



# Health Reimbursement Account

**FOR SAVANNAH RIVER REMEDIATION**

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## **SUMMARY PLAN DESCRIPTION**

Effective Date: January 1, 2013

Amended: January 1, 2016

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## INTRODUCTION

Effective January 1, 2013, Savannah River Remediation LLC (the "Employer") has established the Health Reimbursement Account (the "HRA"). The purpose of this HRA is to reimburse certain participating incumbent Retirees age 65 and older and their 65 and older spouses ("Participants") for certain unreimbursed medical, dental, vision expenses and premiums for such plans ("Eligible Medical Expenses") incurred by the Participant or their eligible Spouse. The HRA is intended to qualify as a medical expense reimbursement plan and meet the requirements for qualification under Internal Revenue Code (IRC) Section 105(b) and Section 106(a), and that benefits paid Retirees hereunder be excludible from their gross incomes by virtue of IRC Section 105(b) and Section 106(a).

This Summary Plan Description, or "SPD," describes the basic features of the HRA, including the rights and responsibilities of covered individuals, the Employer, and the Plan Administrator. This HRA has been established and is operated in accordance with both this SPD and the official Plan Document. The terms of the official Plan Document will control if there is a conflict between this SPD and the official Plan Document.

The Employer has reserved the right to amend or terminate the HRA and any retiree health plan at any time for any reason. No employee, retiree, spouse, dependent or terminated employee has a vested right to receive retiree health coverage or a HRA.

**PART I**  
**GENERAL INFORMATION ABOUT THE PLAN**

*\*You will notice that certain terms and/or phrases are capitalized throughout this SPD. These terms and/or phrases are important and you should remember them. The capitalized terms and phrases are defined either in this SPD or in the official plan document in which this SPD is incorporated.*

**Q 1. What is the Health Reimbursement Account (HRA)?**

The HRA is an Employer provided reimbursement account for “Eligible Medical Expenses” with tax advantages. Once you become a Participant, the Employer establishes a Reimbursement Account for you. The Reimbursement Account is a notional bookkeeping account that keeps a record of HRA dollars allocated to your account and reimbursements made to you under this HRA. You have no property rights in the Reimbursement Account.

The HRA has two (2) components and works as follows:

1. Health Reimbursement Account

- The Employer establishes a notional account called a Health Reimbursement Account (“Reimbursement Account”) for each Participant (see Q-2 for more information on how to become a Participant).
- Each Plan Year, the Employer allocates a specified amount of employer contributions, called “HRA Dollars,” to each Participant’s Reimbursement Account for reimbursement of “Eligible Medical Expenses”.
- Unlike Health Flexible Spending Account (FSA) restrictions, you may carry over HRA dollars that you do not use to subsequent years.
- Since the HRA is Employer funded, you do not make contributions to this account, nor do you have to pay for your HRA coverage.

2. Catastrophic Drug Program

- The Catastrophic Drug Program will fund your HRA for your coinsurance or copayment amount for covered drugs once you enter the catastrophic prescription drug level as defined by your Medicare Part D Prescription Drug Plan. The additional funding to your account will be provided if you submit your application between January 1 and February 28 and your application is approved by RightOpt.
- There will be a combined SRR/SRNS company level program limit of \$500,000 for each plan year and funding will be determined on a year to year basis. You as a program participant may be reimbursed for prescription drug cost up to \$30,000 if the company level program limit has not been exceeded. If the company level program limit has been exceeded, a

prorated amount will be reimbursed to each eligible participant. No individual will be reimbursed for more than \$30,000 unless the Program Limit has not been met. If the program limit has not been met and a participant has exceeded the individual limit of \$30,000, then an additional prorated amount may be provided to the participant. The limits are not adjusted or prorated for mid-year entrants into the HRA.

