

AMENDED AND RESTATED



Summary Plan Description

Welfare Benefits Plan General ERISA Information and Wrap

As of January 1, 2025
Amended and Restated
Revised April 14, 2025

Caution: This document, together with the certificate or policy of insurance booklets or other documents issued by the companies providing benefits under the Savannah River Nuclear Solutions, LLC Welfare Benefits Plan, is your Summary Plan Description. Please review these booklets in addition to this document for detailed information regarding your benefits.

Savannah River Nuclear Solutions, LLC Summary Plan Description

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SAVANNAHRIVERNUCLEAR SOLUTIONS, LLC WELFARE BENEFITS PLAN

GENERAL ERISA INFORMATION AND WRAP SUMMARY PLAN DESCRIPTION INTRODUCTION

Savannah River Nuclear Solutions, LLC (“Employer” or “SRNS”) has adopted and sponsors the Savannah River Nuclear Solutions, LLC Welfare Benefits Plan (“Plan” or “Wrap Plan”) to provide certain benefits to its eligible employees and their dependents. This document is intended to describe the benefits that are made available to participants in the Plan as of January 1, 2025, and constitutes the summary plan description (“SPD”) for the Plan, as required by ERISA.

SRNS also offers its employees the Savannah River Nuclear Solutions, LLC Cafeteria Plan (“Cafeteria Plan”) and the opportunity to make pre-tax contributions toward certain benefits, in accordance with the requirements of Internal Revenue Code Sections 125, 129 and 105(e).

I. DEFINITIONS

Capitalized terms used in this document have the following meanings: “AD&D” means accidental death and dismemberment insurance.

“**Booklets**” means the certificate or policy of insurance booklets or other documents issued by the insurance companies providing benefits under the Component Programs, which are incorporated into this SPD by this reference. The term Booklets is also used to refer to the summary plan description for the Component Program and the annual Open Enrollment documents, which is also incorporated into this SPD by reference.

“**COBRA**” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and regulations thereunder.

“**Code**” means the Internal Revenue Code of 1986, as amended, and regulations thereunder.

“**Component Program**” has the meaning given to that term in Section 2.

“**Dependent**” means a Dependent who is eligible to participate in a Component Program, as defined or otherwise specified in the Booklet for that Component Program.

“**Eligible Employee**” means an Employee of the Employer who meets the eligibility requirements for a Component Program as described in the SPD or applicable Booklets for that benefit. The following individuals are not Eligible Employees: contract employees, temporary employees, nonresident aliens, independent contractors, leased employees, agents, consultants, employees covered by a collective bargaining agreement, and employees in the active service of the armed forces of any country or subdivision of any country.

“**Employee Benefits Policy**” means the insurance policy, if any, governing any benefit for the Plan Year.

“**Employer**” means Savannah River Nuclear Solutions, LLC.

“**ERISA**” means the Employee Retirement Income Security Act of 1974, as amended, and regulations thereunder.

“**Health Care Reform Law**” means the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended, and including all regulations thereunder.

“**HIPAA**” means the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations thereunder.

“**Plan**” means the Savannah River Nuclear Solutions, LLC Welfare Benefits Plan (“Wrap Plan”).

“**Plan Administrator**” means the Health and Welfare Committee of Savannah River Nuclear Solutions, LLC.

“**Plan Year**” means the twelve consecutive month period commencing each January 1 and ending December 31.

“SPD” means the summary plan description.

“Spouse” means (a) for insured Component Programs, an Eligible Employee’s spouse as defined in the Booklet; and (b) for self-insured Component Programs, an Eligible Employee’s legally recognized spouse under federal law; provided in the case of both subsection (a) and subsection (b), the Eligible Employee is not divorced from his or her spouse and they have not had their marriage annulled.

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and any pertinent regulations, rights, notice or other guidance.

II. BENEFITS UNDER THE PLAN

SRNS provides benefits through the following component benefit programs (“Component Programs”):

- Medical;
- Vision coverage;
- Dental coverage;
- Employer Contributory Group Life (Active and Retiree);
- Employer Noncontributory (Active and Retiree noncontributory Life) OAD, Dependent Life, AD&D, and BTA;
- Disability (long-term);
- Employee Assistance Program (EAP);
- Severance Plan
- Voluntary Benefit coverage Accident and Critical Illness
- Flexible Benefit Programs; and
- Health Reimbursement Arrangement (HRA)

The Component Programs are provided either by the Employer on a self-insured basis or pursuant to contracts entered into with certain insurance companies, service providers or HMO contracts. The Booklets summarize the Component Programs and are incorporated herein by reference.

