

Summary Plan Description

Disability Benefits Plans



You may be eligible to receive a portion or full replacement of your income for the time you are considered to be disabled. This Summary Plan Description provides details of your Short and Long Term disability benefits. Read it carefully and refer to it whenever you have a question about your disability benefits.

Savannah River Nuclear Solutions, LLC (referred to as “SRNS” or the “Company”) sponsors a Disability Income Plan comprised of two programs – Short Term Disability and Long Term Disability.

You may be eligible to receive a portion or full replacement of your income for the time you are considered to be disabled under the Plan or up to a maximum payment period.

Other additional disability benefits that are not part of the Disability Income Plan include Special Benefits for Occupational Related Disabilities (the Workers’ Compensation Supplement as defined in the 5B Human Resources Policy Manual) and the Incapability Retirement pension benefit, available through the Savannah River Nuclear Solutions, LLC Multiple Employer Pension Plan (or “Pension Plan”) to Incumbent Employees (as defined in the Pension Plan). Please note that although this document contains references to these benefits, the 5B Human Resources Policy Manual governs the administration of the Workers’ Compensation Supplement and the Pension Plan documents govern the administration of the Incapability Retirement pension benefit.

Eligibility for benefits should not be viewed as a guarantee of employment. Also, while SRNS intends to continue providing comprehensive benefits programs, the Company reserves the right to modify or terminate any of the benefit plans at any time. For more information on the procedures to modify or terminate benefit plans, refer to the General Information Section of this booklet.

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This Summary Plan Description does not create an express or implied contract of employment. Eligibility for benefits should not be viewed as a guarantee of employment. Also, while SRNS intends to continue providing comprehensive benefits programs, the Company reserves the right to modify or terminate any of the benefit plans at any time. The Company will provide advance notification of any future benefit changes.

This Summary Plan Description of benefits is based on current policies and procedures. Participants are responsible for reading the entire Summary for details. SRNS retains the right to change these details at its discretion. These are interpretations made by SRNS and the Company reserves the right to change these interpretations. These Summaries serve as both the plan document(s) and the summary of benefits provided to participants. The Short Term Disability Plan is a separate Plan from the Long Term Disability Plan.



Participating in the Plan

Short Term Disability (STD)

SRNS Non-Craft and SRNS Option A Craft full-service employees become eligible for coverage under the Short Term Disability Plan on their first day of employment, provided they are actively at work. The Short Term Disability Plan has a Company provided basic benefit and an employee paid Buy-Up benefit. This STD benefit provides income replacement for up to 1,040 hours over a rolling 12-month period. You receive 100% income replacement for the first 200 hours of STD. For the remaining 840 hours, you receive 65% income replacement.

Long Term Disability (LTD)

SRNS Non-Craft and SRNS Option A Craft full-service employees become eligible for coverage under the Long Term Disability Plan on their first day of employment, provided they are actively at work. However, there is a pre-existing limitation for disabilities that occur within 12 months from hire date. The LTD plan is a separate plan from the STD plan.

Incapability Retirement (IR)

Under the Pension Plan, Pension Plan participants (Incumbent employees as defined in the Pension Plan with 15 or more years of Eligibility Service, and hired prior to August 1, 2008), may be eligible for an early receipt of vested Pension Plan benefits if your disability prevents you from performing the essential functions of your normal occupation. Refer to the Pension Summary Plan Document for more information on eligibility, benefits, limits and exclusions regarding the Pension Plan, including this Incapability Retirement benefit.

Enrolling in Coverage

Your enrollment in the Basic coverage under the Plan is automatic. You do not need to complete any enrollment forms for coverage to take effect. You do need to complete forms if you desire to participate in the STD Buy-Up option set forth below.

Cost of Coverage

The Company currently pays the full cost of the Disability Income Plans for STD (basic benefit), and LTD benefits. You only pay for the STD Buy-Up plan option. The cost of this coverage is determined on an annual basis and will be communicated to you during your applicable enrollment period. The Incapability Retirement benefit is a provision of the Pension Plan and paid for by the Company. See the Savannah River Nuclear Solutions, LLC Multiple Employer Pension Plan or "Pension Plan" Summary Plan Description for more information. The Company reserves the right to change the cost sharing of these benefits at any time.

Short Term Disability Buy-Up (STD Buy-Up)

Eligible SRNS employees may elect to purchase the STD Buy-Up option upon hiring or during Open Enrollment. The STD Buy-Up option allows you to receive 100% of your base salary for up to the full 1,040 hours of STD. After the first 200 Hours of STD, Employees that do not purchase the STD Buy-Up option will receive 65% of their base salary for up to 840 hours of STD. All other terms regulating STD still apply in the determining eligibility. The contributions for the STD Buy-Up shall be made on an after-tax basis, which means the Buy-up benefit payments are non-taxable to the employee. This benefit is incidental to any benefit provided under the SRNS Cafeteria Plan and is part of the Short Term Disability Plan.



Questions?

Savannah River Nuclear Solutions, LLC Benefits Department

Building 730-2B
Aiken, SC 29808

(803) 725-7772 or (800) 368-7333

or *Service-Center@srs.gov*

Disability Case Management

(803) 725-7425 (5-SICK)

or *5SICK@srs.gov*

Long Term Disability Claims Administrator

Sedgwick Claims Management Services, Inc. (800) 231-0165

Social Security Administration

(800) 772-1213

Disability benefits at a glance

This chart is a brief outline of benefits. Please refer to the detailed information in this Summary Plan Description for more information of benefits, limits and exclusions.

Benefit	When Eligible	Who Pays	Key Plan Provisions
Short Term Disability <i>Non-Craft Employees only</i> Illness and Injury Benefits (Non-Occupational)	First day of active employment	The Company's STD Plan	Provides 100% of base salary for up to 200 hours, and then 65% of base salary for the remaining 840 hours over a rolling 12-month period (after you have missed 40 consecutive, scheduled work hours) due to a disability which requires approval by the Company's Disability Case Manager. Employees can purchase the STD buy-up option to receive 100% of their base salary for up to 1,040 hours. Must be unable to perform the essential functions of your normal occupation.
Short Term Disability <i>Option A Craft Employees only</i> Illness and Injury Benefits (Non-Occupational)	First day of active employment	The Company's STD Plan	Provides 100% of base salary for up to 200 hours, and then 65% of base salary for the remaining 840 hours over a rolling 12-month period (after you have missed 16 consecutive, scheduled work hours) due to a disability which requires approval by the Company's Disability Case Manager. Employees can purchase the STD buy-up option to receive 100% of their base salary for up to 1,040 hours. Must be unable to perform the essential functions of your normal occupation.
Long Term Disability Illness and Injury Benefits (Non-Occupational and Occupational)	First day of active employment <i>(Pre-existing limitation for disabilities that occur within 12 months from hire date)</i>	The Company's LTD Plan	Provides up to 60% of base salary. when all sources of eligible disability and pension benefits are considered. Payments continue as long as you meet the requirements for disability up to the age you become eligible to receive Social Security, 65 or up to 5 years if disabled at/ after age 60. Must be unable to perform the essential functions of your normal occupation for the first 18 months of LTD benefits and then must be unable to perform any reasonable occupation thereafter.
Incapability Retirement Benefits* <i>Applies only to Incumbent Employees eligible for the Pension Plan</i> Pension Benefit <i>*These benefits not payable under the SRNS Disability Income Plan.</i>	After 15 years of Eligible Service <i>(only for employees hired prior to August 1, 2008)</i>	The Company's Pension Plan	Pays a Pension benefit if you cannot perform the essential functions of your normal occupation. Incapability Retirement benefits are provided under the SRNS, LLC Multiple Employer Pension Plan.



Short Term Disability

When Benefits Begin

SRNS Employees (excluding Craft Employees)

If you are unable to work due to a non-occupational illness or injury, you may qualify for Short Term Disability (STD) benefits after you have missed a waiting period of 40 consecutive, scheduled work hours due to an illness or injury that prevents you from performing the Essential Functions of your Normal Occupation.* This waiting period is required for all approved STD cases. The first day of scheduled work missed may be considered as the start of the 40 hours if approved by the Disability Case Manager. A look back period of one week (7 days) may be considered by the Disability Case Manager if the employee missed intermittent time from work. The maximum amount/hours of STD is 1,040 hours, over a rolling 12-month period.