**Q 2. Who can participate in the HRA?**

You are eligible to participate if you meet the following requirements:

- You are a Retiree, age 65 or older, who is eligible for retiree health coverage as an incumbent employee and who was eligible to Participate in the Employer's Medical Plan at the time of retirement; and
- Who has enrolled in Medicare Part A and Part B: and
- Who made a timely election with respect to retiree health coverage and who at time of retirement did not elect COBRA medical or dental coverage; and
- Who, if retired prior to age 65, maintained eligibility under the Employer's Pre-65 Health Plan,;
- Or, is a Spouse (or eligible surviving spouse), aged 65 or older, enrolled in Medicare Part A and Part B, of an individual who has maintained eligibility under the Employer's Pre-65 Retiree or Active employee Health Plan, or this HRA, and whose spouse's hire date would make such an individual eligible for Incumbent Retiree Medical Benefits;
- The eligible Retiree and/or eligible Spouse has initially enrolled in an individual Medicare Medical Plan purchased through RightOpt or My Medicare Advocate (MMA) and have maintained the coverage during the initial plan year.

Each Retiree or Spouse who meets the above requirements and initially enrolls in the Medicare Medical Plan purchased through RightOpt formerly My Medicare Advocate, or its successor, shall be a Participant as of the date of enrollment or start of plan. For purposes of this Plan, an individual is eligible for Incumbent Retiree medical coverage if the individual terminates employment with the Employer and at the time of termination was an active Participant in the Savannah River Nuclear Solutions, LLC Multiple Employer Pension Plan and at the time of termination met the requirements for a Normal, Early, Optional or Incapability Retirement benefit under the terms of such pension plan or predecessor plans.

**In addition to the requirements listed above the participant must be enrolled in a Medicare part D prescription drug plan to be eligible for the Catastrophic Drug Program.**

**Q 3. Are my dependents covered under the HRA?**

The HRA only covers you and your enrolled Spouse who is age 65 or older. Spouses under age 65 or other dependents have no rights or interest in the HRA.

In addition, this HRA will allow you to request reimbursements for a child of yours (as defined by applicable state law) in accordance with a Qualified Medical Child Support Order (“QMCSO”) to the extent the QMCSO does not require reimbursement not otherwise offered under this HRA. The Plan Administrator of this Plan (or its designee) will notify you if a medical child support order has been received. The Plan Administrator will make a determination as to whether the order is a QMCSO. The Plan Administrator will notify both you and the affected child once a determination has been made.

**Q 4. What is the effective date of coverage under this HRA?**

Coverage under this HRA for an eligible Incumbent Retiree and eligible Spouse of an Incumbent who has attained age 65 begins on the date you have met the eligibility requirements and initially enrolled in an individual Medicare Medical Plan purchased through RightOpt formally My Medicare Advocate (MMA).

**Q 5. When does coverage under this HRA end?**

Coverage ends when the Retiree and/or eligible Spouse cancel their enrollment in a medical plan during the initial plan year enrollment through RightOpt or the Plan has been terminated by the Employer. Funding, but not participation, for an eligible Spouse ends at the end of the year of the divorce (see Q-18 for more details). Funding also ends at the end of the year of the death of the applicable participant. It is your duty to notify the Employer of the date of divorce. Failure to notify the Plan Administrator within 60 days of a divorce or death will make you and the Spouse liable for any overpayment by the Plan due to such lack of notice.

**Q 6. How do I enroll in the HRA?**

When you retire on or after age 65 (or as a retiree you turn age 65) as an Eligible Retiree, RightOpt will contact you to assist with enrolling you in a Medicare Advantage or Medicare Medigap Plan. Once enrolled, RightOpt will forward your information to WageWorks, Inc. and WageWorks will establish your Reimbursement Account. . Your spouse may enroll upon attaining the age of 65, or a later date

The Catastrophic Drug program is a component of the HRA.. *See Q-14 for information on how to submit claim for reimbursement.*

**Q 7. What is an “Eligible Medical Expense?”**

**Under the HRA**

“Eligible Medical Expenses” are medical, dental, vision care expenses and premiums for such plans *incurred* by you or your eligible spouse enrolled in HRA plan that satisfies all of the conditions for “medical care” as defined in Internal Revenue Code (IRC) of 1986, as amended Section 213(d). All expenses that are not within the scope of “Eligible Medical Expenses” described in IRC Section 213(d) are excluded. “Incurred” means the date the service or treatment is provided; not when the expense arising from the service or treatment is paid. Thus, an expense that has been paid but not incurred (i.e., pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

In no event will the following expenses be eligible for reimbursement:

- a) Any expense that is not an IRC Section 213(d) expense, specifically excluding expenses for a medicine or drug incurred on or after January 1, 2011 unless such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.
- b) any expenses incurred for qualified long term care services (as defined in IRC Section 106);
- c) expenses incurred *prior to the date* that coverage under this HRA becomes effective;
- d) expenses incurred *after the date* that coverage under this HRA ends; and
- e) Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

Whether an Expense is an “Eligible Medical Expense” is within the sole discretion of the Third Party/Claims Administrator.