This document, together with the Booklets, serves as your summary plan description required by a federal law known as ERISA. You must read this document, the Booklets, and the Employee Benefits Policy to understand your benefits under the Plan. If the terms of this summary document conflict with the terms of the Plan or the Booklets, the terms of the Booklets will control with respect to the specific benefits provided, and with respect to claims and appeals for that Component Program.

The Employer is providing this document to give you an overview of the Plan and to address certain information that may not be addressed in the Booklets.

This document is not intended to give you any substantive rights to benefits that are not already described by the Booklet or Employee Benefits Policy that governs those benefits listed above.

The Plan may recover overpaid benefits, or payments for injuries that were caused by a third party, through its rights to subrogation and reimbursement, as described in this SPD, the Plan and the Booklets.

If you have any questions regarding any of your benefits or how the Plan operates, please contact Human Resources.

III. ELIGIBILITY AND PARTICIPATION REQUIREMENTS

Eligibility

To participate in any Component Program an Eligible Employee must satisfy the eligibility requirements applicable to such Program that are described in the relevant Booklet.

Spouse and Dependent Eligibility

Per the terms of the relevant Booklet for each Component Program, your Dependents eligible for coverage include:

- Your Spouse
- Your unmarried children under age 26 (for medical, dental, vision and supplemental life insurance benefits) who depend on you for support, including stepchildren, foster children and adopted children. Your child of any age who meets the

criteria above and who a doctor certifies in writing to be incapable of getting a self-supporting job because of a physical or mental condition (subject to the insurer/claim administrator's approval of the certification), provided that the child must be unmarried and chiefly dependent on you or your spouse for support and maintenance, and must have at least six (6) months of creditable coverage or was already covered under the Employer's benefits on his or her 26th birthday.

For new hires, Dependent coverage generally begins on the same day as the employee. For other mid-year changes, Dependent coverage generally begins on the date of the event.

Important Note. The Employer requires documentation to verify your Dependent's eligibility. You must submit any documentation within the time frame set by the Plan Administrator after hire or a qualifying life event allowing you to change your election. If you do not provide this documentation, your Dependent's coverage will be retroactively terminated.

If your Spouse or other Dependent is no longer eligible to participate in a Component Program, you must inform Human Resources and cancel his or her coverage. For example, if you are divorced, you must cancel coverage for your Spouse (although your ex-Spouse may be able to continue coverage under COBRA, as described in the Booklets and below).

Qualified Medical Child Support Orders

A qualified medical child support order ("QMCSO") is a state court order or an order of a state administrative agency that requires the Plan to cover a child of an employee who is eligible to receive health care benefits under the Plan. A medical child support order must meet certain requirements to be qualified.

If the Plan receives a QMCSO, the Plan will provide coverage to your child pursuant to the QMCSO even if your child is not your dependent for federal income tax purposes or your child does not reside with you. If the Plan receives a valid QMCSO and you do not enroll your child, the custodial parent or the state may enroll your child.

If you have any questions regarding the requirements for qualification of an order or you would like a copy of the Plan's QMCSO procedures free of charge, please contact Human Resources.

Special Rights on Childbirth

Group health plans and health insurance issuers offering group insurance coverage 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 normal 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 the above periods. In any case, such 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 the above periods.

Participation Restrictions

The following participation restrictions generally apply to the Plan, in addition to any other restrictions described in the Booklets:

- You may not participate in the Plan as an Eligible Employee and as a Spouse or other Dependent;
- A Spouse or other Dependent may be enrolled in the Plan by only one Eligible Employee; and
- You may enroll your Spouse or other Dependent in the Plan only if you also enroll in the Plan.

Medical Coverage: Patient Protections

- If a medical benefit option requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If the medical benefit plan option designates a primary care provider automatically, until you make a designation, the Plan designates one for you. For information on how to select a primary care provider, and how to obtain a list of the participating primary care providers, please refer to the medical benefit option Booklets.
- For children, you may designate a pediatrician as the primary care provider.
- You do not need prior authorization from the Plan or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the benefit networks who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures,

including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. You can locate health care professionals who specialize in obstetrics or gynecology by referring to the medical benefit option Booklets.