* This assumes full time status. For part time employees, a pro-rated amount, commensurate with the number of hours worked per week, will be used as the waiting period. In addition, a pro-rated amount of short term disability hours will also be allotted. (Example: If working a part time schedule of 20 hours per week, the waiting period will be 20 consecutive, scheduled work hours. The maximum number of paid short term disability hours over the rolling 12-month calendar in this example would be 520.)

Option A Craft Employees

If you are unable to work due to a non-occupational illness or injury, you may qualify for STD benefits after you have missed a waiting period of 16 consecutive, scheduled work hours due to an illness or injury that prevents you from performing the Essential Functions of Your Normal Occupation.

Transplants

STD benefits will be paid for transplant recipients. STD benefits may be paid for transplant donors if the donor and recipient are biological family members and both are covered under the SRNS, LLC Medical Plan.

Coordination With Other Sources of Income— VA Disability

If an employee is already receiving a military disability benefit for the same condition they are seeking STD for, the amount of that benefit would be offset from the STD amount. The member would need to provide a copy of their current VA Disability payment prior to STD approval. The offset would be calculated as follows: (Amount of monthly military disability benefit x 12 months) / 2,080 annual hours = an hourly rate. This calculated hourly rate would be subtracted from the member's hourly rate of pay to determine a weekly or monthly STD amount.

How to File a Claim

When you are first aware of a need for disability due to a non-occupational illness/ injury or scheduled surgery, contact Disability Case Management (DCM / 5SICK) at 803-725-7425 (5-SICK), or e-mail 5sick@srs.gov. You will be informed of the following:

- A waiting period of 40 consecutive, scheduled work hours (or 16 consecutive scheduled work hours for Option A Craft Employees) must be missed before paid disability time begins. During the waiting period, you may use Time Bank or take the time unpaid if no Time Bank hours are available.
- Sign a release of medical information, (HIPAA) form, from your treating physician provider office, obtain a copy of your medical documentation (clinical assessment notes / progress notes, and a work excuse with any necessary restrictions) from your treating medical physician, and provide those records to DCM / 5SICK. All medical documentation must be received by the DCM / 5SICK no more than two weeks from the start date.
- DCM/5SICK reserves the right to require supplemental medical documentation from your health care provider and/or require an examination on you while you are claiming benefits under this Plan. You must submit any additional required documentation within [14 days] if the request, or your benefits may be discontinued. You may be required to submit to an independent medical examination, and cancellation of an appointment or failure to appear for a scheduled appointment may result in suspension or cessation of your benefits. Benefits under this Plan will be paid only if DCM/5SICK decides in its discretion that you are entitled to them.
- DCM/5SICK reserves the right to determine if your proof of disability is satisfactory. If you provide forged, fraudulent, or altered proof, your claim will be denied.
- Promptly contact your immediate Supervisor to report the need for an absence due to an illness or injury.
- Contact DCM / 5SICK prior to returning to work, following short term disability. You will also need to contact Site Medical to pre-schedule your return-to-work appointment prior to returning to work.

Qualifying for STD

For purposes of the STD Plan, the term “Disabled”, or “Disability” means you are unable to perform the essential functions of your normal occupation, have received approval from DCM / 5SICK, and are not at work. Your STD benefits are designed to provide benefits only if, because of a non-occupational illness or injury, you qualify for short term disability benefits as defined by the Plan and determined by the DCM / 5SICK. You will be asked by the DCM / 5SICK to have your treating medical physician to provide medical documentation.

Essential Functions of Your Normal Occupation (that cannot be accommodated) means that you are unable to perform the essential functions of the occupation you routinely performed at the time disability began.

The Company has designated the DCM / 5SICK with the authority to determine, at its discretion, eligibility for benefits approval and payments. The DCM / 5SICK may require medical documentation periodically during your STD absence.

If you were unable to work due to a non-occupational illness or injury lasting more than the 40 consecutive, scheduled work hours, and you failed to contact DCM / 5SICK / 5sick before your scheduled work shift, Short Term Disability benefits may not be paid retroactively.

If your STD benefits are denied, you have the right to appeal. (See the STD Appeals section for details.)

Progressive Return to Duty

Work Hardening is a systematic program of gradually progressive, work-related activities, performed to recondition the employee in order to facilitate a return to full employment. This program benefits employees who may be working less than full capacity due to a short term non-occupational injury / illness. This program is limited, and temporary and work hours must be progressed to full duty.

You must notify DCM / 5SICK when placed in the Work Hardening program by Site Medical or recommended by your treating medical physician. DCM / 5SICK may approve the work hardening schedule hours as STD, for 1 to 3 weeks, depending on medical necessity. When on a Work Hardening schedule, the employee must work the minimum required hours as outlined by DCM / 5SICK in order to be eligible for STD benefit approval.

If you have exhausted the STD benefit, you should complete your workday with Time Bank hours. Work schedules for exempt employees who have Time Bank hours will be adjusted to the approved progressive/ work hardening hours. Time Bank hours used during a Work Hardening schedule must be taken in full day increments. Note that you must be returned to work following a disability before Time Bank hours can be used (unless STD is no longer approved).

Recurrent Disability

Under the STD Plan, a Recurrent Disability is defined as a request for additional STD benefits for the same or related illness within the first 14 consecutive calendar days from a return to work from a prior disability (unless on an ongoing treatment plan approved by DCM / 5SICK). If approved by the DCM / 5SICK, your STD benefits for Recurrent Disabilities may resume without requiring another 40-hour waiting period (16 hour waiting period in the case of Option A Craft Employees). Any re-occurrence or new non-occupational illness or injury that occurs after the first 14 consecutive calendar days from a return to work will be treated as a new disability and will require another 40-hour waiting period (16 hour waiting period in the case of Option A Craft Employees), therefore, a maximum of up to 200-hours will be allotted at 100% of an employee’s base pay. If the STD Buy-up option is selected, the remaining 840-hours will be paid at 100% of an employee’s base pay. If the Buy-up option is not selected, the remaining 840-hours will be paid at 65% of an employee’s base pay.

Post-operative doctor’s visits that occur within the first 14 consecutive calendar days from a return to work from a disability case may be considered as part of your Disability when the surgery necessitates a follow-up action used to close out the surgical procedure (such as removal of sutures, removal or adjustment of a brace or cast).

Post-operative doctor’s visits will not be considered as part of your Disability if they are for follow-up visits with your physician to be released from medical care. Routine visits to ensure you are progressing normally will not be treated as a Disability but will be treated the same as other physician visits, such that you may use Time Bank hours, make-up or AR time in accordance with company policy, or take a company-approved unpaid leave, which may include FMLA.

Disability and Driving

The inability to operate a motor vehicle and/or instruction by your private physician not to drive, does not constitute a disability under the Plan, unless operating a motor vehicle, or similar action, is an essential function of your job and work scope and restrictions cannot be accommodated.

Benefit Amount

The amount of an employee's STD benefits equals 100% of their Base Salary for up to 200 hours at the time the STD is approved, and then 65% of an employee's base salary for the remaining 840 hours of STD. For employees that elected the STD Buy Up benefit, the STD pay will be 100% of the base pay for the remaining 840 hours.

The maximum duration of approved STD benefits is 1,040 hours over a rolling 12-month period (e.g., if you charged 40 hours to Disability in January, you will have those 40 hours of Disability restored to your 1,040 maximum in the following January). Hours are regained day-by-day as they were used. Your base salary does not include overtime, shift differential, premium pay, bonus payments, quality awards, detail pay or any other form of special or extra compensation that is not part of your base pay earnings.

If, during the time you are receiving STD benefits, your base salary changes, your STD payments will be adjusted accordingly.

If you receive military disability compensation for a disability, your STD benefit for the same disability will be offset.