#### **Under the Catastrophic Drug Program**

You will be eligible to apply for additional funding to be added to your HRA once you have entered the Medicare Part D Catastrophic Drug Coverage Stage 4 as documented through your Medicare Part D Prescription Drug Plan explanation of benefits. The prescription drug must be covered by your Medicare Part D Drug Plan that you are enrolled in to be eligible for the additional funding. Your application for additional funding must be postmarked by February 28 for the prior calendar year expenses above the catastrophic level.

#### **Q 8. Who contributes to my Health Reimbursement Account?**

While you are a Retiree, or an eligible Spouse, meeting the requirements of, and participating in, this Plan, the Employer allocates HRA dollars to your Reimbursement Account. You do not contribute to this account, nor do you pay for this coverage.

#### **Q 9. How are HRA Dollars allocated to my Reimbursement Account?**

##### **Under the HRA**

Each Plan Year, the Employer allocates a specified amount of HRA Dollars to your Reimbursement Account.

**Effective January 1, 2013:**

The allocated amount is: (i) \$2,400, for an eligible Retiree; (ii) \$2,400, for an eligible Spouse. The amount is prorated for mid-year enrollments.

**Effective January 1, 2017**

The HRA stipend amount will be an age-banded four-tiered structure, as follows:

	Tier 1	Tier 2	Tier 3	Tier 4
<b>Age Band</b>	65-69	70-74	75-79	80+
<b>Amount</b>	\$2,508	\$2,604	\$2,808	\$3,000

- New stipend amounts will be applied at the beginning of the year in which you transition to a new age band. For example, if you turn 70 at any time during 2017, you will receive a Tier 2 stipend for that year.
- Each participant will receive his or her own stipend based on his or her own age. For example, if you are 71, you will receive the Tier 2 amount. If your spouse is 67, he or she will receive the Tier 1 amount.
- For new enrollments, the stipend will be prorated by the number of months in the plan for that year.
- You must complete an initial enrollment in the plan to be eligible for the stipend.

The amount of HRA Dollars allocated to your Reimbursement Account is determined at the sole discretion of the Employer, in a uniform and non-discriminatory manner and may vary depending on circumstances, including but not limited to, marital status. The Employer reserves the right to amend or change the contribution amount at any time for any reason.

HRA Dollars are allocated to your Reimbursement Account at the beginning of the year.

**Catastrophic Drug Program – Effective 01/01/2016**

The Catastrophic Drug Program was approved for Plan Year beginning 01/01/2016. Claims for the Plan Year are to be funded to your HRA by Mid-April of the following year.

You must submit your year-end Medicare Part D Plan Explanation Of Benefits (EOB) documenting your out-of-pocket catastrophic level (Stage 4) prescription drug expenses for the calendar year. The Medicare Part D EOB should be submitted annually, along with the Program application, and must be postmarked between January 1 and February 28 of each year. The EOB and Application will be submitted to RightOpt for evaluation. If your application for additional funding is accepted, RightOpt will notify Wage Works of the additional funding to your HRA equal to your out-of-pocket expenses for covered drugs within the program limits.

The Catastrophic Drug Program will be evaluated and funded at a fixed amount each calendar year and is subject to change or elimination. Any unused available program funding from the company does not carry over to the following year for the Catastrophic Drug Program.

For 2016 there will be a combined SRR/SRNS company level program limit of \$500,000. A program participant may be reimbursed for Catastrophic Level prescription drug cost up to \$30,000 if the company level program limit has not been exceeded.

