2026 Open Enrollment Benefits Guide

For Savannah River Nuclear Solutions
retirees under age 65 and their eligible dependents

Open Enrollment is October 1-31, 2025

25CC00057

For retirees under age 65 and their dependents

Enroll at any time between October 1-31, 2025.

2026 Open Enrollment Benefits Guide

For Retirees Under Age 65 and their Dependents

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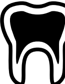
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To view this guide online, go to
www.srs.gov/general/jobs/benefits/index_r.htm

While SRNS intends to continue providing comprehensive benefit programs, the companies reserve the right to modify or terminate any of the benefit plans at any time. SRNS 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”).

SRNS Plans Benefits Guide

What benefit choices do you have for yourself and your eligible dependents?

We encourage you to:

- Read through this Benefits Guide
- Share the information with your eligible family members
- Review your current coverage
- SRNS Retirees please see the following document Savannah River Nuclear Solutions, LLC Pre-65 Retiree Health Plan Summary Plan Description Plan # 509, EIN 26-0240191
- The document referred to above can be located at **www.srs.gov/general/jobs/benefits/index_r.htm**

Once you understand the options available to you, follow the instructions below. If you want to change your current coverage, make your changes on the attached form and return it to the SRNS Service Center postmarked anytime between now and October 31, 2025.

How to Enroll

No changes? Do nothing.

To make changes, complete the Open Enrollment Request for Change Form on the last page of this guide. To add coverage for dependent(s) that have not been previously covered, you will need to provide acceptable documentation (i.e., birth certificate, marriage decree etc.) for proof of eligibility with the completed Open Enrollment form. The list of acceptable documentation can be viewed at ***www.srs.gov/general/jobs/benefits/index_r.htm***

You can mail the completed form to the address below; please include your employee ID on the label. You may also scan and email the form to ***service-center@srs.gov***.

Your form must be postmarked by October 31, 2025. No changes will be accepted after Open Enrollment ends.

SRNS Service Center

Building 992-2W

Savannah River Site

Aiken, SC 29808

You will receive a confirmation statement in late November that confirms your elections and covered dependents for 2026.

Changes for 2026

Medical and Dental Plans premiums

Medical and Dental premiums will remain the same from the previous year. See the charts on page 10 for your premium amounts.

Basic Medical Plan, HDHP, deductible to increase

The employee-only coverage deductible will increase to $2,000 and family coverage deductible will increase to $4,000. Keep an eye out for a new BlueCross BlueShield insurance card with the new deductible listed on it. The My Health Toolkit App will automatically update the card on January 1.

Health Savings Account (HSA) maximum contribution increase

For 2026, the IRS has increased the amount you can contribute up to $4,400 for Individual Only coverage, and up to $8,750 for all other coverage levels. Individuals over 55 may contribute $5,400 for Individual Only coverage and up to $9,750 for all other coverage levels. Contributions to your HSA cannot be made from your pension and must be made through direct payments to HSA Bank.

HSA Employer Seed Funding Reminder

SRNS retiree HSA contribution funding will not be upfronted on January 1. The amounts are not changing for 2026 and will continue to remain $500 for single coverage and $1,000 for family coverage. SRNS will make a contribution of 1/12 of the eligible funding which will be deposited monthly as long as the incumbent retiree is eligible (when the retiree ages out of the Pre-65 plan or becomes ineligible to participate, then the retiree is no longer eligible to receive the employer contribution). Dependents are not eligible to elect an HSA or receive HSA contributions through SRNS.

SRNS Marketplace

SRNS Marketplace is open for business and allows SRNS employees to access thousands of discounts that cannot be found anywhere else in one location. The easy-to-use online marketplace allows employees to find deals on pet insurance, restaurants, shopping, family care, car rentals, favorite local establishments and much more!

Sign up and start saving!

1) Go to ***https://srnsmarketplace.benefithub.com/***

2) Enter Referral Code: HRNGNX

3) Complete registration

Pharmacy Mail Saver Program continues for 2026

This program requires participants to have prescriptions for drugs that are considered “maintenance” filled through an OptumRx Mail pharmacy. More details can be found on page 13 of this booklet.

Remember that your deductible will reset on January 1, 2026.