IV. ENROLLMENT

Initial Enrollment

If you are an Eligible Employee, you may enroll by timely completing an application for each Component Program in which you wish to enroll. If you waive coverage at your initial enrollment, you will not be able to enroll until the next open enrollment period unless you experience a qualified life event.

Open Enrollment

Open enrollment occurs prior to the beginning of each Plan Year. During open enrollment, you may enroll in, or change, benefits for the following Plan Year by following the instructions given to you by the Plan Administrator. During open enrollment you will receive current descriptions of benefits and details regarding the enrollment process.

Mid-Year Election Changes

Special Enrollment

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") has special enrollment rules for certain health plans. HIPAA special enrollment rights include the following:

1. If you declined enrollment in the medical plan for yourself or your Spouse or your other Dependents because of other medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (e.g., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period) you may be able to elect pre-tax medical coverage prospectively for yourself and your Spouse and other Dependents who lost such coverage. Refer to the applicable Booklet for the time period within which you must enroll.
2. If you have a new Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your other newly acquired Dependents on a pre-tax basis. Refer to the applicable Booklet for the time period within which you must enroll. Coverage arising as a result of birth, adoption, or placement for adoption will become effective in accordance with the terms of the Booklets.
3. If you or your Dependent becomes eligible for a state premium assistance subsidy under the medical plan from Medicaid or a state child health plan, you may pay for any medical plan premiums on a pre-tax basis. Refer to the applicable Booklet for the time period within which you must enroll.
4. If you or your Dependent's Medicaid or state child health plan coverage is terminated as a result of loss of eligibility, you may pay for any medical plan premiums on a pre-tax basis. Refer to the applicable Booklet for the time period within which you must enroll.

Change In Status Events Permitting Mid-Year Election Changes

Generally, once you enroll for coverage in a Component Program (during initial enrollment or during a subsequent open enrollment period) your benefit elections stay in effect for the relevant Plan Year (which runs from January 1 through December 31 of the following year). However, if you experience one of the following "change in status" events that is consistent with and corresponds to the change in your circumstances, you may be able to make a mid-year election to change benefits if it is permitted by the relevant Booklet:

- You experience a "family status change" that affects your, your Spouse's, or your other Dependents' eligibility for benefits. A "family status change" is any of the following events that results in a loss or gain of eligibility or coverage:
 - You marry. In this case you may elect coverage for yourself, your Spouse and/or any other newly acquired Dependents. Alternatively, you may cancel coverage for yourself and your covered Dependents if you decide to obtain coverage under your Spouse's plan.
 - You divorce or legally separate from your Spouse or your marriage is annulled. In this case you must cancel coverage for your Spouse, but your Spouse may continue coverage under COBRA.

- Your Spouse or another Dependent dies. In this case, you may cancel the coverage of the deceased.
 - A person becomes a Dependent through birth, adoption, or placement for adoption. In this case, you may increase your coverage to include yourself, your Spouse, and/or the new Dependent.
 - Your Spouse or other Dependent becomes ineligible for coverage. In this case, you may cancel only the ineligible Dependent's coverage.
 - You, your Spouse, or other Dependent experiences a change in employment status or worksite that affects eligibility under the Plan or eligibility under your Spouse's or Dependent's plan. In this case, you may increase or decrease coverage in a manner that is consistent with the change in employment status.
 - You, your Spouse, or other Dependent changes place of residence. In this case, you may change your coverage in accordance with the change of residence.
- The Plan receives a QMCSO that requires you to enroll a child.
 - You or your Spouse or other Dependent become eligible for or lose eligibility for Medicare or Medicaid coverage.
 - You take a leave of absence under the Family and Medical Leave Act.
 - If benefit coverage is significantly curtailed or ceases, you may revoke your election with respect to that coverage and may prospectively elect alternative coverage offered under the Plan.
 - If your share of any premium increases significantly, you may increase your contributions or revoke your coverage. Insignificant premium changes will be automatically reflected in your salary reductions.
 - If there is a significant addition to or improvement in coverage, you may be able to elect that option.
 - If there is a change in coverage under another employer's plan, you may be able to make a corresponding election change.