When Benefits End

Eligibility for STD benefits ends when one of the following conditions occurs:

- You lose eligibility under the Plan;
- You return to work (other than in a reduced capacity for a Company approved progressive return/work hardening);
- You are no longer approved for Disability by DCM / 5SICK;
- You refuse to supply medical documents & information or take action required by DCM / 5SICK or the Plan Administrator;
- You refuse the Company's request for an Independent Medical Evaluation, or Site Medical evaluation;
- You are no longer under the regular treatment of a treating medical physician for your Disability or are no longer receiving appropriate medical care;
- Noncompliance with a prescribed treatment program ordered by your treating medical physician, or mental health provider;
- You are working for another employer, or are self-employed while on STD;
- Your maximum benefit period for STD of 1,040 hours has been exhausted;
- You are no longer an active full service SRNS or Option A Craft employee;
- You are on an approved STD and work another job or engage in any outside employment or business.
- You engage in physical activities that are grossly inconsistent with your approved Disability medical condition.
- You have a disciplinary action pending.
- You have violated SRNS policies, and/or procedures.
- You are incapable of performing your job scope due to a loss or suspension of your security clearance.
- Your employment is terminated by SRNS; or
- You test positive for alcohol, or an illegal substance while on site.
- You die.

When STD Cases Close

Short Term Disability cases will close 14 consecutive calendar days from a return to work from a Disability, if not undergoing current/active treatment on a weekly or bi-weekly basis for a medical condition (as approved by Disability Case Management.) This pertains to individuals that have returned to work, following completion of a treatment for a medical condition, from which they have recovered. The maximum duration of a continuous disability case is 365 days. Treatments that occur once a month are not included for STD approval.

LTD and LOA After Exhausting STD

If you remain disabled at the end of the maximum approved STD benefit (1,040 hours over a rolling 12-month period), you may be eligible to receive Long Term Disability (LTD) benefits, depending on the extent of your disability. DCM / 5SICK will notify the LTD Claims Administrator of a possible LTD claim prior to the exhaustion of your 1,040 hours of STD benefits.

If you've exhausted STD, but it is anticipated by the DCM / 5SICK that you may return to full time duty, you may be granted a leave of absence (LOA) up to 30 days. Request for a LOA will be reviewed on a case-by-case basis by the DCM / 5SICK.

Written documentation will be required from your medical provider, showing a definitive return to work date in order to be considered for the LOA. The LOA is unpaid unless you have remaining Time Bank hours that you choose to use. If you were approved for an LOA, or if you exhaust your 1,040 hours of STD, you must return to work performing the essential functions of your normal occupation with or without accommodations for at least 30 consecutive calendar days before you can be approved to use any STD hours that may have been restored to your STD bank from the rolling 12-month schedule.

For employees that are eligible for FMLA (Family & Medical Leave Act), STD hours run concurrently with FMLA if FMLA hours are available.

STD Effect on Time Bank

Monthly Time Bank accruals will continue to be earned for the first 30 consecutive calendar days that an employee is on STD. Following this initial 30-day period, monthly Time Bank accruals will cease until the employee has returned to work.

NOTE: Time Bank adjustments will not be made if the 30-day period ends any date within the month from the STD start date. The adjustment will be made the following month if the employee remains out of work on STD.

Exclusions

Benefits are not paid for a Disability caused by or resulting from:

- Act or commission of criminal or illegal activities
- An act of war, whether declared or undeclared, or participation in an insurrection, rebellion, riot or civil commotion
- The member's blood alcohol level was at, or in excess of, the amount established under applicable state law to create a presumption and/or inference that the member was under the influence of alcohol when measured by law enforcement or medical personnel while operating a motor vehicle.
- Drug Use – under the influence of any drug or substance or taking some action, the purpose of which is to create a euphoric state or alter consciousness. The individual (or the individual's representative) must provide any available test results showing drug/substance levels upon request. If the individual refuses to provide these results, no benefits will be provided.
- When you are incarcerated for the commission of a crime, regardless of if the crime contributed to your Disability.
- Non-compliance with a prescribed treatment program ordered by your treating medical physician or mental health provider.
- Any illness or injury resulting from any occupation or work for compensation or profit outside of the SRNS job.
- Actively serving in the armed forces
- Cosmetic procedures determined as not medically necessary by the medical insurance company or personal optional medical procedures that are not medically necessary
- Experimental medical treatments not covered under the medical insurance and not recommended by a physician
- Chiropractor therapy visits not recommended by a physician
- Submission of false medical documentation or information

** Other than Substance Use Disorder Services*

Accessing Your Claim File

If your STD claim has been denied, you have the right to access your claim file. Contact the Site Medical records department at (803) 557-4753.

Retroactive Rescissions

Retroactive rescissions of coverage are considered a form of denial of benefits and therefore trigger the Plan's appeals procedures.

Overpayments

The Plan has the right to recover overpayments from you and to take any appropriate collection activity available to collect overpaid amounts.

Independence and Impartiality

The STD claims and appeal processes are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making benefit determinations.

STD Buy-up and Leave of Absence (LOA)

If you are on a Company-approved paid leave of absence (LOA), payment for your STD coverage will continue as if you were actively at work.

If you are on a Company-approved Unpaid LOA, such as a FMLA or on an approved furlough, you will be able to continue your STD coverage as long as you pay the required monthly premium contribution in advance. When you return from the Unpaid LOA as an active employee, your premium will resume deductions from your paycheck. Before your Unpaid LOA begins, be sure to contact the SRNS Service Center for additional information and instructions on making the required premium contributions.

If, while on a Company-approved Unpaid LOA, you fail to make your STD Buy-up premium payments in a timely manner (that is no later than 31 days after the beginning of the month), your STD Buy-up coverage will be terminated retroactively to the beginning of the month for which the premium contribution was not made. While this will terminate the additional STD Buy-up coverage, you will still be covered under the Company paid Short Term Disability Coverage as described on page 5 of the Summary Plan Description. When you return as an active employee from the Unpaid LOA, the STD coverage that you had just prior to the Unpaid LOA will resume, with premiums deducted from your paycheck. However, you will have forfeited STD coverage during the period of time in which you did not pay any required premiums. Any STD initiated during that unpaid period of time will be treated as if you waived the STD Buy-up option.

STD Claims and Appeals

This section provides a high-level summary of the claims and appeals process applicable to the STD Plan. A full description of process applicable to the STD Plan can be found in the section “Claims and Appeals Process for STD and LTD Plans.”

If your request for STD benefits has been denied by the DCM / 5SICK, you have the right to appeal to the Plan Administrator. To begin the appeal process, you must complete the STD Appeals forms and submit it to the Plan Administrator within 180 days of the date of denial of the claim. Your request for review must state the reason for appealing the claim denial (the STD appeal claim form can be obtained by contacting DCM / 5SICK) and the basis upon which the review is requested, including but not limited to, pertinent Plan provisions, prior decisions and/or statements of facts or circumstances in your possession which are relevant to your claim.

You should identify the Plan by using the correct Plan name as shown in the Plan Information section of this document. As part of the appeal procedure, you should submit written comments, medical documents, records and other information relating to the claim. Please see ERISA rights in the General Information Section for more information regarding your rights to plan documents and records.

Within 45 days after receiving your appeal, the Plan Administrator will provide you with a written decision. If more time is needed to review your appeal, the Plan Administrator may utilize a 45-day extension. If this additional time is needed, you will be notified in writing.

Before an appeal can be denied, claimants will be given notice and a reasonable opportunity to respond whenever an appeal denial is based on new or additional rationales or evidence, which was not considered during the initial claim analysis.

The Plan Administrator, and those persons acting on the Plan Administrator’s behalf, are vested with full power and sole discretion to interpret all the terms of the Plan and will make the final determination based solely on the applicable facts and evidence.

All decisions of the Plan Administrator are final and binding. Plan Administrator:

Disability Income Plan Administrator Savannah River Nuclear Solutions, LLC Building 730-2B, Room 115

Aiken, SC 29808 (803) 725-7772 or (800) 368-7333



Long Term Disability Plan

Qualifying for Long Term Disability (LTD)

LTD benefits may begin after you have exhausted your 1,040 hours of Short Term Disability benefits, Workers' Compensation Supplement, and/or any company-approved leaves of absence relating to a company-approved disability. You may qualify for LTD benefits if you are still unable to perform the Essential Functions of Your Normal Occupation. As you near the end of your 1,040 hours of the Short Term Disability, you may begin the application process for Long Term Disability.

LTD benefits, if approved by the LTD Claims Administrator, begin (are effective) on the 1st of the month following the later of the:

- last date on which you received STD benefits, or
- end of a Company approved (30-day extension) Leave of Absence

Between the end of STD and the first month following your LTD approval, you may use Time Bank hours, if available. If no Time Bank hours are available, your timecard should be completed using time off without pay until the end of the month. LTD benefits are payable at the end of the month, after they are effective.