Frequently Asked Questions

How do I pay for benefits? You and SRNS share the cost of your benefit coverage. The amount you are responsible for paying depends on the options and coverage levels you elect: Individual only, Individual + one, or Individual + two or more. Medical and Dental premiums will be taken as a payroll deduction as long as there are sufficient funds. In accordance with our policy, failure to remit premium payment by the deadline will result in termination of your benefits. Should your enrollment be cancelled for non-payment of premium(s), you will not be allowed to reenroll in the future. You will be responsible for repaying any claims that BlueCross BlueShield of South Carolina will have to process as part of this cancellation. In addition, you would not be eligible to participate in the Retiree Health Reimbursement Account (HRA) in the future.

How do I make changes during the year?

The only time that you can enroll in or change your benefits other than during Open Enrollment is when you experience a qualified life status change. 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

You will need 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, within 60 days you must contact the SRNS Service Center at (803) 725-7772, or (800) 368-7333 or by email ***service-center@srs.gov*** to request your change.

For this guide and other Open Enrollment resources, go to ***www.srs.gov/general/jobs/benefits/index_r.htm***

To confirm which plan you are currently enrolled in, review your pension deposit advice or check stub. You can also call the SRNS Service Center at (803) 725-7772.

To print a new Open Enrollment Request for Change Form, go to ***www.srs.gov/general/jobs/benefits/index_r.htm*** If you need for us to mail you a paper form, call the SRNS Service Center at (803) 725-7772, but note that this option may put you at risk for meeting the October 31 deadline.

If you turn 65 after the New Year, and your spouse is still under 65, you will be dropped from coverage on the first day of your 65th birth month (this may be the first day of the preceding month if your birthday is on the first day of the month). Your spouse and/or dependent may be eligible to remain covered.

Questions?

The SRNS Service Center is available to answer your questions about your current coverage or the enrollment process. Call (803) 725-7772 or (800) 368-7333. You can also email the Service Center at ***Service-Center@srs.gov***.

Hours of Operation: Monday-Thursday from 7 a.m. to 4 p.m.

Open Enrollment changes will not be accepted over the phone. You must return your changes, in writing, through the Open Enrollment Request for Change Form.

Do not send the form back if you are not making any changes.

HIPAA: Notice of Privacy Practices

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

This notice of privacy practices (this "Notice") applies to the health plans and programs (the "Group Health Plan") sponsored by Savannah River Nuclear Solutions, LLC (the "Company"). The Group Health Plan includes the following Company-sponsored plans and benefits that are subject to the administrative simplification section of the Health Insurance Portability and Accountability Act and its implementing regulations: the Active Medical Plan the Pre-65 Retiree Medical Plan, the Active Dental Plan, the Pre-65 Retiree Dental Plan, the Active Vision Plan, the Employee Assistance Program, and Flexible Spending Accounts (Traditional and Limited).

This Notice of Privacy Practices summarizes the Group Health Plan's responsibilities and your rights concerning protected health information, which is information that identifies you and relates to your physical or mental health, treatment, and payment for health care services. The Group Health Plan is required to abide by the terms of this Notice, which is currently in effect.

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

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

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

   To Comply with Federal and State Requirements. We will disclose medical information about you when required to do so by federal, state, or local law. For example, we may disclose medical information when required by the U.S. Department of Labor or other government agencies that regulate us; to federal, state, and local law enforcement officials; in response to a judicial order, subpoena, or other lawful process; and to address matters of public interest as required or permitted by law (for example, reporting child abuse and neglect, threats to public health and safety, and for national security reasons). We are required to disclose medical information about you to the Secretary of the U.S. Department of Health and Human Services if the Secretary is investigating or determining compliance with HIPAA, or to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law. We may disclose your medical information to a health oversight agency for activities authorized by law (such as audits, investigations, inspections, and licensure).

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

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

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

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

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

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

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

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

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone who is able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

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.

   Disclosure to Others Involved in Your Care. We may disclose medical information about you to a relative, a friend, or to any other person you identify, provided the information is directly relevant to that person's

involvement with your health care or payment for that care. For example, if a family member or caregiver calls us with prior knowledge of a claim and asks us to help verify the status of a claim, we may agree to help them confirm whether or not the claim has been received and paid.

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 a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. If the Plans do agree to a request, a restriction may later be terminated by your written request, by agreement between you and the Plans (including orally), or unilaterally by the Plans for health information created or received after the Plans have notified you that they have removed the restrictions and for emergency treatment.