If you are permitted to make a mid-year election under the terms of the Plan and the Booklet, you must follow the procedures described in the Booklets (including compliance with any time periods). If you do not follow the correct procedures, you may not make an enrollment change until you experience another event that permits you to make a mid-year election or the next open enrollment. Please contact Human Resources for further information regarding any of the above events.

Change in Employment Status

If you stop participating in the Plan because you cease to be eligible, and later you become eligible again, you may recommence participation in the Plan. If you become eligible again within 31 days of ceasing to be eligible, you may not make any changes to your prior election (except if you qualify for a mid-year election change). However, if you become eligible again more than 31 days after ceasing to be eligible, you may make a new election.

Other Changes

The Plan Administrator may reduce your salary reductions (and therefore increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual (as defined by the Internal Revenue Code), if necessary to prevent the application of the federal "nondiscrimination" rules. Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Internal Revenue Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you or such other person is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

V. COST OF BENEFITS

Cost of Benefits

Each year the Employer reviews the costs of the benefits provided under the Plan and determines the amount, if any, employees will be required to contribute towards the premiums for Covered Programs. Contact Human Resources for a summary of the current cost of benefits.

Tax Treatment

If you are an employee you will not be taxed on the value of Employer-provided medical, dental and vision coverage for yourself, your Spouse and your children under the age of 26.

Refer to the Booklet and contact the Plan Administrator or your tax advisor if you have questions regarding the tax treatment of other Component Programs.

VI. TERMINATION OF PARTICIPATION

Termination of Your Coverage

In addition to the events listed in the Booklets that will cause a termination of your coverage under the Plan, your coverage will terminate on the date that any of the following events occur:

- You revoke your election form and do not submit a replacement;
- You cease to be eligible to participate in the Plan;
- The Plan is discontinued; or
- You do not pay your share of the contributions to the Plan, if any, within the time limit set by the Plan Administrator; or
- You report for active military service, unless coverage is continued through USERRA as explained below; or
- Your coverage is the result of fraud or an intentional misrepresentation; or
- Other circumstances described in the Booklets.

Termination of Spouse or Other Dependent Coverage

In addition to the events listed in the Booklets that will terminate coverage for your Spouse or other Dependents under the Plan, their coverage will terminate on the date that any of the following events occur:

- You or the Eligible Employee revoke your election form and do not submit a replacement;
- You or your Spouse or other Dependent are no longer eligible to participate in the Plan;
- Spouse or other Dependent coverage under the Plan is discontinued;
- The Plan is discontinued;
- Your Spouse or other Dependent becomes an employee of the Employer; or
- You do not pay your Spouse or other Dependent's share of the contributions to the Plan within 31 days of their due date; or
- Coverage is the result of fraud or an intentional misrepresentation; or
- For other reasons described in the Booklets.

Retroactive Termination

In the case of coverage under a group health plan, the Plan Administrator may retroactively terminate coverage as follows:

- If there is fraud or an intentional misrepresentation of a material fact;
- For failure to pay required contributions toward the cost of coverage; or
- For any purpose that is not considered a "rescission" under Health Care Reform Law.

When required by law or regulation, the Plan Administrator will provide written notice of retroactive termination. The Plan may recover from you amounts it paid for services provided to you or your covered dependents after the date coverage was terminated.

Federal Continuation Coverage

Depending on the reason that coverage was terminated, you, your Spouse and your other Dependents might be able to continue coverage temporarily under COBRA or USERRA.

If coverage ceases because of certain "qualifying events" (for example, termination of employment, reduction in hours, divorce, death or

child's ceasing to meet the Plan's definition of Dependent) specified in a federal law called COBRA, then you, your Spouse and other Dependents may have the right to purchase continuing coverage under the Plan for a limited period of time.

For more information about COBRA rights, please refer to the COBRA information that has been previously furnished to you and your Spouse (if covered under the Plan), and also refer to the specific COBRA information in the Booklets and Plan document. Please contact Human Resources if you need another copy.

The Plan provides no greater COBRA rights than what COBRA requires— nothing in this SPD is intended to expand your rights beyond COBRA's requirements. COBRA does not apply to any benefits that are not health (medical, dental, vision) benefits (e.g., Life, LTD, or AD&D benefits).

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the Uniformed Services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage available pursuant to USERRA is available from the Employer.

