductible	15% after deductible	15% after deductible ²
Ambulance Services	20% after deductible	20% after deductible	15% after deductible	15% after deductible ²
Hospital and Surgical Services	20% after deductible	20% after deductible	15% after deductible	15% after deductible ²
Emergency Room: Life threatening Emergency Room: Non-emergency	20% after deductible 30% after deductible	20% after deductible ² 30% after deductible ²	15% after deductible 30% after deductible	15% after deductible ² 30% after deductible ²
Diagnostic Services ⁴	20% after deductible	20% after deductible	15% after deductible	15% after deductible
Home Health, Hospice and Durable Medical Equipment Services	20% after deductible	20% after deductible	15% after deductible	15% after deductible
Blue Care OnDemand	Cost varies by service. See Summary Plan Description for details	N/A	Cost varies by service. See Summary Plan Description for details	N/A

¹ All family members combined ² Based on allowable charge; you pay the balance after the provider's charge ³ Limited to \$750 total per person, per year ⁴ Pre-certification is required for major diagnostic services (MRI, MRA, CT scans, PET scans, etc.) Certain musculoskeletal non-emergent in-patient and out-patient surgeries and outpatient pain management services now require preauthorization.

Admissions, rehabilitation, behavioral health, and some outpatient services require precertification. If you do not receive a precertification before receiving services, your charges may be denied, and you will be responsible for the full cost. For more detailed information on your plan benefits, view the Summary Plan Description at https://www.srs.gov/general/jobs/benefits/index_r.htm or by contacting BlueCross Customer Service at (800) 325-6596 or <http://www.southcarolinablues.com>

SRNS, BSRA and SRMC Pre-65 Retiree Prescription Drug Plan

You automatically receive prescription drug coverage through BlueCross when you enroll in a medical plan. Your coinsurance begins after you reach your deductible. Visit www.southcarolinablues.com for more information and for prescription drug lists. The Basic plan Prescription Drug Plan is designed to help you save money by offering:

More low-cost medications available on the Preventive Drug List. Preventive drugs are used to prevent conditions such as high blood pressure, high cholesterol, heart attack, stroke, and prenatal nutrient deficiency.

Multiple levels of prescription options. The amount you pay depends on the level of medication that you choose or the brand that is available.

Preventive Drugs

Prescription drugs classified as preventive by Health Care Reform are covered at 100% and are not subject to the deductible under either plan.

This list is subject to change as the Patient Protection and Affordable Care Act guidelines are updated or modified. If you have questions, call (800) 325-6596.

An expanded Preventive Drug List is available for the Basic plan, making certain preventive and maintenance medications more accessible and affordable for members. These drugs will require copays but are not subject to the deductible. To determine if the drug you are taking is on the list, go to www.srs.gov/general/jobs/benefits/documents/Preventive_Drug_List.pdf

Pharmacy Administration

Your pharmacy benefit is administered by OptumRx, an independent company contracted by BlueCross BlueShield of South Carolina. Most plan members will see little or no effect. Changes include a new mail-service pharmacy, OptumRx Home Delivery and a new preferred specialty pharmacy, BriovaRx. Questions should be directed to BlueCross.

Retail Pharmacy (30 day supply)

Retail	Basic		Standard	
	After you meet the deductible, you pay...		After you meet the deductible, you pay...	
30 day supply	In-network	Out-of-network ^{1,2}	In-network	Out-of-network ^{1,2}
Generic	\$10 copay	\$10 copay	10% coinsurance	10% coinsurance
Preferred	20% coinsurance, up to \$35 max	20% coinsurance, up to \$35 max	20% coinsurance	20% coinsurance
Non-preferred brand	30% coinsurance, up to \$50 max	30% coinsurance, up to \$50 max	30% coinsurance	30% coinsurance
Specialty	30% coinsurance, up to \$50 max	Not covered	30% coinsurance	Not covered

¹Based on allowable charge; you pay the balance after the provider's charge. ²Prescription drug programs are subject to the BlueCross Mandatory Generic, Step Therapy and Quantity Management Programs.