To request restrictions, you must make your request in writing and must tell us the following information:

- What information you want to limit.
- Whether you want to limit our use, disclosure, or both.
- To whom you want the limits to apply.

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. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plans.

You may request the amendment by submitting a request in writing to the Privacy Contact identified below and you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend any of the following information:

- Information that is not part of the medical information kept by or for the Plans.
- Information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- Information that is not part of the information which you would be permitted to inspect and copy.
- Information that is accurate and complete.

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

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

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

5. **Group Health Plan Duties.** The Group Health Plan is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.
6. **Changes to This Notice.** The Group Health Plan reserves the right to change the terms of this Notice at any time, and to make the new notice of privacy practices effective for all protected health information that the Group Health Plan maintains.
7. **Complaints.** You may complain to the Group Health Plan or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by the Group Health Plan. You may file a complaint with the Group Health Plan by notifying the Privacy Contact identified below. The Group Health Plan will not retaliate against you for filing a complaint.

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

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: 730-2B Room 115; 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.

2026 Premium Rates for Medical and Dental Plans

Medical Plan	Basic	Standard
Type	Monthly Premium	Monthly Premium
Individual only	$122	$297
Individual + one	$248	$596
Individual + two or more	$499	$1,117
Dental Plan	**Prime**	**Standard**
Type	Monthly Premium	Monthly Premium
Individual only	$27	$9
Individual + one	$53	$19
Individual + two or more	$80	$28

Medical Plans: Basic and Standard

SRNS offers 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). Here's how the Basic HDHP plus the Health Savings Account (HSA) add up to a great benefit.

- You pay less each month for premiums.
- Save money for the future: You can deposit the money you save on premiums in an HSA. Use these funds to pay for qualified medical, dental and vision expenses or save them for future health care needs. And to help you meet your savings needs, SRNS will make an employer contribution to your HSA.

See the Health Savings Account section on page 15 to learn more about the way you can save by using this special, tax-advantaged account for eligible medical expenses.

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 12 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 (when using in-network providers).

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

	Basic		Standard	
Type	In-network	Out-of-network [2]	In-network	Out-of-network [2]
Deductible (Individual/Family	$2,000 / $4,000 [1]	$2,000 / $4,000 [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] / 30% after deductible [2]
Physical and Occupational Therapy	20% after deductible	20% after deductible	15% after deductible	15% after deductible
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[2]	15% after deductible	15% after deductible [2]
Home Health, Hospice and Durable Medical Equipment Services	20% after deductible	20% after deductible[2]	15% after deductible	15% after deductible [2]
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
HSA: SRNS Annual Contribution [5]	Employee Only: $500 All Other Coverage Levels: $1,000***		None	

*[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. [5]Those eligible to receive the Employer Seed will receive the annual amount prorated each month into their account.

*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_r.htm** or contact BlueCross Customer Service at (800) 325-6596 or **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 administrated 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.

Pharmacy Benefit Manager: OptumRx: (800) 325-6596 • Specialty Pharmacy: BriovaRx: (877) 259-9428

Retail Pharmacy *(30 day supply)*

Retail	Basic *After you meet the deductible, you pay...*		Standard *After you meet the deductible, you pay...*	
30 day supply	In-network	Out-of-network [1]	In-network	Out-of-network [1]
Generic[2]	$10	$10	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

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

Mail Order *(90 day supply)*

Mail	Basic *After you meet the deductible, you pay...*		Standard *After you meet the deductible, you pay...*	
90 day supply	In-network	Out-of-network	In-network	Out-of-network
Generic	$25	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

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 is incremental payments. **Remember that your deductible will reset on January 1, 2026.**

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 (800) 325-6596.
- 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.

Health Savings Account

A Health Savings Account (HSA) is a tax-advantaged savings account that helps you pay eligible medical, dental and vision costs on a tax-free basis. When you take charge of your health and manage how your health care dollars are spent, you can keep more money in your HSA.

Your deposits to this account (and any resulting investment earnings) are entirely exempt from federal income taxes as long as they are used to pay for eligible health care costs, which include medical and dental services, prescriptions, eyeglasses and many other types of expenses. As a retiree, contributions cannot be made through your pension check. You will need to set up contributions directly through HSA Bank. Dependents are not eligible to elect an HSA or receive HSA contributions through SRNS or BSRA.