After receiving 18 months of LTD benefits, you must be unable to work at any Reasonable Occupation or your LTD benefits will be discontinued. If you are approved for LTD, you will be required to provide proof of continuing disability, including medical examinations on an annual basis.

Essential Functions of Your Normal Occupation means that you are unable to perform the essential functions of the occupation you routinely performed at the time disability began.

Reasonable Occupation means any occupation that you are reasonably capable to perform within your documented current medical restrictions.

LTD Claims Filing

Disability Case Management (DCM / 5SICK) will notify the LTD Claims Administrator of a possible LTD claim as you near the exhaustion of your STD benefit time period. Sedgwick Claims Management Services, Inc, (Sedgwick CMS) is the LTD Claims Administrator.

The LTD Claims Administrator will mail you a packet of information for you to complete. Included in this packet is a "Release of Information" (ROI) form. This form allows the LTD Claims Administrator to collect information and medical documentation regarding your case and begin processing claim information required to qualify for LTD.

This information may include, but is not limited to, an authorization to release medical records and reports to any outside disability review group, medical or health history, chart notes, prescriptions, diagnostic test results, x-ray reports, records received from other health providers, information regarding pre-existing health or medical conditions or illness, as well as your occupation and employment activities, employee/employment records, earnings or finances, application for insurance coverage, prior claim files and claims history and objective medical documentation that supports your LTD. In addition, proof of your income may be requested as well. You must also be willing to undergo an Independent Medical Evaluation, as required. The cost of the examination will be paid by the Plan.

As the LTD Claims Administrator for the Plan, Sedgwick CMS has discretionary authority to determine your qualification for LTD benefits. The LTD Claims Administrator's determination will be made within 45 calendar days from the date you return the completed application package to the LTD Claims Administrator. If the LTD Claims Administrator requires additional time to review your application and supporting documentation to determine your eligibility for LTD benefits, the LTD Claims Administrator will notify you in writing of the additional time and anticipated decision date. The LTD Claims Administrator has full discretionary authority to make all claims decisions.

If the documentation does not support that you meet the definition for LTD benefits, your claim will be denied. The LTD Administrator reserves the right to determine if your proof of disability is satisfactory. If you provide forged, fraudulent, or altered proof, your claim will be denied.

Pre-Existing Condition Limitation

LTD benefits are NOT payable for disabilities resulting, directly or indirectly, from a Pre-Existing Condition unless the disability begins after 12 months of employment with the Company.

For purposes of the LTD Plan, a "Pre-Existing Condition" is an accident, illness or injury for which you sought (or had symptoms or conditions which would cause a reasonable person to seek) diagnosis, treatment, or care as determined by the LTD Claims Administrator, in the 6 months before employment starts with the Company. For purposes of identifying a Pre-Existing Condition, treatment includes, but is not limited to:

- Medical exams, tests, hospitalization or emergency room treatment, a physician's attendance, or observation, and
- Use of drugs, medicines, medicinal services, supplies, and equipment.

Benefit Amount

Your Long Term Disability benefit, when coordinated with other sources of income, will be a maximum of 60% of your base salary, up to a maximum of \$10,000 per month. There is no minimum benefit. Your base salary does not include overtime, shift differential, premium pay, bonus payments, quality awards, detail pay or any other form of special or extra compensation that is not part of your base pay earnings. LTD payments are taxable income. LTD payments will be issued by the Company and are paid at the end of each month.

Social Security Advocate

A Social Security Disability Advocate (contracted by the Claims Administrator) will assist you in applying for disability benefits from the Social Security Administration (SSA). The Social Security Disability Advocate will work on your behalf to get disability benefits approved from the SSA. Working with an advocate helps facilitate the processing of applications and eases the navigation through the SSA process. There is no charge to you for this service. If your disability application is denied by SSA, the Company's Social Security Disability Advocate will assist you with SSA appeals. Once your application is approved and SSA Disability Income (SSDI) is awarded, LTD payments from SRNS will be offset by the amount of SSDI. Additionally, you will also be required to reimburse the Company and/or the Plan for any overpayment due to a retroactive award of SSDI. It is your responsibility to notify the LTD Claims Administrator of a retroactive award and to reimburse any amounts owed under the terms of the LTD Plan. If you fail to make the required reimbursement, the amount owing will be deducted from future Plan payments.

You are required to apply for Social Security disability benefits to receive Long Term Disability benefits. If you are not awarded Social Security disability benefits when you first apply, you are required to appeal your claim with Social Security through the Administrative Law Judge hearing level.

Coordination with Other Sources of Income

Any income from another employer or self-employment, excluding Claim Administrator approved rehabilitation programs, may result in the termination of your LTD benefits. Other income sources that will reduce the amount of your LTD benefits include:

- Social Security disability benefits that can begin at any age
- Social Security retirement payments that can begin at age 62
- State or federal Workers' Compensation disability or occupational disease benefits
- Gross pension payments from the Company Pension Plan for which you are eligible
- Veteran's Administration (VA) Disability Compensation
- Any other state, federal or employer-sponsored program

You are required to apply for all other income sources for which you are eligible, including Social Security benefits. If your claim is denied, you are required to appeal (up to the administrative law judge for Social Security disability benefits), provided an appeal is available. As a condition of payment under this Plan, you must allow the Plan to obtain information about any other income sources. Any increase in Other Sources of Income during the period of Disability due to a cost of living adjustment will not be considered in calculating the net LTD benefit after the first reduction for Other Sources of Income. You must notify the LTD Claims Administrator when there is an increase in other sources of income (e.g. cost of living increase).

You will be required to submit satisfactory proof of your disability initially and may be required to submit proof of continued disability in the future. In addition, proof of your income will be requested as well to determine continued qualification and to validate applicable offsets.

Because your Long Term Disability benefit payment is offset by income you receive or you are eligible to receive from other income sources, the amount actually payable from the Long Term Disability Plan may vary from month to month. Once a benefit amount from one of the other income sources becomes available, the 60% maximum LTD benefit is offset by any additional income. The new calculation may result in either an overpayment or underpayment to you. Any underpayment will be paid to you from the Plan. You must repay any overpayment back to the Plan. The overpayment should be paid in a lump sum. In some situations, the Plan may agree to accept a repayment in installment payments, or by deductions taken from your monthly benefit. The Plan reserves the right to offset overpayments against future benefit payments until reimbursement is received.

The Plan has the right to recover overpayments from your estate and to take any appropriate collection activity available to collect overpaid amounts.

Note: If an overpayment occurs because you conceal, misrepresent or give misleading information (for example regarding your employment, earnings, medical condition or receipt of SSDI) your benefit may be terminated, and you must repay the amount of the overpayment.

For example, your monthly Eligible earnings are \$4,000; thus, your maximum LTD benefit would be \$2,400 (\$4,000 at 60%). Your LTD benefit will be offset by your Social Security award (minus \$1,000 for example) and any gross amount you are eligible to receive from the Pension Plan (minus \$800 for example). Your LTD benefit would be \$600.

Example	
\$4,000	Monthly Eligible Earnings
X6 0%	
\$2,400	Maximum LTD Benefit
– \$1,000	Social Security Award
– \$800	Gross Pension Benefit
	(before spousal coverage reductions and/or any other deductions)
\$600	Monthly LTD Benefit

Payments you receive from disability policies you have purchased as an individual will not be considered as an income offset to your LTD benefit.

Your monthly LTD benefit will be reduced as follows if you receive a lump sum award from any other income source earnings during your period of disability:

- The lump sum payment is prorated by dividing that amount by the number of months for which the settlement in advance was provided;
- If the number of months is not known, or if there is no specific allocation of the lump sum payment, the Plan will determine a reasonable prorating period.

Mental, Nervous and Substance Abuse Limitations

LTD benefits will be paid on a limited basis for a disability caused by, or contributed by, Substance Abuse or Mental or Nervous Disorder or Disease. No further benefits will be paid once 24 months of Disability benefits (6 months of Short Term and 18 months of Long Term) have been paid.