Mail Order (90 day supply)

Mail	Basic		Standard	
	After you meet the deductible, you pay...		After you meet the deductible, you pay...	
90 day supply	In-network	Out-of-network	In-network	Out-of-network
Generic	\$25 copay	Not covered	10% coinsurance	Not covered
Preferred	20% coinsurance, up to \$87.50 max	Not covered	20% coinsurance	Not covered
Non-preferred brand	30% coinsurance, up to \$125 max	Not covered	30% coinsurance	Not covered
Specialty	30% coinsurance, up to \$125 max	Not covered	30% coinsurance	Not covered

Pharmacy Mail Saver Program

Effective January 1, 2023, participants in the medical plans will be required to have prescriptions for drugs that are considered "maintenance" filled through an OptumRx Mail pharmacy. If you are not already getting your maintenance medications through the mail pharmacy, you will need a new prescription from your doctor written specifically for a 90-day supply. You can continue to get 30-day prescriptions for any acute (short-term) medications, such as antibiotics or pain medications, at any in-network retail pharmacy. Specialty drugs and controlled substances are not included in this program. The program only includes drugs that are taken to treat chronic conditions such as high blood pressure, asthma and high cholesterol, or drugs that are taken routinely, such as birth control pills. *Please note:* If you do not enroll in Mail Service, your maintenance prescriptions will not be covered by your pharmacy benefit once your grace fills are used. OptumRx will pay for the postage for your prescriptions. They also have created a payment installation plan to assist participants in paying for the 90 day supply in incremental payments.

Grace fills

You can get up to two 30-day prescriptions for each maintenance drug you may be getting at any in-network retail pharmacy before the requirement to fill through the mail pharmacy goes into effect.

What Do I Need To Do?

Talk to your doctor about obtaining 90-day prescriptions for your maintenance medications. You can get started with mail service in several ways:

- Contact OptumRx Mail Service by phone at (855) 811-2218.
- Have your doctor's office call in a 90-day prescription to (800) 791-7658 or have your doctor e-prescribe to OptumRx Mail Service.
- You can complete a mail service order form and send it to OptumRx Mail Service with your doctor's prescription.



SRNS, BSRA and SRMC Pre-65 Retiree Dental plans

You have two plans to choose from: Prime and Standard. Both plans are administered by BlueCross.

Note: Craft Option A employees are not eligible.

Questions about the Dental Plan? Need an In-Network Dentist?

Contact BlueCross at (800) 325-6596 or www.southcarolinablues.com

Dental Plan	Prime	Standard
Deductible	None	\$25 per person / \$50 per family
Maximum Annual Benefit ¹	\$2,000 per person, per year	\$1,000 per person, per year
Preventive and Diagnostic ²	You pay \$0	You pay \$0
Minor Restorative Services Basic Dental Oral Surgery Periodontic Benefits	You pay 20%	You pay 50%
Major Restorative Services Prosthodontic Benefits Dental Implants	You pay 40%	You pay 50%
Temporomandibular Joint Disorders (TMJ and TMD) Coverage	You pay 50% (Lifetime Maximum: \$500)	None
Orthodontics	You pay 50% (Lifetime Maximum: \$2,000)	None

¹ Temporomandibular Joint Disorders (TMJ and TMD) and Orthodontics payments do not count toward the maximum annual benefit under Prime

² Unless you have reached your Maximum Annual Benefit



Legal Notices

Wellness Program Notice

The SRNS/BSRA Wellness Program is a voluntary program available to all active employees and pre-65 retirees and their spouses who are enrolled in our health plans (participants). 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 have the option to complete voluntary health and wellness surveys 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 health and wellness survey or to participate in a blood test or other medical examinations.

If you decide to complete any health and wellness surveys, the 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 or BSRA.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. The SRNS/BSRA/SRMC wellness program administered through BlueCross may use aggregate information it collects to design a program based on identified health risks in the workplace. BlueCross will never disclose any of your personal information, except as necessary to respond to a request from you for a reasonable accommodation, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment, nor may you be subjected to retaliation if you choose not to participate in the wellness program.

Your health information will not be sold, exchanged, transferred or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

Any medical information obtained through the wellness program is maintained by BlueCross, and any information stored electronically will be encrypted. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, you will be notified immediately.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the SRNS Medical Plan Administrator at (803) 952-5746 or the SRMC Medical Plan Administrator at (803) 208-3978.

Women and Cancer

The SRNS/BSRA/SRMC Medical Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema. Call your Plan Administrator at (803) 725-7772 for more information.

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 this 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.

Dependent Coverage up to Age 26

The SRNS/BSRA/SRMC group health plans provide dependent coverage for the children of a participant until a participant's child attains the age of 26. The adult dependent child can be covered even if they are married and/or are eligible for coverage through their employment. Coverage ends on the last day of the month in which the dependent turns 26.

HIPAA Late Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage); however, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, 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; however, you must

request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 day after the determination of eligibility for such assistance.

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

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.

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 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 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, 2021. You should contact your state for more information on eligibility.