- a. If the company level program limit has been exceeded, a prorated amount will be reimbursed to each eligible participant. No individual will be reimbursed for more than \$30,000 unless the Program Limit has not been met.
- b. If the program limit has not been met and a participant has exceeded the individual limit then an additional prorated amount may be provided to the participant.

Catastrophic Drug program funding will be allocated to the HRA by Mid-April of each year for the prior Plan Year Catastrophic Drug expenses. (Example: For Plan Year 2016, additional funding will be allocated in Mid-April 2017.) Please note that if you have any claims pending in the Wage Works system, this additional allocation will systematically pay those pending claims first.

For both the HRA and the Catastrophic Drug Program: If a Participant dies or becomes divorced during the Plan Year the allocation for that year does not change. However, the Employer allocation for the deceased or divorced Participant for the following year will be eliminated. If you fail to timely notify the Employer of a death or divorce (within 60 days of the event), you will be responsible to reimburse the Employer for any overpayment.

**Q 10. What happens if I do not use all of the HRA Dollars allocated to my Reimbursement Account during the Plan Year?**

Unlike Health FSA dollars, if you do not use all of the HRA Dollars allocated to your Reimbursement Account, all of the HRA Dollars remain in your Reimbursement Account for reimbursement of Eligible Medical Expenses during a subsequent Plan Year (to the extent you remain covered under the Plan).

**Q 11. What is the maximum amount of reimbursement that I may receive under the HRA?**

**Under the HRA**

The maximum reimbursement amount that you can receive is equal to your Reimbursement Account balance at the time the request for reimbursement is processed. Any portion of a claim for reimbursement that exceeds the maximum reimbursement amount will be pended and processed when the Reimbursement Account becomes sufficient. Pended claims will be processed and, if appropriate, paid before any new claims are processed and paid.

**Under the Catastrophic Drug Program**

There will be a combined SRR/SRNS company level program limit of \$500,000. You as a program participant may be approved for additional funding into to your existing HRA

for your 5% coinsurance amount for covered prescription drug costs once you are in the Medicare Part D Plan catastrophic level up to \$30,000 if the company level program limit has not been exceeded. See Q 9 for more detailed information.

**Q 12. Can my level of coverage change under the HRA during the Plan Year?**

**HRA**

Yes, your level of coverage would be based on marital status with you or your spouse meeting eligibility during the year. HRA dollars are allocated at the beginning of a Plan Year. If you or your Spouse are eligible and attain age 65 during the year, the additional dollar amount for the additional participant will be prorated for the first year of eligibility. An amount will not be reduced due to a death or divorce during the year.

**Catastrophic Drug Program**

No, you are approved for additional funding in the calendar year that follows the year that you had approved expenses in the catastrophic level of your Medicare Part D prescription drug plan. For example: You incur expenses above the Catastrophic level of your Medicare Part D Drug plan in calendar year 2016. You submit your year end 2016 Medicare Part D Plan Explanation Of Benefits (EOB) along with your application, postmarked between January 1 and February 28. .. If approved by RightOpt, your HRA is funded for the additional amount around Mid-April of that year.. The Catastrophic Drug Program and Individual reimbursement limits are not adjusted or prorated after they are allocated to you HRA.

**Q 13. How do I receive reimbursement under the HRA?**

**HRA**

WageWorks, Inc. has been hired as a Third Party / Claims Administrator to reimburse you and / or pay providers for eligible expenses you incur. Step by step instructions for reimbursement are described in the WageWorks Reimbursement Guide. You have Three (3) of reimbursement options:

1. Use the **“Pay My Provider”** option on the WageWorks website if you want to request that a check be issued directly to your provider with funds deducted from your HRA. The payment to the service provider can be a one-time payment or recurring monthly payments. The participant **can only enroll online via the WageWorks website to select this option**. The participant is required to submit a premium statement (coupon slips or a letter from the health insurance company is also acceptable) including adequate documentation (Participant’s name, healthcare company provider name, date(s) of service, premium amount) for reimbursement. The required premium statement and documentation may be mailed or faxed to the WageWorks Claims Administrator if preferred over electronic scan. **NOTE: YOU MUST REENROLL IN THE OPTION EACH YEAR AND IF YOU PREMIUMS CHANGE AFTER YOUR INITIAL ENROLLMENT, YOU ARE RESPONSIBLE FOR NOTIFYING WAGE WORKS.**