For purposes of the LTD Plan, “Mental or Nervous Disorder or Disease” means a mental disorder as listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association. A Mental or Nervous Disorder or Disease, as so defined, may be related to or be caused by physical or biological factors, or result in physical symptoms or expressions.

For the purposes of the LTD Plan, Mental or Nervous Disorder or Disease does not include any mental disorder listed within any of the following categories found in the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association:

- Mental Retardation;
- Motor Skills Disorder;
- Delirium, Dementia, and Amnesic and other Cognitive Disorders;
- Narcolepsy, Obstructive Sleep Apnea, and Sleep Disorder due to a general medical condition;
- Stroke, Brain tumors, Closed Head Injury, Other Organic Conditions and;
- Alzheimer’s Disease

The LTD Claims Administrator determines, at its discretion, if a Disability is the result of a Mental or Nervous Disorder or Disease.

Life Insurance

While you are on short term disability, your life insurance benefits (both Non-Contributory and Contributory) continue, as you are still an active employee. When transitioning to long term disability, life insurance benefits can continue under the following conditions:

- If you are an Incumbent (pension eligible, hired prior to 8/1/08)
 - Non-Contributory life insurance benefits continue for the remainder of your life
 - Contributory life insurance benefits continue, as long as premiums are paid
- If you are a Non-Incumbent (not pension eligible, hired on/after 8/1/08)
 - Non-Contributory life insurance benefits continue for a maximum of 24 months (provided you continue to meet the eligibility guidelines for LTD)
 - Contributory life insurance benefits can be converted to an individual life insurance policy by contacting the insurer directly.

Note that life insurance benefits, in all circumstances, are subject to reductions in coverage starting at age 65. (Refer to the Life Insurance SPD for further details).

When Benefits End

You will continue to receive your Long Term Disability benefits through the end of the month during which you turn age 65, as long as you continue to meet the qualification criteria for disability and are approved for payments by the LTD Claims Administrator.

If you become disabled at/after age 60, you will receive Long Term Disability benefits as long as you remain disabled, up to a maximum of five years. You will be required to provide medical documentation that supports your Long Term Disability.

In addition, the LTD Claims Administrator will ask you to authorize your physicians to release medical information to the Plan that is required to determine your continued participation under the Plan on an annual basis.

If, at any time, you refuse to provide medical documentation, earnings documentation, or you are determined by the LTD Claims Administrator to be no longer qualified for LTD, your benefits will end.

Your LTD benefits are discontinued when:

- you exhaust your benefits;
- you are no longer determined to be eligible for benefits;
- you return to work;
- you are no longer under the regular treatment of a Treating Provider for your Disability or are no longer receiving Appropriate Care;
- you refuse to participate in a requested Independent Medical Evaluation;
- you refuse to supply documents, information or take action required by the LTD Claims Administrator;
- you are working for another employer or self-employed for remuneration or profit (excluding approved rehabilitation programs);
- you have a disciplinary action pending;
- you have violated SRNS policies, and/or procedures;
- you are incapable of performing your job scope due to a loss or suspension of your security clearance;
- your employment is terminated by SRNS;
- you test positive for alcohol, or an illegal substance while on site;
- you die.

Exclusions

Benefits are not paid for a Long Term Disability caused by or resulting from:

- Act or commission of criminal or illegal activities;
- The member's blood alcohol level was at, or in excess of, the amount established under applicable state law to create a presumption and/or inference that the member was under the influence of alcohol when measured by law enforcement or medical personnel.
- Drug Use – under the influence of any drug or substance or taking some action, the purpose of which is to create a euphoric state or alter consciousness. The individual (or the individual's representative) must provide any available test results showing

drug/substance levels upon request. If the individual refuses to provide these results, no benefits will be provided.

- When you are incarcerated for the commission of a crime, regardless of if the crime contributed to your Disability;
- Non-compliance with a prescribed treatment program, ordered by your medical provider.
- Any illness or injury resulting from any occupation or work for compensation or profit other than for SRNS or as an Option A Craft Employee;
- Actively serving in the armed forces;
- An act of war, whether declared or undeclared, or participation in an insurrection, rebellion, riot or civil commotion;
- An illness or injury occurring after your employment ends for any reason;
- Cosmetic procedures not medically necessary

Health Benefits

Your health benefits will continue through the pay date when your STD ends. When your LTD begins, health benefits can continue under the following scenarios:

- If you are not Retiree/Pension eligible (“Non-Incumbent”)

If approved for LTD, you will be offered up to 24 months of Medical and Dental coverage, in lieu of COBRA, on the SRNS Pre-65 Retiree Health Plan. (When you are age 65 or older OR you become disabled under federal guidelines at any age, you must enroll in Medicare). COBRA will also be offered for Medical, Dental and Vision coverage.

This 24-month benefit is contingent upon your premiums being paid and your continued eligibility/approval on the LTD Plan.

- If you are Retiree/Pension eligible (“Incumbent”)

If under age 65, Medical and Dental benefits continue on the SRNS Pre-65 Retiree Health Plan. (If/when you become disabled under federal guidelines at any age, you must enroll in Medicare).

If you are age 65 or over, you must enroll in Medicare and enroll in a Medicare supplement plan through the Medicare advocate sponsored by SRNS. An annual stipend will be provided.

COBRA will be offered for Vision coverage.

For more information concerning the SRNS Pre-65 Retiree Health Plan, refer to the Medical, Dental and Vision Summary Plan Descriptions.

Accessing Your Claim File

If your LTD claim has been denied, you have the right to access your claim file. Contact Sedgwick CMS at (800) 231-0165.

Retroactive Rescissions

Retroactive rescissions of coverage are considered a form of denial of benefits, and therefore trigger the Plan’s appeals procedures.

Independence and Impartiality

The LTD claims and appeal processes are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making benefit determinations.

LTD Claims and Appeals

This section provides a high-level summary of the claims and appeals process applicable to the LTD Plan. A full description of process applicable to the STD Plan can be found in the section “Claims and Appeals Process for STD and LTD Plans.”

If your claim has been initially denied, you may appeal the denial to the LTD Claims Administrator. To begin the appeal process, you must contact the LTD Claims Administrator within 180 days of the date on the initial denial letter. Your request for review must state the reason for appealing the claim denial and the basis upon which the review is requested, including but not limited to, pertinent Plan provisions, prior decisions and/or statements of facts or circumstances in your possession which are relevant to your claim.

LTD Claims Administrator:

Sedgwick Claims Management Services, Inc., P.O. Box 14454, Lexington, KY 40512-4454, (800) 231-0165

As a participant in the Plan, you have the right to request and examine, without charge, at the Plan Administrator's office and at other specified locations such as your personnel office, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, Pension and Welfare Benefits Administration, such as detailed annual reports and plan descriptions. You have a right to obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may ask a reasonable charge for the copies. The Plan will provide these documents within 30 days of receiving the employee's written request.

Within 45 days after receiving your appeal, the LTD Claims Administrator will provide you with a written decision. If more time is needed to review your appeal, the LTD Claims Administrator may utilize a 45-day extension. If this additional time is needed, you will be notified in writing.

Before an appeal can be denied, claimants will be given notice and a reasonable opportunity to respond whenever an appeal denial is based on new or additional rationales or evidence, which was not considered during the initial claim analysis. This process allows 21 days for response from the claimant before a final decision is rendered. If new information is received, the LTD Claims Administrator has up to 14 days to review the new information. If needed, an Independent Physician Advisor (IPA) will be triggered to address the new information.

If the claim decision is upheld (i.e., your first appeal has also been denied), you may file a final appeal to the LTD Plan Administrator within 60 days of the date of the second denial letter. Your request for review must state the reason for appealing the claim denial and the basis upon which the review is requested, including but not limited to, pertinent Plan provisions, prior decisions and/or statements of facts or circumstances in your possession which are relevant to your claim. The Plan Administrator, and those persons acting on the Plan Administrator's behalf, are vested with full power and sole discretion to interpret all the terms of the Plan, and the discretionary authority to make all determinations of fact or law. All decisions made by the Plan Administrator are final and binding.

After exhausting the administrative claims and appeals process, you may begin legal action and serve legal papers on the Agent for Service of Legal Process. The contact information for the Agent of Service of Legal Process is noted at the end of this booklet.

Please see ERISA rights in the General Information Section for more information regarding your rights to plan documents and records.