Medicaid/CHIP Premium Assistance Program

State	Website	Phone
ALABAMA	http://myalhipp.com/	1-855-692-5447
ALASKA	http://myakhipp.com/ Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	1-866-251-4861
ARKANSAS	http://myarhipp.com/	1-855-MyARHIPP (855-692-7447)
CALIFORNIA	Health Insurance Premium Payment (HIPP) Program: http://dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	916-445-8322
COLORADO	Health First Colorado: https://www.healthfirstcolorado.com/ CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program	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	https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html	1-877-357-3268
GEORGIA	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162 ext. 2131 Phone: (678) 564-1162, Press 2
INDIANA	Healthy Indiana Plan for low-income adults 19-64: http://www.in.gov/fssa/hip All other Medicaid: https://www.in.gov/medicaid/	1-877-438-4479 All other Medicaid: 1-800-457-4584
IOWA	https://dhs.iowa.gov/ime/members Hawki: http://dhs.iowa.gov/Hawki HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	1-800-338-8366 Hawki: 1-800-257-8563 HIPP: 1-888-346-9562
KANSAS	https://www.kancare.ks.gov	1-800-792-4884
KENTUCKY	https://chfs.ky.gov/agencies/dms/member/Pages/kihhipp.aspx Email: KIHIP.PPROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx Kentucky Medicaid: https://chfs.ky.gov	1-855-459-6328 CHIP: 1-877-524-4718
LOUISIANA	www.medicaid.la.gov www.lahipp.la.gov/lahipp	1-888-342-6207 LaHIPP: 1-855-618-5488

State	Website	Phone
MAINE	https://www.maine.gov/dhhs/ofia/applications-forms Private Health Insurance Premium: https://www.maine.gov/dhhs/ofia/applications-forms	1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium: 800-977-6740 TTY: Maine relay 711
MASSACHUSETTS	https://www.mass.gov/masshealth/pa	1-800-862-4840
MINNESOTA	https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1-800-657-3739
MISSOURI	https://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
MONTANA	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-800-694-3084
NEBRASKA	http://www.ACCESSNebraska.ne.gov	(855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
NEVADA	http://dhcnp.nv.gov	1-800-992-0900
NEW HAMPSHIRE	https://www.dhhs.nh.gov/	603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP Website: http://www.njfamilycare.org/index.html	Medicaid: 609-631-2392 CHIP: 1-800-701-0710
NEW YORK	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
NORTH CAROLINA	https://medicaid.ncdhhs.gov/	919-855-4100
NORTH DAKOTA	http://www.nd.gov/dhs/services/medicalserv/medicaid/	1-844-854-4825
OKLAHOMA	http://www.insureoklahoma.org	1-888-365-3742
OREGON	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	1-800-699-9075
PENNSYLVANIA	https://www.dhs.pa.gov/	1-800-692-7462
RHODE ISLAND	http://www.eohhs.ri.gov/	855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA	https://www.scdhhs.gov	1-888-549-0820
SOUTH DAKOTA	http://dss.sd.gov	1-888-828-0059
TEXAS	http://gethipptexas.com/	1-800-440-0493

State	Website	Phone
UTAH	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip	1-877-543-7669
VERMONT	http://www.greenmountaincare.org/	1-800-250-8427
VIRGINIA	https://www.coverva.org/hipp/	Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WASHINGTON	https://www.hca.wa.gov/	1-800-562-3022
WEST VIRGINIA	https://www.mywvhipp.com/	Toll-free phone: 1-855-MyWVHIP (1-855-699-8447)
WISCONSIN	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
WYOMING	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	1-800-251-1269

To see if any more states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact:

U.S. Department of Labor

Employee Benefits Security Administration

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

(877) 267 2323

Menu Option 4, Ext. 61565

Contacts

General Questions

HealthEquity®/WageWorks

P.O. Box 660212

Dallas, TX 75266-0212

CSEnhancedServices@healthequity.com

Phone Number: 888-678-4872

Fax Number: 877-864-9552

cobrabenefits.wageworks.com

Medical and Prescription Drugs

BlueCross Customer Service (800) 325-6596

www.southcarolinablues.com

Dental

BlueCross Customer Service (800) 325-6596

www.southcarolinablues.com

Vision

EyeMed Vision Care

(866) 800-5457

https://eyemed.com/en-us

Summary Plan Descriptions

Active Plans

www.srs.gov/general/jobs/benefits/index_e.htm

Retiree Plans

https://www.srs.gov/general/jobs/benefits/index_r.htm