2. You can request the **“Pay Me Back”** option on the WageWorks website which provides you reimbursement directly from your HRA. This option can be processed online via the WageWorks website or by hard copy mail or fax to the WageWorks Claims Administrator. The claim, supporting documentation and proof of payment must be provided for reimbursement. Documentation must include participant’s name, healthcare provider name, dates of service, type of service, and amount. Examples of proof of payment include: bank statements showing the check to “xyz insurance company” is cleared, insurance company statements showing payment in full for the coverage period, ongoing monthly insurance company statements showing previous months premium payment, copy of your Social Security “Cost of Living Statement” or Medicare Statement clearly indicating the amount of the monthly Part B, C, or D premium, cancelled check for premium payment to insurance company (copy of front & back of cancelled check) and credit card statements showing payment to insurance company and / or receipt reflecting expense and payment (i.e. prescription drug claim, copay, eyeglasses, etc.). **NOTE: YOU MUST REENROLL IN THE OPTION EACH YEAR AND IF YOU PREMIUMS CHANGE AFTER YOUR INITIAL ENROLLMENT, YOU ARE RESPONSIBLE FOR NOTIFYING WAGE WORKS.**
3. **Automatic Premium Reimbursement** is the easiest method of reimbursement. With this option you pay your monthly premium directly to your insurance company. You can enroll in this option by contacting RightOpt. The list of companies offering APR will be provided to you each year in the fall communication to members.

**Because your HRA rolls over from year to year, there is no expiration date or Plan Year deadline for you to file a claim as long as you have an HRA. However, you cannot submit reimbursement for claims incurred prior to initiation of your HRA. If your HRA is terminated, you may submit requests for reimbursement for claims incurred while your HRA was active at any time up to six (6) months after termination of your HRA coverage. Requests for reimbursements submitted after this period will not be reimbursed. (See question Q-18 for the rights of a former Spouse to submit claims due to a divorce).**

### **Catastrophic Drug Program**

To apply for funding under the Catastrophic Drug Program:

**Step 1:** The eligible retiree or spouse submits their year-end Medicare Part D Plan EOB documenting the out-of-pocket catastrophic covered prescription drug expenses for the calendar year along with the Catastrophic Prescription Drug Program application to the address listed on the Application.

**Step 2:** You can contact RightOpt at (877)591-8904 or visit the website at [www.RightOptRetiree.com/SRS](http://www.RightOptRetiree.com/SRS) for additional information and to obtain a Catastrophic Drug Program application.

**Step 3:** The Catastrophic Drug Program application should be submitted annually between January 1 and February 28 to RightOpt. The application must be

postmarked no later than February 28. Any applications postmarked after February 28 will be denied. RightOpt customer service at (877)591-8904 can assist you with any questions you may have regarding the program application process or status of your application.

**Step 4:** RightOpt will evaluate your application and if accepted will notify Wage Works of the additional funding to your HRA. The funding will, in most cases, be equal your out-of-pocket expenses for covered drugs within the program limits. If you are a participant with a joint HRA, the additional funds will go into the joint account no matter which participant incurs the prescription drug claims. If the application is rejected the participant will be notified in writing by RightOpt.

**Step 5:** Once the account has been funded as a result of your approved Catastrophic Drug Program application your reimbursements are processed under the normal process of your existing HRA. You will be notified by RightOpt that your application for additional funding has been approved.

**Your claim is deemed filed when it is received by the Third Party / Claims Administrator.** If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Any unclaimed reimbursement amount (i.e., failing to cash a reimbursement check) will be forfeited and returned to the Employer if not claimed (or cashed) within 12 months of the date that the check was issued. If your claim for reimbursement is denied, in whole or in part, you will be notified according to the HRA's claims review procedures described in Q-15 below.