HSA tax savings advantages

- Unused funds remain in the account and can grow — with interest — from year to year. There are no “use it or lose it” rules for an HSA (like there are for FSA). So, you can save your HSA funds for future health care needs, such as retiree medical expenses. And, when you take charge of your health and manage how your health care dollars are spent, you can keep more money in your HSA.
- Investment income is tax-free.
- An HSA allows you to save for the future — tax-free, as long as it is used for qualified expenses.
- The HSA is portable; you can take it with you when you leave or retire.

Are you eligible to enroll in the HSA?

You must enroll in the Basic plan in order to be eligible for the HSA.

In addition, you may NOT be eligible if:

- You or your spouse is participating in a Health Care Flexible Spending Account through another employer or with SRNS/BSRA/SRMC.
- You are enrolled in Medicare.
- You are claimed as a dependent on another person’s tax return.
- You are covered under TRICARE or other health coverage except what is permitted by the IRS
- You are a veteran who has received medical treatment through the Veterans Health Administration within the last three months (excluding all dental care, all vision care, preventive prescription drugs and preventive medical treatments for you or your children, or treatments received related to a disability incurred while in military service).

How to use your HSA

First time enrollees will receive a debit card from HSA Bank, which you can use like your personal debit card to pay for health care expenses directly. You can also pay bills online or request personal checks. Contact HSA Bank at (866) 471-5946 or ***www.hsabank.com*** with questions. If you are a current enrollee, check the expiration date on your card; contact HSA Bank to request a new card if your current card is expired.

Contribution Levels and Amounts	
Type	Amount
SRNS Contribution***	Individual Only: $500 All Other Coverage Levels: $1,000
New! Maximum Contribution[1] (Under 55)	Individual Only: $4,400 All Other Coverage Levels: $8,750
New! Maximum Contribution[1] (Over 55)	Employee Only: $5,400 All Other Coverage Levels: $9,750

[1] Including SRNS contribution

****The amounts are not changing for 2026 and will continue to remain $500 for single coverage and $1,000 for family coverage. SRNS will make a monthly contribution of 1/12 of the eligible funding which will be deposited at the end of each month as long as the employee is eligible (when the retiree ages out of the Pre-65 plan or becomes ineligible to participate, then the retiree is no longer eligible to receive the employer contribution. Dependents are not eligible to elect an HSA or receive HSA contributions through SRNS.*

Dental Plans

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.

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.

Questions about the Dental Plan? Need to find an In-Network Provider?
Contact BlueCross Customer Service 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*

COBRA Continuation Coverage

Dependents that become ineligible for the Pre-65 Health Plan must be removed from your coverage, but they may be eligible for COBRA continuation coverage. (Note: A spouse turning 65 may be eligible for the SRNS Health Reimbursement Account.)

Coverage for a dependent ends on the date the dependent becomes ineligible. If the ineligible dependent is not removed from your coverage at this time, you and/or said dependent will be responsible for any and all claims incurred after the dependent became ineligible.

An ineligible dependent may, however, qualify for COBRA continuation coverage if you notify the SRNS Service Center within 60 days of your dependent's loss of eligibility. If elected, your dependent's COBRA continuation coverage will become effective the date dependent coverage is terminated.

Your notice within the 60-day period also may, according to the rules of the Plan, entitle you to a refund of any premium contribution made for this dependent's coverage after the event date, if any. Questions on benefit options or qualifying change in status requirements may be directed to the SRNS Service Center by calling (803) 725-7772 or (800) 368-7333 or emailing ***Service-Center@srs.gov***.

Removal of ineligible dependents from all benefits within 60 days of your dependent's loss of eligibility is required in order for them to become eligible for COBRA coverage. Dependents removed during Open Enrollment will not receive a COBRA application unless requested.

Additionally, your dependents may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the marketplace, your dependents may qualify for lower monthly premiums and lower out-of-pocket costs. Remember that your dependents can only be removed during Open Enrollment, unless there is an otherwise qualifying change in status.

Impacts to Eligibility for Retiree Reimbursement Account and COBRA

If you or your spouse elect COBRA medical or dental coverage, the electing individual — you or your spouse — will have waived the right to enroll in the SRNS Retiree Health Reimbursement Account, if otherwise eligible.

Questions?

The SRNS Service Center is available to answer your questions about your current coverage or the 2026 enrollment process. Call (803) 725-7772 or (800) 368-7333. You can also email the Service Center at ***Service-Center@srs.gov***.