Alternatives to COBRA

You should examine your options carefully before accepting or declining COBRA. 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). Some of these options may cost less than COBRA continuation coverage, but remember that COBRA coverage generally applies from the date of your qualifying event, whereas coverage under the Health Insurance Marketplace applies prospectively, leaving you with a gap in coverage. You can learn more about these options at www.healthcare.gov.

Converting Coverage After Termination

If you are eligible to convert your coverage to an individual policy, you will be sent a conversion notice within the last one hundred eighty (180) days of COBRA coverage. Contact the applicable HMO or insurance company for information on converting to an individual policy. HMOs and insurance companies will sometimes permit you to continue membership or equivalent coverage under an individual policy. Conversion rights may also be available to your Spouse and/or Dependents. However, the cost of conversion coverage is usually high, and conversion coverage often will not offer the same comprehensive coverage as the Plan. For more information about conversion rights, contact the applicable HMO or insurance company.

Contact the Employer to determine if you have conversion rights with respect to any other benefit or review the benefit Booklet for the Component Program.

Leaves of Absence

The Plan Administrator will provide you with information regarding your coverage if you take a leave of absence.

VII. PLAN ADMINISTRATION

Plan Administration

The Plan is administered by the Health and Welfare Committee of Savannah River Nuclear Solutions, LLC ("Plan Administrator"). The principal duty of the Plan Administrator is to see that the Plan is operated, in accordance with its terms, for the exclusive benefit of persons entitled to participate. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities. Any decision of the Plan Administrator that does not constitute an abuse of discretion must be upheld by a court of law.

The Employer bears the incidental costs of administering the Plan.

Your Questions

If you have any general questions regarding the Plan, please contact Human Resources.

VIII. AMENDMENT OR TERMINATION OF THE PLAN

The Employer and the Plan Administrator have the right to amend or terminate the Plan or any Component Program at any time and for any reason.

IX. NO CONTRACT OF EMPLOYMENT

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Employer to the effect that you will be employed for any specific period of time.

X. CLAIMS PROCEDURES

The Plan Administrator has delegated claims administration to the claims administrators in the Booklets for the Component Programs. The relevant claims administrator has the full power and sole discretionary authority to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable Booklet, and has final responsibility for determining the amount of any benefits payable and providing the claims procedures to be followed and the claims forms to be used. Any construction of the terms of the Plan for which there is a rational basis that is adopted by the relevant claims administrator shall be final and legally binding on all parties, and subject to review only if that interpretation or other action is arbitrary, capricious or otherwise an abuse of discretion. Any review of a final decision or action of the claims administrator will be based only on such evidence presented to or considered by the claims administrator at the time it made the decision that is the subject of the review. All participants in the Plan consent to actions of the applicable claims administrator made in its sole discretion and agree to the narrow standard of review described in this section.

The Plan Administrator shall be entitled to rely conclusively upon all tables, valuations, certificates, opinions, and reports which that are furnished by an actuary, accountant, controller, counsel, insurer, third party administrator, or other person who is employed or engaged for such purposes. Moreover, the Plan Administrator and Employer shall be entitled to rely upon information furnished to the Plan Administrator or Employer by an Eligible Employee or Dependent, including such person's current mailing address.

Unless specifically provided otherwise in a Component Program or pursuant to applicable law, a claim for benefits under this Plan (including the Component Programs) must be made within one year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the employee or covered family member, or his or her designee, to make sure this requirement is met.

Unless specifically provided otherwise under a Component Program or pursuant to applicable law, a suit for benefits under this Plan must be filed with the appropriate court, after exhausting administrative remedies, within two (2) years from the accrual of the cause of action. Generally, a welfare benefit claim will accrue when an expense has been incurred, or when the claimant knows, or with reasonable diligence should have known, of the underlying facts giving rise to the claim, regardless of whether the claimant is aware of the legal significance of such facts.

However, a welfare benefit claim will accrue, at an earlier point in time, when there has been a clear repudiation of the welfare benefit claim by the Employer, the Plan Administrator, or its agent. For example, a claim involving eligibility will accrue as of the date the employee first became eligible or was first excluded from eligibility under the relevant plan. A claim involving reimbursement of an expense will accrue when the expense was incurred.