**Q 14. What happens if my claim for benefits is denied?**

If you are denied a benefit under the Plan, you should precede in accordance with the following claims review procedures:

**Step 1:** *Notice is received from WageWorks, Inc. (Third Party/Claims Administrator).* If your claim is denied, you will receive written notice from the Third Party/Claims Administrator that your claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of the Third Party/Claims Administrator, the Third Party/Claims Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Third Party/Claims Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

**Step 2:** *Review your notice carefully.* Once you have received your notice from the Third Party/Claims Administrator, review it carefully. The notice should contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;

- a description of any additional information necessary for you to complete your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a right to request all documentation relevant to your claim.

**Step 3:** *If you disagree with the decision, file an appeal.* If you do not agree with the decision of the Third Party/Claims Administrator, you may file a written appeal. You must file your appeal no later than 180 days after receipt of the notice described in Step 1. The Plan has established two (2) levels of appeal; therefore, you must file your written first level of appeal with the Third Party/Claims Administrator. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information (including information previously submitted) that you believe would support your claim to: WageWorks Claims Appeal Board, P.O. Box 991, Mequon, WI 53092-0991 or fax to 877-220-3248.

**Step 4:** *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing no later than 30 days after receipt of the appeal by the Third Party/Claims Administrator.

**Step 5:** *Review your notice carefully.* You should take the same action that you took in Step 2 described above. The notice should contain the same type of information that is provided in the first Notice of Denial provided by the Third Party/Claims Administrator.

**Step 6:** *If you still disagree with the Third Party/Claims Administrator's decision, file a 2<sup>nd</sup> Level Appeal with the Third Party/Claims Administrator.* If you still do not agree with the Third Party/Claims Administrator's decision, you may file a second level written appeal with the Third Party/Claims Administrator within 60 days after receiving the first level appeal denial notice. You should gather any additional information that is identified in the notice as necessary to correct your claim and any other information that you believe would support your claim.

#### **Other important information regarding your appeals**

- The Third Party/Claims Administrator has discretionary authority to decide all reimbursement claims and all claims and processing issues on appeal. Any decision by the Third Party/Claims Administrator that does not constitute an abuse of discretion must be upheld by a court of law. The SRR Plan Administrator has authority to decide all issues relative to eligibility in the Plan.
- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and

- You cannot file suit in federal court until you have exhausted these appeals procedures.
- You may request copies of information from the Third Party/Claims Administrator that will assist you with your appeal.

**Q 15. What happens if I am denied eligibility for a HRA?**

If your eligibility for a HRA is denied, you should file your appeal in writing with the Plan Administrator (see Part III.2 for Plan Administrator contact information) as soon as reasonably possible, but no later than 30 days after receipt of denial notification. The appeal should include documentation supporting why you believe you should be eligible for a HRA account.

Q 15a. What happens if my application for the Catastrophic Drug Program is denied? If your application for the Catastrophic Drug Program is denied, you should file your appeal in writing with RightOpt as soon as reasonably possible, but no later than 30 days after receipt of denial notification. The appeal should include documentation supporting why you believe you should be eligible for the Catastrophic Drug Program. The appeal should be sent to: RightOpt

11 Stanwix Street  
Suite 700  
Pittsburgh, PA 15222

**Q 16. What happens if I receive overpayments or reimbursements made in error from this HRA?**

If it is later determined that you and/or your eligible Spouse receives an overpayment or a payment was made in error (i.e., you were reimbursed for an expense under the HRA that is later paid for by another health plan), you will be required to repay the overpayment or erroneous reimbursement to the HRA. You or a surviving eligible spouse is also required to notify the Plan Administrator within 60 days of any divorce or death.

If you do not refund the overpayment or erroneous payment, the Plan reserves the right to offset future reimbursement equal to the overpayment or erroneous payment. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may consider the payment to be taxable income to you. In addition, if the Plan Administrator determines that you have submitted a fraudulent claim, the Plan Administrator may permanently terminate your coverage under this HRA.

**Q 17 What happens on death or divorce?**

Your HRA account does not end on death or divorce.