Hours of Operation: Monday-Thursday from 7 a.m. to 4 p.m.

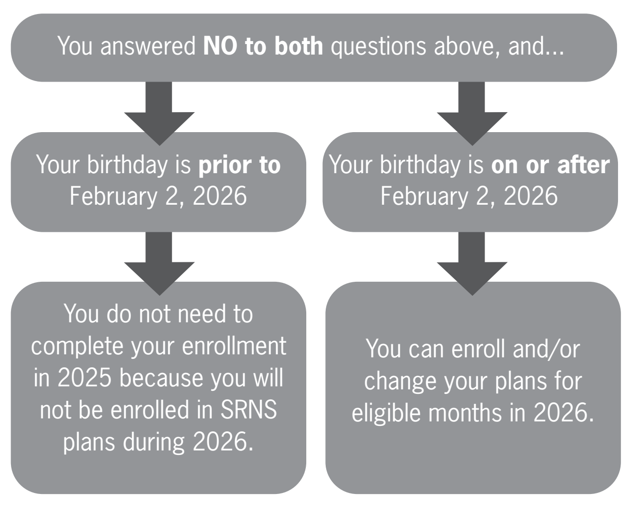
Enrolling in Medicare

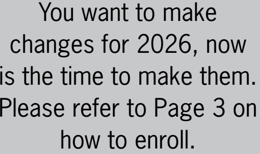
Turning 65 soon? Here's what you need to do for 2026 Open Enrollment.

First, you need to ask yourself two questions:

1. Do you have a spouse under 65 who will remain on the plan after your eligibility ends?
2. Do you have children who will remain on the plan after your eligibility ends?

Based on those two questions, follow the chart below to find out your next steps. If your 65th birthday is on the first day of the month, then your Medicare eligibility date will be the first day of the prior month. Therefore, your employer coverage will end the last day of the month prior to your Medicare eligibility date.





Medicare Effective Date

Please review the chart below to find out your Medicare effective date and your last day of employer coverage.

If you turn 65 on...	Medicare Effective Date	Last Day in the employer Plan
October 1	9/1/2025	08/31/2025
October 2-31	10/1/2025	09/30/2025
November 1	10/1/2025	09/30/2025
November 2-30	11/1/2025	10/31/2025
December 1	11/1/2025	10/31/2025
December 2-31	12/1/2025	11/30/2025
January 1	12/1/2025	11/30/2025
January 2-31	1/1/2026	12/31/2025
February 1	1/1/2026	12/31/2025
February 2-28	2/1/2026	1/31/2026

When does Medicare become your primary insurance?

If you are currently covered under an SRNS Pre-65 Retiree Medical Plan as a retiree or dependent, you may not be aware of the impact to your health coverage when you become disabled and subsequently eligible for Medicare. Keep reading for more information.

Are you covered under the Active Employee Plan?

As long as you remain under the Active benefit plan, BCBS is your primary insurance. You may want to waive Part A (if enrolled in the Basic Medical and Health Savings Account) and B at that time. However, if you have Ends Stage Renal Disease (ESRD) there are special rules concerning Medicare. If you have ESRD and Medicare entitled you need to enroll in Medicare Part B. However; at the time you move to the Pre-65 retiree plan, you should ensure that Medicare Part B is in effect the same date the Pre-65 Medical plan starts. If not, BCBS will not pay what Medicare would have paid.

Are you covered under the Pre-65 Retiree Health Plan?

If you or a covered dependent is or becomes Medicare eligible (prior to age 65) while covered under the Pre-65 Retiree Medical Plan, Medicare becomes your primary payer for medical coverage. This means that you should enroll in Medicare Part B. Your BlueCross BlueShield of South Carolina (BCBS) coverage becomes your secondary form of insurance. Note that you do not need to enroll in a Medicare Part D drug plan, as the BCBS plan will continue to provide prescription coverage until you reach age 65 (or continue to be eligible). Your BCBS premiums will remain the same.

This information does not reflect a change in SRNS benefits. You can find this information listed in the: Medicare annual Open Enrollment booklets, the SRNS annual Open Enrollment booklets, as well as the Pre-65 Retiree Health Plan Summary Plan Description (SPD), which can be found on the internet at ***www.srs.gov/general/jobs/benefits/index_r.htm*** under the Medical and Dental side menu.