A participant must timely exhaust his or her administrative remedies under the welfare benefit plan before timely seeking a judicial remedy. If, as of the date of this SPD, the limitation period has started to run, but has not run in its entirety, the claimant has the greater of: (i) the limitation periods described above, or (ii) six (6) months from the date of this SPD, to file an administrative claim, and six (6) months after the final decision on such administrative claim to seek judicial review, or if an administrative claim is currently pending, the claimant must seek judicial review within six (6) months after the final decision on such administrative claim.

XI. GENERAL INFORMATION

Plan Name	Savannah River Nuclear Solutions, LLC Welfare Benefits Plan ("Wrap Plan")
Plan Sponsor	Savannah River Nuclear Solutions, LLC
Plan Sponsor EIN	26-0240191
Plan Number	525
Plan Year	January 1 through December 31
Plan Administrator	<p>Health and Welfare Benefit Committee of Savannah River Nuclear Solutions, LLC</p> <p>The Plan Administrator has the right to delegate decision-making authority to another party, at its sole discretion. The decision of the Plan Administrator, or its designee, is final.</p> <p>Building 730-1B Aiken, SC 29808 Phone: 803-775-7772</p>
Plan Administrator EIN	27-0584392
Agent for Service of Legal Process – service of process may also be made to the Plan Administrator	<p>Corporation Service Company 1703 Laurel Street Columbia, SC 29201 Phone: 800-927-9800</p>
Type of Administration	<p>Self-administered, third party or insurance company administration, depending on the benefit. Claims for benefits are sent to the relevant claims' administrator, who is responsible for paying benefits and has authority for making final claims determinations.</p>
Plan Funding	<p>Some benefits are self-funded, and some are fully insured – see Claims Administration section. Contributions/premiums for both self-funded and fully insured benefits are paid by the Employer out of general assets and/or by employees through pre-tax or post-tax salary reductions. There is no trust.</p>
Treatment of Rebates [Insured benefits only]	<p>Any refund, rebate, dividend, experience adjustment, or other similar payment under the group contracts will be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse the Employer for premiums that it has paid and administrative costs it has incurred in maintaining the Plan.</p>

XII. INSURED BENEFITS

The Employer provides certain benefits under the Plan through group insurance contracts with the insurance companies listed below, who have the authority to require eligible individuals to furnish them with such information as they determine is necessary for the proper administration of the relevant benefit. The insurance companies, not the Employer, are the named fiduciaries and claims administrators for the relevant benefit and are responsible for determining and paying claims with respect to the insured component benefit programs.

The insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. The insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurer for a review of the denied claim. The insurer will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. If you do not appeal on time, you may lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court. Refer to the Booklets for more information about the claims process for insured benefits.

Any refund, rebate, dividend, experience adjustment, or other similar payment under the group insurance contracts will be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse the Employer for premiums that it has paid.

Type of Benefits	Benefits Carrier/Insurance Company/Claims Administrator
Vision	EyeMed Vision Care, LLC / First American Administrators Inc. and Insurer: P.O. Box 8504 Mason, OH 45040-7111 www.eyemed.com Phone: 866.800.5457
Employer: Noncontributory Term Life (Basic), Dependent Life, AD&D(Basic and Optional), BTA and Contributory Group Life Insurance (Optional) and Retiree Term Life Insurance (Basic and Optional)	The Prudential insurance Company of America. Prudential Group Life Claim Division P.O. Box 8517, Philadelphia, PA 19176 www.prudential.com/mybenefits Phone: 800.524.0542
Aflac Accident and Critical Illness	Aflac Continental American Insurance Company PO Box 427 Columbia, South Carolina 29202 www.aflacgroupinsurance.com Phone: 803.433.3036

XIII. SELF-INSURED BENEFITS

The Employer provides the benefits listed in the following table on a self-insured basis, which means that benefits are paid out of the Employer's general assets and are not guaranteed under a contract or policy of insurance. The Employer or the providers listed below are the claims administrators for these benefits, which means that the Employer or the listed provider is the claims administrator for the applicable benefit and is responsible for evaluating all benefit claims for that benefit and for paying claims.

To obtain benefits from a self-insured plan, you must submit a claim to the claims administrator for that benefit in accordance with the relevant claims procedure. The claims administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim.