If you die and your Spouse is under age 65 and, therefore, not eligible for an HRA, your estate may submit eligible claims incurred by you for reimbursement. If, after payment of such claims, there are still funds in the HRA, the remaining funds shall be forfeited and revert to the Employer. Eligibility or participation in the Pre-65 Retiree Health Plan does not end with the HRA participant's death. Participation or eligibility will continue

as long as the spouse or dependent maintains coverage or eligibility under either a Pre-65 Retiree Health Plan or another Group Health Plan. An eligible Spouse may also participate in a HRA, provided the eligibility requirements are satisfied as of the date of enrollment.

If you die and your Spouse is over age 65 and covered by the HRA, your Spouse will continue to receive the spouse's HRA allocation up to the date of death and may seek reimbursement from all funds allocated to the account. Upon the subsequent death of the Spouse, the Spouse's estate may seek reimbursement of any eligible claims incurred prior to death. Any funds remaining will be forfeited and revert to the Employer.

If you become divorced, and your former Spouse is under age 65, your former Spouse has no independent right to a HRA. If your former Spouse is enrolled in the Pre-65 Retiree Health Plan, your former Spouse and dependents may have COBRA rights under that plan. The Pre-65 Retiree Health Plan will notify your former Spouse and dependents of any applicable COBRA rights.

If you become divorced, and your former Spouse is age 65 or older, your former Spouse may continue to submit claims for reimbursement under the HRA for a period of 36 months following the divorce or until the divorce decree establishes a different ownership of the account. Your former Spouse's coverage under the individual Medicare Medical Plan will continue provided the former Spouse continues to pay the required premium. If your former Spouse received an HRA allocation for the year of the divorce, that allocation will remain in the HRA and will be available for reimbursement for expenses incurred by you or your former Spouse, if submitted for reimbursement within 36 months following the divorce, unless a domestic relations order establishes to the contrary. As of the first day of the calendar year following the divorce, your former Spouse will no longer be entitled to receive an HRA allocation from the Employer. If you or your former Spouse fails to timely notify the Employer of a divorce, or death, you and your former Spouse shall be responsible to reimburse the Employer for any overpayment made from the HRA account. The notification must be within 60 days of the date of divorce or death.

**Q 18. How long will the Plan remain in effect?**

Although the Employer expects to continue the Plan, it has the right to modify or terminate the program at any time for any reason. An employee, former employee, retiree, spouse or dependent has no vested right to retiree medical benefits.

**Q 19. Does the Plan coordinate benefits with other Component Medical Plans?**

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). As such, this HRA does not coordinate benefits with any other group or individual health coverage except as provided herein.

**Q 20. Who do I contact if I have questions about the HRA?**

If you have any questions about the HRA, you should contact RightOpt.

**PART II**  
**ERISA RIGHTS**

This HRA is a welfare benefit plan as defined in the Employee Retirement Income Security Act (ERISA) of 1974. ERISA provides that you, as a Plan Participant, will be entitled to:

**1. Receive Information about Your Plan and Benefits**

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**2. Continue Component Medical Plan Coverage**

- Continue health coverage for you or your Spouse or dependents, if there is a loss of coverage under a Component Medical Plan (e.g. such as the pre-65 retiree health plan) as a result of a qualifying event. Review this SPD and the documents governing the Component Medical Plan on the rules governing such continuation.
- Obtain reduction or elimination of exclusionary periods of coverage for pre-existing conditions under a medical plan, if you have creditable coverage under another plan. You should be provided a certificate of creditable coverage, free of charge, from your Component Medical Plan or a health insurance issuer when you lose coverage under such plan. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

**3. Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and Beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

**4. Enforcement of Your Rights**

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can

take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (i.e., if it finds your claim is frivolous).

**5. Assistance with Your Questions**

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

**PART III  
PLAN INFORMATION**

The following provides information specific to the above-named Employer's Retiree Reimbursement Account for Incumbent Retirees.

