

2025 Open Enrollment Benefits Guide

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

COBRA for Pre-65 Plan eligible medical and dental participants
of SRNS and BSRA

Pre-65 Plan eligible medical and dental participants



Open Enrollment is November 4-15, 2024

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

**Enroll at any time
between November 4-15, 2024.**

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



Getting started on your enrollment

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

COBRA Healthcare Benefit Options for SRNS

- Medical
- Dental
- Vision

SRNS Displaced Worker Healthcare Benefit Options

- Medical

Former Limited Service Employees Healthcare Benefit Options

- Basic Medical only

COBRA Healthcare Benefit Options for those who were covered under the Pre-65 Retiree Health Plan for SRNS and BSRA

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

Changes to your 2025 benefits

The election you make for 2025 will remain throughout 2025 for you and the dependents you elect to cover, unless:

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

If you make no changes, your 2025 Medical, Dental and Vision benefits and covered dependents will remain the same as in 2024 but at the 2025 contribution rate.

If you wish to change your coverage for 2025, your response is required.

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

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

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

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

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

You may continue to have COBRA coverage under a option if your new group plan does not offer a similar benefit. For

example, if a new group plan offers medical coverage, you may continue your Dental coverage throughout the duration of your COBRA eligibility period.

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

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



Changes for 2025

Here's a quick summary of the changes in this year's benefits for 2025. All changes to the benefits plans take effect on January 1, 2025.

All Medical Plans premium increases

Your monthly premiums are increasing beginning January 1.

My Health Toolkit App

You can always use the digital card provided on the BCBS My Health ToolKit app. The app also provides quick and easy access to your Explanation of Benefits (EOBs). You may also access this information online at <https://www.southcarolinablues.com/> by creating an online account. The process is simple and only takes a few minutes.

Pharmacy Mail Saver Program continues in 2025

The SRNS Active Medical Plan will require that reoccurring prescriptions be ordered through the OptumRx mail order process.

This program continues to require participants to have prescriptions for drugs that are considered "maintenance" filled through an OptumRx Mail pharmacy.

More details can be found on Page 14 of this booklet. **Remember that your deductible will reset on January 1, 2025.**

FSA Contribution Limits Increase

The limits for both the Healthcare Traditional and Limited Purpose FSAs were increased in 2024 to \$3,200 (formerly \$3,050). This will be the limit for 2025, unless a new limit is deemed by the IRS which will be communicated to participants. For those re-enrolling in the FSA, the roll over amount will be \$640.

Basic Medical Plan, HDHP, deductible to increase

The IRS has increased the minimum annual deductible amounts by \$50 for employee-only coverage (to \$1,650) and by \$100 for family coverage (to \$3,300). 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.



Frequently Asked Questions

How do I...

... add or remove dependents?

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

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

A few examples of qualified life status changes include:

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

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

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

Terms you really should know

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

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

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

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



HIPAA: Notice of Privacy Practices (January 1, 2024)

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.

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 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.

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 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. 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: 730-1B 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.



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).

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

Plan Features

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

Standard

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

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

Need an In-Network Provider?

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

Medical Plans Comparison

	Basic		Standard	
Type	In-network	Out-of-network ²	In-network	Out-of-network ²
Deductible (Individual/Family)	\$1,650 / \$3,300 ¹	\$1,650 / \$3,300 ¹	\$600 / \$1,200	\$600 / \$1,200
Out-of-Pocket Maximum (Individual/Family)	\$4,500 / \$7,150	\$4,500 / \$7,150	\$2,000 / \$4,000	\$2,000 / \$4,000
Office Visit: Primary Office Visit: Specialist	20% after deductible	20% after deductible	\$20 copay \$30 copay	15% after deductible ²
Preventive Care	\$0	Not covered	\$0	Not covered
Chiropractic Treatment ³	20% after deductible	20% after deductible	15% after deductible	20% after deductible
Allergy/Hormone Injections	20% after deductible	20% after deductible	15% after deductible	15% after deductible ²
Physical and Occupational Therapy	20% after deductible	20% after deductible	15% after deductible	15% after deductible ²
Ambulance Services	20% after deductible	20% after deductible	15% after deductible	15% after deductible ²
Hospital and Surgical Services	20% after deductible	20% after deductible	15% after deductible	15% after deductible ²
Emergency Room: Life threatening Emergency Room: Non-emergency	20% after deductible 30% after deductible	20% after deductible ² 30% after deductible ²	15% after deductible 30% after deductible	15% after deductible ² 30% after deductible ²
Diagnostic Services ⁴	20% after deductible	20% after deductible	15% after deductible	15% after deductible
Home Health, Hospice and Durable Medical Equipment Services	20% after deductible	20% after deductible	15% after deductible	15% after deductible
Blue Care OnDemand	Cost varies by service. See Summary Plan Description for details	N/A	Cost varies by service. See Summary Plan Description for details	N/A

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

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



Prescription Drug Plan

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

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

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

Preventive Drugs

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

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

An expanded Preventive Drug List is available for the Basic plan, making certain preventive and maintenance medications more accessible and affordable for members. These drugs will require copays but are not subject to the deductible. To determine if the drug you are taking is on the list, go to https://www.srs.gov/general/jobs/benefits/index_e.htm then go to **Medical>BCBS - Prescription Drugs**.