The claims administrator will decide your claim in accordance with the claims procedures for the applicable component benefit program. For component benefit programs subject to ERISA, the claims procedures will be reasonable and will comply with applicable ERISA requirements. If the Plan Administrator denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the claims administrator for a review of the denied claim. The claims administrator will decide your appeal in accordance with reasonable claims procedures, as required by ERISA (if ERISA applies). If you do not appeal on time, you may lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). Special time limits apply to disability claims, so please consult the Booklets.

See the Booklets for information about how to appeal a denied claim under a self-insured benefit, and for details regarding the appeals procedures.

Benefits Carrier Contact Information and Type of Benefits	Claims Administrator
Savannah River Nuclear Solutions, LLC Medical Plan Administrator 803.725.7772 or 800.368.7333 Building 730-1B, Aiken SC 29808 Medical, Dental, Pharmacy and EAP	BlueCross BlueShield BlueCross BlueShield of South Carolina www.SouthCarolinaBlues.com ; Monday-Thursday 8 a.m.-6 p.m.; Friday 8 a.m.-4 p.m. EST; Claims Processing Center PO Box 100300, Columbia, SC 29202 Phone: 800.325.6596
Savannah River Nuclear Solutions, LLC Disability Income Plan Administrator 803.725.7772 or 800.368.7333 Building 730-1B, Aiken SC 29808 Disability Long Term (LTD)	Long Term Disability Claims Administrator Sedgwick Claims Management Services, Inc. P.O. Box 14454 Lexington, KY 40512-4454 Phone: 800.231.0165
Savannah River Nuclear Solutions, LLC SRNS Health and Welfare Plan Administrator 803.725.7772 or 800.368.7333 Building 730-1B, Aiken SC 29808 Severance Plan	Savannah River Nuclear Solutions, LLC H&W Plan Administrator 730-1B Aiken, SC 29808 Phone: 803.725.7772 or 800.368.7333
Savannah River Nuclear Solutions, LLC SRNS Health and Welfare Plan Administrator 803.725.7772 or 800.368.7333 SRNS Benefits Administration Building 730-1B, Aiken SC 29808 Flexible Spending Programs (FSA)	HSA Bank P.O. Box 939 Sheboygan, WI 53082-0939 https://myaccounts.hsabank.com/Login.aspx Phone: 800.357.6246

Savannah River Nuclear Solutions, LLC
Health and Welfare Benefits Committee
Attention: Health and Welfare Plan Administrator
803.725.7772 or 800.368.7333
Building 730-1B, Aiken SC 29808

LIG Solutions (a Gallagher Company)
6100 Rockside Woods Blvd N. Suite 310
Independence, OH 44131.
Phone: 855.662.0681

Health Equity/WageWorks (HRA Claims
Administration)
Corporate Address:
15 W Scenic Pointe Drive Ste. 100
Draper, UT 84020

Address for Retirees to send Claims:
P.O. Box 14053
Lexington, KY 40512
Phone: 877.924.3967

Health Reimbursement Arrangement (HRA)

XIV. SUBROGATION AND REIMBURSEMENT RIGHTS

Acts of Third Parties

When you or your covered dependent are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (medical, dental and vision) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery. In this section "you" means the employee, his or her estate, or former employee and his or her dependents covered under the Plan.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any other sources of payment. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury. The Plan may recover overpaid benefits, or payments for injuries that were caused by a third party, through its rights to subrogation and reimbursement. These Plan rights are described in the Booklets, and this language is intended to supplement that language.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree (and any person receiving benefits under the Plan agrees) that the Plan:

- Has special recovery rules as described in this section and as described in the Booklets, and that you will assist the Employer (or its designee) in the Plan's recovery.
- Has a right of recovery that will extend to any amount paid with respect to, associated with, or stemming from the injuries incurred, whether paid directly or indirectly to the injured party, his spouse, dependents, beneficiaries or estate, or whether held in trust or constructive trust for the benefit of the injured party, his spouse, dependents, beneficiaries or estate.
- Has an equitable lien on any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury;
- Is entitled to recover on a first dollar basis, regardless of whether the claimant has been made whole for his or her injuries;
- Has a contractual claim that includes not only the medical expenses paid by the Plan, but also the costs and expenses, including attorney's fees, incurred by the Plan with respect to any claim for reimbursement or subrogation; and
- May recover amounts regardless of whether the funds have been commingled with other assets and may recover from any available funds, without the need to trace the source of the funds.
- May terminate your participation and/or may offset any amounts to which it is entitled against future claims. You further agree that any amounts recovered on behalf of a participant are plan assets and the participant is therefore a fiduciary of the Plan with respect to amounts recovered from third parties.