*\*The effective date of this Plan Information is January 1, 2013.*

**I. GENERAL PLAN INFORMATION**

1. Name, Address, and Telephone Number of the Employer/Plan Sponsor:	<b>Savannah River Remediation LLC</b> Building 766-H rm. 1066F, Attn: Health and Welfare Plan Administrator Aiken, SC 29808 803-725-7772
2. Name, Address, and telephone Number of the Plan Administrator:  The Plan Administrator has delegated discretionary authority over claims and appeals to the Third Party/Claims Administrator; retaining authority on Plan Eligibility only.	Welfare and Benefits Committee <b>Savannah River Remediation LLC</b> Building 766-H rm. 1066F, Attn: Health and Welfare Plan Administrator Aiken, SC 29808 803-725-7772
3. Address for Service of Legal Process:	<b>CT Corporation</b> 2 Office Park Court Suite 103 Columbia, SC 29223 800-528-8790
4. Employer's Federal Tax Identification Number:	26-3972730
5. Plan Number:	510
6. Original Effective Date of the HRA:	January 1, 2013

7. Short Plan Year:  Plan Year:	N/A  Calendar Year
8. Affiliated Employers participating in the Plan:	N/A
9. Third Party/Claims Administrator  The Plan Administrator has delegated discretionary authority regarding claims and appeals to the Third Party/Claims Administrator	<b>WageWorks, Inc.</b> <b>10375 North Baldev Court</b> <b>Mequon, WI 53092</b>
10. How is the HRA funded?	General Assets of Employer
11. Catastrophic Drug Program information and appeals: (Catastrophic Drug Program only)	RightOpt 11 Stanwix Street Suite 700 Pittsburgh, PA 15222 Phone: 1-877-591-8904

**PART IV  
DEFINITIONS**

**A. “Affiliated Employer”** means any entity that is considered with the Employer to be a single Employer in accordance with Code Section 414(b), (c), or (m).

**B. “Anniversary Date”** means the first day of any Plan Year.

**C. “Board of Directors”** means the Board of Directors or other governing body of the Employer (the “Board”). Upon adopting this Plan, the Board of Directors appoints the Plan Administrator to act on the Employer’s behalf in all matters regarding the Plan.

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

**E. “Dependent”** means (a) a “Dependent” as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, and (b) any child (as defined in Code Section 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age twenty-seven (27).

**F. “Effective Date”** of this Plan means January 1, 2013.

**G. “Eligible Medical Expenses”** means those expenses incurred by a Participant or eligible spouse that satisfy the conditions for reimbursement for medical, dental, or vision expenses and premiums for such plans as established by the Code.

**H. “Employer”** means the Employer indicated in the Preamble and any Affiliated Employer who is authorized by the Employer to adopt the Plan. Affiliated Employers who adopt the Plan are bound by the terms of the Plan unless they clearly terminate their participation.

**I. “ERISA”** shall mean the Employee Retirement Income Security Act of 1974, as amended.

**J. “Highly Compensated Individual”** means an individual defined under Code Section 105(h), as amended, as a “highly compensated individual” or a “highly compensated employee”

**K. “Medicare Provider”** means RightOpt formerly My Medicare Advocate (MMA) or such other company chosen by the Employer to facilitate the Participant’s purchase of Medicare supplemental programs.

**L. “Participant”** means a Retiree or an eligible Spouse of a Retiree who has attained age 65 who becomes covered under the Plan pursuant to Article II of this Plan Document.

**M. “Plan”** means this Retiree Reimbursement Account.

**N. “Plan Administrator”** means the Health and Welfare Benefit Committee of the Employer.

**O. “Plan Year”** shall mean the calendar year.

**P. “Retiree” or “Incumbent Retiree”** means an individual who satisfies the Retiree Eligibility requirements set forth in the Employee’s Post-65 Retiree Health Plan, and incorporated herein by reference.

**Q. “Health Reimbursement Account”** means the notional bookkeeping account to which HRA Dollars are allocated to each Participant to be used to reimburse “Eligible Medical Expenses”. The HRA is maintained by the Plan Administrator for accounting purposes, and is not representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant account(s).

**R. “HRA Dollars”** means any amount that the Employer contributes on behalf of each Participant to provide benefits under the Plan. The amount of HRA Dollars shall be uniform and nondiscriminatory. Employer contributions may not be disbursed to a Participant as additional, taxable compensation.

**S. “Spouse”** means an individual who is legally married to a Participant as recognized under state law.

**T. “Summary Plan Description” or “SPD”** means the HRA SPD with the same name as this Plan.

**U. “Third Party / Claims Administrator”** means WageWorks, Inc. or its successor or assigns.