The Incapability Retirement pension benefit under the Pension Plan may be available even if you are not receiving Long Term Disability benefits.

Language Services

Should you need claims related correspondence translated in a language other than English, contact the LTD Claims Administrator. Verbal and written translations are available upon request.



Incapability Retirement (IR)

Please refer to the Pension Summary Plan Document for more information on benefits, limits and exclusions regarding the Pension Plan, including this Incapability Retirement benefit. This summary is provided for convenience only and does not replace the Pension Summary Plan Document. The official Pension Plan document governs the actual operation of the Pension Plan and the payment of benefits. If there is a conflict between the Pension Plan and this summary, the Pension Plan will control.

To be eligible for an Incapability Retirement benefit, you must be an SRNS or Option A Craft, full-service Incumbent Employee eligible for the Pension Plan with at least 15 years of Eligibility Service. If you are incapable of performing the Essential Functions of Your Normal Occupation due to a disability, you may qualify for an Incapability Retirement from the Pension Plan.

The Incapability Retirement benefit is an unreduced pension equal to the pension benefit earned as of the date retired under the Incapability Retirement provision of the Pension Plan.

You are required to apply for Social Security disability benefits and appeal (through the Administrative Law judge hearing level) if you are denied Social Security disability benefits.

SRNS' contracted Social Security Disability Advocate will assist you in applying for disability benefits from the Social Security Administration (SSA). The Social Security Disability Advocate will work on your behalf to get disability benefits approved from the SSA. Working with an advocate helps facilitate the processing of applications and eases the navigation through the SSA process.

There is no charge to you for this service. If your disability application is denied by SSA, the Social Security Disability Advocate will assist you with SSA appeals. You are required to notify the Disability Dept. when you receive any Social Security award or denial notice and to pay any amounts owed to the Plan.

If there are any overpayments of the Incapability benefit, and you fail to repay, such amounts will be deducted from future pension payments. Incapability Retirement benefits, if approved, begin (are effective) on the 1st of the month following the later of the: 1. last date on which you received STD benefits, or 2. end of a Company approved (30-day extension) Leave of Absence. Between the end of STD and the first month following your Incapability Retirement approval, you may use Time Bank hours, if available. If no Time Bank hours are available, you will be placed on an unpaid leave of absence until the end of the month. Incapability Retirement benefits are payable at the end of the month, after they are effective.

You will be required to submit satisfactory proof of your disability initially and may be required to submit proof of continued disability on an annual basis. In addition, proof of your income will be requested as well to determine continued qualification and to validate applicable offsets.

For more information concerning the amount of your Incapability Retirement benefit call the Service Center.

Independence and Impartiality

The IR claims and appeal processes are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making benefit determinations.

Your Incapability benefits may be discontinued when you no longer qualify, including but not limited to:

- You do not provide sufficient documentation;
- You are determined by the LTD Claims Administrator to be no longer qualified for Incapability Retirement benefits;
- You return to work;
- You die (please refer to the Pension Plan for Survivor benefits).

IR Appeals

If your claim has been initially denied, you may appeal the denial to the Incapability Retirement Claims Administrator. To begin the appeal process, you must contact the Incapability Retirement Claims Administrator within 180 days of the date on the initial denial letter. Your request for review must state the reason for appealing the claim denial and the basis upon which the review is requested, including but not limited to, pertinent Plan provisions, prior decisions and statements of facts or circumstances in your possession which are relevant to your claim.

Incapability Retirement Claims Administrator:

Sedgwick Claims Management Services, Inc.

P.O. Box 14454

Lexington, KY 40512-4454

(800) 231-0165

Within 45 days after receiving your appeal, the Incapability Retirement Claims Administrator will provide you with a written decision. If more time is needed to review your appeal, the Incapability Retirement Claims Administrator may utilize a 45-day extension. If this additional time is needed, you will be notified in writing.

If the claim decision is upheld (i.e., your first appeal has also been denied), you may file a second appeal to the Pension Plan Administrator within 60 days of the date of the second denial letter. Your request for review must state the reason for appealing the claim denial and the basis upon which the review is requested, including but not limited to, pertinent Plan provisions, prior decisions and statements of facts or circumstances in your possession which are relevant to your claim. The Pension Plan Administrator, and those persons acting on the behalf of the Plan Administrator, are vested with full power and sole discretion to interpret all the terms of the Plan and the discretionary authority to make all determinations of fact or law. All decisions made by the Plan Administrator are final and binding. The Pension Plan Administrator will respond within 45 days of receiving the appeal. If the Pension Plan Administrator needs more time, the Administrator may utilize a 45-day extension.

After exhausting the administrative claims and appeals process with the Plan Administrator, you may begin legal action and serve legal papers on the Agent for Legal Process. The contact information for the Agent of Legal Process is noted at the end of this booklet.

Claims and Appeals Process for STD and LTD Plans

The claim and appeal procedures set forth above for the STD and LTD Plans are subject to the following procedures developed by the U.S. Department of Labor for disability claims and appeals:

For any claim or appeal that is filed after April 1, 2018, is based on a disability:

- a) Filing Initial Disability Claim. If you make a claim based on disability, that claim should be in the form of a letter stating why you are disabled, and should be accompanied, at a minimum, by either (1) a letter from your physician that indicates you are disabled or (2) a copy of the determination from the Social Security Administration that indicates you are disabled. You will be advised of the acceptance or rejection of your claim within 45 days after your claim is received, unless special circumstances require an extension of time for processing the claim. If the Plan or LTD Claims Administrator requires an extension, written notice of the extension will be furnished to you prior to the end of the initial 45-day period. The extension will not exceed an additional period of 30 days. The extension notice from the Plan or LTD Claims Administrator will state the circumstances requiring delay; and the date the Plan or LTD Claims Administrator expects to decide the review. With respect to the disability extension, the notice will also set forth: (i) the standards of entitlement to a benefit; (ii) any unresolved issues; and (iii) information needed to resolve those issues. A second extension may be required, if necessary, due to circumstances beyond the control of the Plan or LTD Claims Administrator.

A disability claim must be filed within (1) one year of the time that you are aware, or with reasonable investigation should have been aware, of the disability. Any claim filed after this time period will be denied based solely on timeliness. If additional information is required to process the claim, you must be given at least 45 days to supply the required information. The period that you are given to provide the requested information does not count against the time period for deciding a claim.

If your claim is denied, it must be denied in writing and the denial must state in detail the specific reasons for the denial, the specific Plan provisions upon which the denial is based, any additional material or information which you may provide which would entitle you to the benefits you claim, and an explanation of why such material or information is necessary. These requirements are explained in more detail in the paragraphs entitled "Adverse Determination," Section 11.02, and "New or Additional Evidence," Section 11.03, below. The notice of denial must also explain the steps to be taken if you or your beneficiary wishes to submit a claim for review, i.e., an appeal of a denial.

- b) Request for Review (i.e. Appeal) of Denied Disability Claim. If you choose to submit a claim for review by the Plan or LTD Claims Administrator, then within 180 days after the date your Disability claim is denied, you or your authorized representative must make a written request to the Plan or LTD Claims Administrator for review. A claim will be reviewed by a different subgroup of the Plan or LTD Claims Administrator than the subgroup that reviewed your initial claim. The reviewing Plan or LTD Claims Administrator shall not be comprised of a subordinate of the person(s) who made the initial claim denial. The reviewing Plan or LTD Claims Administrator shall give no deference to the initial denial. Your request for review of your denied claim should include a statement of the reasons your claim should be allowed.

You or your representative may examine any documents the Plan or LTD Claims Administrator has in its files that are relevant to your claim, and you may also submit additional written comments to the Plan or LTD Claims Administrator that support your claim.

The Plan or LTD Claims Administrator will advise you of its decision in writing within 45 days following receipt of your request for review, unless special circumstances require an extension of time for processing. If an extension is necessary, a 45-day extension will be granted if you are notified of such extension before the original deadline for the decision on review. The extension notice must explain the circumstances requiring delay; and the date the Plan or LTD Claims Administrator expects to decide the review. With respect to the disability extension, the notice will also set forth: (i) the standards of entitlement to a benefit, (ii) any unresolved issues, and (iii) information needed to resolve those issues. If you are given additional time to produce information, such time period does not count against the time period for deciding the claim. If an extension is necessary, a decision will be made as soon as possible, but not later than 90 days after the Plan or LTD Claims Administrator receives your request for review.