Pharmacy Administration

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

Retail Pharmacy (30 day supply)

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

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

Mail Order (90 day supply)

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

Pharmacy Mail Service Program

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

Grace fills

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

What Do I Need To Do?

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

- Contact OptumRx Mail Service by phone at (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.



Dental Plans

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

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

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

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

Plan Benefits

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

Find an In-Network Dentist

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

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

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

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

² Unless you have reached your Maximum Annual Benefit



Vision Plans

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

Vision plans comparison

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

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

¹reimbursed up to

SRNS and BSRA Retiree Medical Plans Comparison

	Basic		Standard	
Type	In-network	Out-of-network ²	In-network	Out-of-network ²
Deductible (Individual/Family)	\$1,650 / \$3,300 ¹	\$1,650 / \$3,300 ¹	\$600 / \$1,200	\$600 / \$1,200
Out-of-Pocket Maximum (Individual/Family)	\$4,500 / \$7,150	\$4,500 / \$7,150	\$2,000 / \$4,000	\$2,000 / \$4,000
Office Visit: Primary Office Visit: Specialist	20% after deductible	20% after deductible	\$20 copay \$30 copay	15% after deductible ²
Preventive Care	\$0	Not covered	\$0	Not covered
Chiropractic Treatment ³	20% after deductible	20% after deductible	15% after deductible	20% after deductible
Allergy/Hormone Injections	20% after deductible	20% after deductible	15% after deductible	15% after deductible ²
Physical and Occupational Therapy	20% after deductible	20% after deductible	15% after deductible	15% after deductible ²
Ambulance Services	20% after deductible	20% after deductible	15% after deductible	15% after deductible ²
Hospital and Surgical Services	20% after deductible	20% after deductible	15% after deductible	15% after deductible ²
Emergency Room: Life threatening Emergency Room: Non-emergency	20% after deductible 30% after deductible	20% after deductible ² 30% after deductible ²	15% after deductible 30% after deductible	15% after deductible ² 30% after deductible ²
Diagnostic Services ⁴	20% after deductible	20% after deductible	15% after deductible	15% after deductible
Home Health, Hospice and Durable Medical Equipment Services	20% after deductible	20% after deductible	15% after deductible	15% after deductible
Blue Care OnDemand	Cost varies by service. See Summary Plan Description for details	N/A	Cost varies by service. See Summary Plan Description for details	N/A

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

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

SRNS and BSRA Pre-65 Retiree Prescription Drug Plan

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

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

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

Preventive Drugs

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

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

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

Pharmacy Administration

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

Retail Pharmacy (30 day supply)

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

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

Mail Order (90 day supply)

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

Pharmacy Mail Saver Program

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

Grace fills

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

What Do I Need To Do?

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

- Contact OptumRx Mail Service by phone at (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.



SRNS and BSRA Pre-65 Retiree Dental plans

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

Note: Craft Option A employees are not eligible.

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

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

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

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

² Unless you have reached your Maximum Annual Benefit



Legal Notices

Wellness Program Notice

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

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

Protections from Disclosure of Medical Information

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

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

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

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

Women and Cancer

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

Genetic Information Non-Discrimination Act

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

Dependent Coverage up to Age 26

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

HIPAA Late Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage); however, you must request enrollment within 60 days after 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.
- When Medicare is the primary provider for those covered under active medical plan.

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, 2024. 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: https://health.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: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx 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.flmedicaidtplecovery.com/flmedicaidtplecovery.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	https://hhs.iowa.gov/ Hawki: http://dhs.iowa.gov/Hawki HIPP: https://hhs.iowa.gov/hipaa	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: KIHIPPPROGRAM@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/ofa/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/info-details/masshealth-premium-assistance-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://mydss.mo.gov/mhd/healthcare	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 5218
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	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 Rte 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-MyWVHIP (1-855-699-8447) Medicaid: 304-558-1700
WISCONSIN	https://www.dhs.wisconsin.gov/badgercareplus/hipp.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, 2024, 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

WageWorks Cobra Member Customer Service

P.O. Box 660212

Dallas, TX 75266-0212

Call Center: 866-924-6937

mybenefits.wageworks.com

Medical and Prescription Drugs

BlueCross Customer Service (800) 325-6596

www.southcarolinablues.com

Dental

BlueCross Customer Service (800) 325-6596

www.southcarolinablues.com

Vision

EyeMed Vision Care

(866) 800-5457

<https://eyemed.com/en-us>

Summary Plan Descriptions

Active Plans

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

Retiree Plans

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