In addition, you agree that if you (or your attorney or other representative) receive any payment from a third party – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party's acts or omissions, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds, and if the injured party, his spouse, dependents, attorney, beneficiary, estate or other third party distribute funds without regard to the Plan's rights of subrogation or reimbursement, such individual or individuals will be personally liable to the Plan for the amounts so distributed.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses.

Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Summary. You may be required to enter into a reimbursement agreement acknowledging and agreeing to your obligations.
- Notify the Plan within thirty (30) days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.
- Promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.
- Agree that any amounts recovered on behalf of a participant are plan assets and the participant is therefore a fiduciary of the Plan with respect to amounts recovered from third parties.
- Agree that if you fail to comply with the requirements of this section, your participation in the plan may be terminated and/or the plan may offset any such amounts against future claims.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the subrogation provisions in these "Acts of Third Party" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the more favorable provisions to the Plan will govern. If the right of recovery provisions in these "Acts of Third Party" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the more favorable provisions to the Plan will govern.

Recovery of Overpayment

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses (plus interest) from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

XV. STATEMENT OF ERISA RIGHTS

Your Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Employer's principal office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Employer, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report, if any is required by ERISA to be prepared, in which case the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights

Continue health care coverage for yourself, your Spouse, or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Receive a copy of the Plan's qualified medical child support order procedures without charge from the Plan Administrator.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. 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. 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 plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (Form 5500), if any, 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 Employer, as Plan Administrator, to provide the materials and pay you up to \$110 per 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 a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed above), you may file suit in a state or federal court.

If it should happen that 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, 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 fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact Human Resources. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

XVI. MANDATED BENEFITS AND SERVICES

The Booklets detail the mandated benefits and services for each specific type of benefit offered. However, the following provisions apply whether or not the group health plan documents include such provision.

Maternity/Newborn Coverage – Newborns' and Mothers' Health Protection Act (NMHPA)

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998 (WHCRA)

The WHCRA requires a group health plan to notify you, as a participant or beneficiary, of your potential rights related to coverage in connection with a mastectomy. Your plan may provide medical and surgical benefits in connection with a mastectomy and reconstructive surgery. If it does, coverage will be provided in a manner determined in consultation with your attending physician and the patient for (a) all stages of reconstruction on the breast on which the mastectomy was performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; (c) prostheses; and (d) treatment of physical complications of the mastectomy, including lymphedema. This coverage, if available under your group health plan, is subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under the plan. For specific information, please refer to your benefits booklet or contact the employer/Plan Administrator.

Genetic Information Nondiscrimination Act (GINA)

Among other safeguards, GINA prohibits an employer from discriminating against employees on the basis of genetic information and limits a plan's ability to acquire or monitor genetic information except as expressly provided in the Act. As with other compliance duties, the Plan and Employer will satisfy all applicable laws and regulations related to GINA requirements.

HIPAA Privacy Rule

SRNS is required to provide a Notice of Privacy Practices, which describes how medical information about you may be used and disclosed and how you get access to this information. The HIPAA Notice of Privacy Practices, incorporated herein by this reference, is posted on the Employer's internal portal or you may request a copy from Human Resources. The healthcare insurers and claims administrators also have HIPAA privacy policies and notices posted on their websites or you can call the number on your benefit ID card to request a copy of their policies.

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).

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") and Battelle Savannah River Alliance, LLC. 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 pre-certification and preauthorization of services concurrent and retrospective review.

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

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

Required By Law. The Group Health Plan may use or disclose protected health information as required by law.

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

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

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

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

Law Enforcement. The Group Health Plan may disclose protected health information, subject to specific limitations, for certain law enforcement purposes, including in response to legal process or as otherwise required by law; to identify or locate a suspect, fugitive, material witness or missing person; to provide requested information about the victim of a crime; to alert law enforcement that a person may have died as a result of a crime; and 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 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 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. In certain circumstances, the Group Health Plan may temporarily suspend your right to an accounting. 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: 730-1B Room 120; 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.

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

**Savannah River Nuclear Solutions
Welfare Benefits Plan
General ERISA Information and Wrap**

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