The decision on review will be in writing and will include specific reasons for the decision, as well as specific references to the Plan provisions upon which the decision is based. The decision of the Plan or LTD Claims Administrator will be final and will be subject to no further appeal or review.

Independence and Impartiality

The Plan must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) must not be made based upon the likelihood that the individual will support the denial of benefits. On appeal, the Administrator must consider all information submitted by Participant, regardless of whether it was part of the original claim.

Adverse Determination of Permanent Disability

Any adverse determination of a claim, either initially or on review, shall provide a discussion and an explanation of the following, as applicable:

- a) The views presented by Participant to the Plan of the health care professionals treating him or her and vocational professionals who evaluated him or her;
- b) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with Participant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
- c) With regard to a permanent disability determination, a discussion of any determination made by the Social Security Administration.
- d) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- e) A discussion of either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination, or, alternatively, in the case of a permanent disability determination, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.
- f) A statement that Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Participant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to the Department of Labor regulations, which are hereby incorporated by reference.
- g) A statement that any period for filing a lawsuit will expire no later than one (1) year following the date of the final decision on review.

In case of an adverse benefit determination with respect to permanent disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner if required by the procedures described below.

The term adverse determination means:

- i. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and
- ii. In the case of a Plan providing disability benefits, the term "adverse benefit determination" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Requirements With Respect to New or Additional Evidence or New or Additional Rationale in a Review of a Permanent Disability Determination

In a review of permanent disability benefits, the following rules govern new or additional evidence, or a new or additional rationale relied upon by the Administrator:

- a) Before the Plan can issue an adverse benefit determination on review on a permanent disability benefit claim, the Administrator shall provide Participant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in

advance of the date on which the notice of adverse benefit determination on review is required to be provided hereunder, to give Participant a reasonable opportunity to respond prior to that date; and

- b) Before the Plan can issue an adverse benefit determination on review on a permanent disability benefit claim based on a new or additional rationale, the Administrator shall provide Participant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided hereunder, to give Participant a reasonable opportunity to respond prior to that date.

Requirement for Culturally and Linguistically Appropriate Notice for Permanent Disability Determination With Respect to an Applicable Non-English Language

Additional disclosures are required with respect to an “Applicable Non-English Language.” With respect to an address in any United States county to which a notice regarding an adverse determination with respect to a permanent disability is sent, a non-English language is an “Applicable Non-English Language” requiring additional disclosure if 10% or more of the population residing in the county is literate only in the same non-English language, as determined by guidance based on American Community Survey data published by the United States Census Bureau. In such a case, the Administrator must comply with the following additional requirements:

- a) The Administrator must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language;
- b) The Administrator must provide, upon request, a “notice” in any applicable non-English language; and
- c) The Administrator must include in the English versions of all such notices a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

Failure to Comply With Disability Claims Procedures

If the Plan fails to strictly adhere to all the requirements of this Section with respect to a claim, Participant is deemed to have exhausted the administrative remedies available under the Plan, except as provided below. Accordingly, Participant is entitled to pursue any available remedies under ERISA Section 502(a) (i.e., bring suit in federal court) on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If Participant chooses to pursue remedies under ERISA Section 502(a) under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

Notwithstanding the foregoing, the administrative remedies available under a Plan with respect to claims for benefits will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to Participant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and Participant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. Participant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within two (2) days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects Participant’s request for immediate review on the basis that the Plan met the standards for the exception under this Section, the claim shall be considered as re-filed on appeal upon the Plan’s receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide Participant with notice of the resubmission.

If you have questions about any plan, you should contact the Plan Administrator. If you have any questions about the statement quoted above, or if you should need other assistance or information concerning your rights under ERISA, you should contact the United States Department of Labor at the following address:

U.S. Department of Labor, Employee Benefits Security Administration 61 Forsyth Street, SW, Atlanta, GA 30323

You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210



General Information

The information contained in this section provides important legal and administrative information about how the Employee Benefit Plans are administered, your rights to benefits from these plans and the process of attempting to resolve a problem you might have with any of the plans. The information in this section explains:

- Your rights under Employee Retirement Income Security Act of 1974, as amended (ERISA);
- How to contact the Plan Administrator or Plan Trustee;
- Additional information on rights that you may have as a plan participant.

This Summary Plan Description does not constitute an implied or expressed contract or a guarantee of employment. You should read this material carefully and keep it for future reference.

Plan Sponsor

All ERISA-covered benefit plans referred to in this Summary Plan Description are sponsored by Savannah River Nuclear Solutions, LLC (referred to in this document as SRNS or the Company).

Plan Administrator

The Plan Administrator is responsible for maintaining the records related to and administration of ERISA-covered benefit plans. The Plan Administrator also has the sole discretion to decide all issues of fact or law. The Plan Administrator reserves the right to request, at any time, documents to determine eligibility for benefits and to resolve appeals. The Plan Administrator(s) for the retirement plans and self-insured welfare plans is designated by the Company Health & Welfare and Savings & Pension Benefits Committees. Correspondence to the Plan Administrator should be sent to the address noted for the Plan Administrator in the Plan Information section below.

Plan Numbers

A Plan Number has been assigned to each plan for identification purposes. The Plan Numbers are listed in the Plan Directory located at the end of this Summary Plan Description, along with the formal name of each plan. You should use the formal name of the Plan and the Plan Number in all correspondence relating to the plans.

Plan Documents

Any insurance company contracts and trust agreements that govern the operation of the plans are incorporated herein and made part of the Plans.

In the event of a conflict between an insurance contract and this document, the terms of the insurance contract will control. Copies of plan documents, together with Plan annual reports and descriptions are available for review by any plan participant, spouse or beneficiary. If you would like to review a copy of these documents, contact your Plan Administrator.

Plan Financing and Administration

The Short Term Disability Income Plan is self-insured, self-administered and paid from the general assets of the Company. The buy-up benefit under the STD Plan is funded by after-tax contributions from the eligible employees that are held in trust. The Long Term Disability Income Plan is self-insured and paid from the general assets of the Company. The Long Term Disability and Incapability Retirement Claims Administrator is Sedgwick CMS. The Incapability Retirement benefit is a provision of the Pension Plan and paid from the Pension Trust.

Future of the Plans

While the Company expects to continue the plans for an indefinite period of time, the Company, by action of its Board of Directors and/or the Company Benefits Committee, reserves the right at any time and from time to time to modify or amend in whole or in part any or all of the provisions of the plans.

Assignment of Benefits

The Plan is used exclusively to provide benefits to you. Benefits under the Plans cannot be assigned, sold, transferred, or encumbered, in whole or in part, either directly or by operation of law or otherwise, and any attempt to do so shall be null and void except to the extent required by law. Health care providers are not, and shall not be construed as, either "participants" or "beneficiaries" under the Plans and have no rights to receive benefits from the Plans or to pursue legal causes of action on behalf of (or in place of) participants and beneficiaries under any circumstances.

No Guarantee of Employment

No person shall have any legal or equitable rights against SRNS or the Plan, except as, and only to the extent, expressly provided for in the Plan or by law. Neither the establishment nor amendment of the Plan or the creation of any fund or account, or the payment of benefits, nor any action of SRNS or the Plan Administrator shall be held or construed to confer upon any person any right to be continued as an employee or to affect the terms of their employment in any way, or, upon dismissal, any right or interest in any account or fund other than as herein provided. Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any employee and SRNS to the effect that the employee will be employed for any specific period of time. All employees are considered to be employed at the will of SRNS.

Subrogation

If the Plans pay any claim on your behalf for injury or sickness for which another party is responsible, or for which uninsured/underinsured motorist (UIM) or personal Injury protection (PIP) insurance or other similar type of insurance or contract exists, the Plans are entitled to be repaid for the amounts paid out of any recovery from that responsible party. The responsible party is also known as the “third party” because it is a party other than you or these Plans. Your submission of claims for injury or sickness caused by a third party constitutes your agreement to the terms of this provision and your grant to these Plans a first priority equitable lien by agreement. The Plan Administrator (or its delegate) has sole discretionary authority to determine when to pursue an equitable lien and to resolve all disputes regarding subrogation and reimbursement.