Actions you should take if covered under the Pre-65 Retiree Medical Plan…

If you become eligible (for example, as the result of disability) for Medicare, you will be sent a Medicare Part A and Part B card. You will be asked if you wish to elect Part B. DO NOT DECLINE THIS COVERAGE. BCBS will pay claims as a secondary payer, regardless of whether you enrolled in Medicare Part B or not. This is referred to as the “Phantom B” or “carve-out” provision, as referenced in the Pre-65 Retiree Health Plan SPD. The Plan also allows BCBS to go back 12 months and retroactively re-process claims as secondary payer.

Questions?

If you (or your spouse or covered dependent child) become disabled and have questions about your insurance, contact the SRNS Service Center at ***Service-Center@srs.gov***, (803) 725-7772 or (800) 368-7333. You can also email the Service Center at ***Service-Center@srs.gov***

Legal Notices

Women and Cancer

The SRNS 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 otherwise specifically allowed by this law. To comply with this law, we're 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.

Wellness Program Notice

The SRNS 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 the health and wellness survey, 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.

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 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 and 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 protected health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by applicable 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 and/or business associates of plan sponsors who receive 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/BSRA Medical Plan Administrator at (803) 952-5746.

Dependent Coverage up to Age 26

The SRNS 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 that 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 you or your dependents' other coverage ends (or other qualifying event). 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, 2025. 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 Fax: 916-440-5676
COLORADO	Health First Colorado: https://www.healthfirstcolorado.com/ CHP+: https://hcpf.colorado.gov/child-health-plan-plus Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com	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.flmedicaidtplrecovery.com/flmedicaidtplrecovery.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 Press 1 Phone: (678) 564-1162, Press 2
INDIANA	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/	Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA	IOWA: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/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 HIPP: 1-800-967-4660

State	Website	Phone
KENTUCKY	https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Email: KIHIPP.PROGRAM@ky.gov KCHIP: https://kynect.ky.gov Kentucky Medicaid: https://chfs.ky.gov/agencies/dms	1-855-459-6328 CHIP: 1-877-524-4718
LOUISIANA	www.medicaid.la.gov www.ldh.la.gov/lahipp	1-888-342-6207 LaHIPP: 1-855-618-5488
MAINE	https://www.mymaineconnection.gov/benefits/s/?language=en_US Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/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 Email: masspremassistance@accenture.com	1-800-862-4840 TTY: 711
MINNESOTA	https://mn.gov/dhs/people-we-serve/children-and-families/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 Email: HHSHIPPProgram@mt.gov	1-800-694-3084
NEBRASKA	http://www.ACCESSNebraska.ne.gov	(855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
NEVADA	http://dhcfp.nv.gov	1-800-992-0900
NEW HAMPSHIRE	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 15218
NEW JERSEY	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP Website: http://www.njfamilycare.org/index.html	Medicaid: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP:1-800-701-0710 (TTY: 711)
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	https://www.hhs.nd.gov/healthcare	1-844-854-4825
OKLAHOMA	http://www.insureoklahoma.org	1-888-365-3742

State	Website	Phone
OREGON	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	1-800-699-9075
PENNSYLVANIA	https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx	1-800-692-7462 CHIP: 1-800-986-KIDS (5437)
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	https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	1-800-440-0493
UTAH	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	1-888-222-2542
VERMONT	https://dvha.vermont.gov/members/medicaid/hipp-program	1-800-250-8427
VIRGINIA	https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON	https://www.hca.wa.gov/	1-800-562-3022
WEST VIRGINIA	https://www.mywvhipp.com/ https://dhhr.wv.gov/bms/	Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) Medicaid: 304-558-1700
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, 2025, 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

SRNS Service Center
Hours: Monday-Thursday, 7 a.m.-4 p.m.
(803) 725-7772 or (800) 368-7333

Email: ***Service-Center@srs.gov***

Online: ***www.srs.gov/general/jobs/benefits/index_r.htm***

Medical and Prescription Drugs

BlueCross Customer Service (800) 325-6596

www.southcarolinablues.com

Optum Rx Pharmacy: (800) 325-6596
Briova Rx Specialty Pharmacy: (877) 259-9428

Dental

BlueCross Customer Service (800) 325-6596

www.southcarolinablues.com

Health Savings Account

HSA Bank (866) 471-5946

www.hsabank.com

Summary Plan Descriptions

Medical and Dental

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

Revised as of 7/2025

HEALTHCARE BENEFIT PROGRAM
2026 ENROLLMENT FORM
(Pre-65 Retiree)

SRNS Retiree Enrollment Form

Return Form To:
SRNS
Service Center
Bldg. 992-2W
Aiken, SC 29808
803-725-7772 or 1-800-368-7333
Email: Service-Center@srs.gov

(Please Print)

Retiree Name (Last, First, Middle)	Employee ID Number	Phone Number	Effective Date

Use this worksheet to make changes to your current benefits or to enroll in your 2026 Healthcare elections. Check the box next to each benefit and coverage level you desire. If your form is not returned, you will be automatically re-enrolled in the same Medical and Dental healthcare options you were in last year. In addition, complete the dependent data below for dependents if you wish to add/drop a dependent to your Medical and/or Dental plans.

MEDICAL

I request enrollment in **Medical** coverage as specified:

Medical	Basic	Standard	Waive
Individual Only	☐	☐	☐
Individual +one	☐	☐	
Individual + two or more	☐	☐	

DENTAL

I request enrollment in **Dental** coverage as specified:

Dental	Prime	Standard	Waive
Individual Only	☐	☐	☐
Individual +one	☐	☐	
Individual + two or more	☐	☐	

If enrolling in the *Basic* Medical Plan, you also have the option of enrolling in a Health Savings Account (HSA). An HSA is a tax-advantaged account that you can use to set aside funds to pay for IRS qualified medical expenses. You can make annual contributions directly to HSA bank of a maximum of $4,400 Single and $8,750 for all other coverage levels, less the company contributions. (If you are age 55 or older, you can contribute an additional $1,000 to your HSA.) Any unused funds will roll over from year to year. Please note that contributions cannot be made through payroll/pension deduction. Only the retiree is eligible for the HSA and Employer Seed.

I authorize the Company to submit data to HSA Bank on my behalf. ☐ OR I do not want an HSA ☐

2026 Rates

Medical	Basic	Standard
Individual Only	$122.00	$297.00
Individual +one	$248.00	$596.00
Individual + two or more	$499.00	$1,117.00
Dental	**Standard**	**Prime**
Individual Only	$9.00	$27.00
Individual +one	$19.00	$53.00
Individual + two or more	$28.00	$80.00

Dependent Data

If you elect coverage for your dependents, they will be enrolled in the same option that you elect for yourself.
Documentation on dependent eligibility is required for coverage to be effective.

Dependents Name (Last, First, Middle)	Relationship	Gender		Social Security Number	Birth Date	Medical	Dental
		Male	Female				
1)						☐	☐
2)						☐	☐
3)						☐	☐

Important Medicare Information:

Your retirement from SRNS provides you with coverage under the SRS Health Choice Medical Plan. When you become eligible for Medicare, Medicare (Parts A and B) become your primary medical coverage, unless otherwise specified by Medicare rules.

In coordinating coverage with Medicare, BlueCross BlueShield of South Carolina (BlueCross) calculates the normal benefit payable for a covered expense, then "carves out" (or subtracts) the amount that Medicare would pay for your expense. The difference between the normal SRNS Plan Benefit and the Medicare benefit is the amount that BlueCross would pay. You are then responsible to the medical provider for any remaining amount up to the Medicare allowable amount. The SRNS Plan should not be confused with what is referred to as a Medicare Supplemental or Medigap Plan. The Medicare "carve out" method of payment will only apply to those covered individuals who are eligible for Medicare.

It is important to understand that BlueCross will calculate the payment of a claim with the "carve out" approach as described above after you (or your eligible dependent) become eligible for Medicare, even if you have not enrolled in Medicare Part B coverage. Therefore, if you do not enroll in Medicare Part B, the SRNS Plan will not pay for what would have been covered under Medicare part B and your out-of-pocket costs will increase.

I have read the explanation of benefit choices and authorize the elections I have made, as well as the payments I have elected. I understand that these elections are binding, and I can only make changes according to the Qualifying Changes in Status provisions of the Plan. I certify that the information I have provided is complete and correct (including the eligibility of my dependents with the Plan terms) to the best of my knowledge.

Retiree Signature____ Date____________________

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

Important

Open Enrollment Materials

Open Enrollment is October 1–31, 2025

Service Center

service-center@srs.gov
Local: 803.725.7772
Toll-free: 800.368.7333