The Plans are entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the full amount of benefits paid by the Plans for your injury or sickness caused by the third party, whether or not you have been made whole. The Plans’ right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. This right allows the Plans to pursue any claim against any third party or insurer, whether or not you choose to pursue that claim. The Plans’ rights and priority extend to the full amount of all claims paid or to be paid by the Plans for injury or sickness caused by the third party and extend to any costs that result from the enforcement of its rights.

The Plans’ first priority right will not be reduced due to your own negligence. In addition, the Plans’ first priority right will not be subject to any reduction on the ground that you are not made whole or by application of the common fund doctrine or any other responsibility for payment of attorneys’ fees and costs.

If you retain an attorney or other agent to represent you in attempting to collect from a third party, you must require that legal representative to reimburse the Plans directly from any settlement or recovery. Before accepting any settlement on your claim against a third party, you or your legal representative must notify the Plans in writing of the terms or conditions upon which the settlement is offered, and you or your legal representative must notify the third party of the Plans’ first priority interest in any settlement established by this provision. You must also cooperate with the Plans in recovering amounts paid by the Plans on your behalf. If you or your legal representative fail to cooperate fully with the Plans in the recovery of amounts paid by the Plans for injury or sickness caused by a third party as described above, you are responsible for reimbursing the Plans in full for such benefit.

You or your legal representative must, within 14 business days of receiving a request from the Plans, provide all requested information and sign and return all requested documents for purposes of exercising the Plans’ rights under this provision.

To the extent that you recover from a third party, you agree to hold, and to instruct your attorney to hold, any recovered amounts in trust or in a segregated account until your subrogation, reimbursement, and equitable rights of recovery are fully determined.

Overpayments

If, for any reason, an overpayment is erroneously made under any of these plans, the participant shall be responsible for refunding the amount to the plan. The repayment shall be made pursuant to the method established by the Plan Administrator. The methods of repayment may include, but are not limited to, you making the repayment in a lump sum, or installment payments, or by deductions taken from payroll. The Plan reserves the right to offset overpayments against future benefit payments until reimbursement is received. The Plan has the right to recover overpayments from your estate and to take any appropriate collection activity available to collect overpaid amounts.

Note: If an overpayment occurs because you conceal, misrepresent or give misleading information (for example regarding your employment, earnings, medical condition or receipt of SSDI) your benefit may be terminated, and you must repay the amount of the overpayment.

Legal Service

If you believe you have been improperly denied a benefit under any of the plans, and after you have exhausted the administrative claims and appeals process, you may begin legal action and serve legal papers on the agent for service of process, the Plan Administrator, any trustee of the plans or the related insurance companies or claims administrators.

The addresses for the insurance companies, claims administrators and/or trustees can be found in the Plan Information section at the end of this booklet. The Plan Administrator's address is also shown in the Plan Information section. For legal action, the name and address for the agent for service of process on the Plan Administrator is:

Corporation Service Company

1703 Laurel Street

Columbia, SC 29201

Phone: (800) 927-9800



ERISA rights

Although ERISA does not require that an employer provide benefits, it does set standards on how a plan is run and requires that you be kept informed of your rights and benefits.

As a participant or beneficiary in the Employee Benefits Program, you are entitled to certain rights and protection under ERISA. Federal regulations require that all Summary Plan Descriptions include the following statement:

ERISA provides that you may:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as your personnel office, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, Pension and Welfare Benefits Administration, such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- The Plan Administrator is required by law to furnish each participant with a copy of the Plan's "Summary Annual Report" or SAR.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefits Plans. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. The fiduciaries are given specific authority under the plan. The determination of matters under their authority will be final and binding.

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 benefit or exercising your rights under ERISA. If your application for a benefit 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 Administrator review and reconsider your application.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from a 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 \$110.00 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 an application for benefits which you believe was improperly denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that the 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, Pension and Welfare Benefits Administration, 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/or fees. If you lose, the court may order you to pay these costs and/or fees (for example, if it finds your claim frivolous or without reasonable cause).



Plan information

Type of Plan: Disability Income Benefits – Long Term Disability

Plan Name: SRNS Disability Income Plan

Plan Year: January 1 - December 31

Plan Number: 525

Plan Sponsor: Savannah River Nuclear Solutions, LLC

Plan Sponsor

Employer

Identification

Number: 26-0240191

Plan

Administrator: Disability Income Plan Administrator

Savannah River Nuclear Solutions, LLC

Building 730-2B

Aiken, SC 29808

Phone: (803) 725-7772

(800) 368-7333

Agent for Legal

Process:

Corporation Service Company

1703 Laurel Street

Columbia, SC 29201

Phone: (800) 927-9800

LTD and IR Claims

Administrator: Sedgwick Claims Management Services, Inc.

P.O. Box 14454

Lexington, KY 40512-4454

Phone: (800) 231-0165

Funding:

Plan is unfunded and paid from the general assets of the Company.



Plan information

Type of Plan: Disability Income Benefits – Short Term Disability

Plan Name: SRNS Disability Income Plan

Plan Year: January 1 - December 31

Plan Number: 526

Plan Sponsor: Savannah River Nuclear Solutions, LLC

Plan Sponsor
Employer
Identification

Number: 26-0240191

Plan

Administrator: Disability Income Plan Administrator

Savannah River Nuclear Solutions, LLC
Building 730-2B
Aiken, SC 29808
Phone: (803) 725-7772
(800) 368-7333

Agent for Legal
Process:

Corporation Service Company
1703 Laurel Street
Columbia, SC 29201
Phone: (800) 927-9800

LTD and IR Claims

Administrator: Sedgwick Claims Management Services, Inc.
P.O. Box 14454
Lexington, KY 40512-4454
Phone: (800) 231-0165

Funding:

Plan is unfunded and paid from the general assets of the Company held in a grantor trust. Any employee contributions are incidental to a cafeteria plan, generally utilized within 90 days and are held in a grantor trust.

Contacts

Short Term Disability Contact Information

DCM / 5SICK: (803) 725-7425 (5-SICK)

E-mail: 5sick@srs.gov

Long Term Disability Contact Information Sedgwick Claims Management Service

P.O. Box 14454

Lexington, KY 40512-4454

Phone: (800) 231-0165

Fax: (952) 826-3889



Glossary of helpful terms

Appropriate Care means the determination of an accurate and medically supported diagnosis of disability by a Treating Provider, or a plan established by a Treating Provider of ongoing medical treatment and care of your disability that conforms to generally accepted medical standards, including frequency of treatment and care.

Disability Case Management (DCM / SSICK) means staff functioning as case managers for the purpose of approving and managing short term disability claims.

Eligible Earnings means your regular base pay, as of the pay period prior to your Disability start date. Eligible earnings do not include overtime, shift differential, bonus payments, quality awards, detail pay and any other form of special or extra compensation that is not considered part of your base pay earnings.

Essential Functions of Your Normal Occupation are the fundamental job duties intrinsic to the employment position that you hold. These do not include marginal or peripheral functions. In determining the essential functions of a job, the focus is on the purpose of the function and result to be accomplished, rather than how the function is performed.

Full Service Employee (FSE) is an employee on the active payroll who is scheduled to work 20 or more hours per week, and who is hired to fill a permanent job vacancy. There are two sub-categories of full service employees – full time employees (works a minimum average of 40 hours per week) and part time employees (scheduled to work a minimum of 20 hours per week.)

Incapability Retirement Participants in the Pension Plan who are eligible for an early pension benefit, if they have a minimum of 15 years of Eligibility Service (regardless of age) and cannot perform the duties of their own job.

Incumbent Employees are employees who meet eligibility requirements and actively participate in the Pension Plan. (This is a closed group. If you terminate employment from the Company and are subsequently rehired, you will no longer be an Incumbent employee.)

Independent Medical Evaluation (IME) means a medical examination performed by an independent Treating Provider.

Option A Craft Employees include Craft employees who selected the Company benefit plan effective 4/1/1989 and have been continuously employed by the Company and predecessor companies. This is a closed group. If you terminate employment from the Company, and are subsequently rehired, you will no longer be considered an Option A Craft employee with Disability Plan eligibility.

Plan means the SRNS Short Term Disability Plan or Long Term Disability Plan.

Reasonable Occupation means any occupation that you are reasonably capable to perform within your documented current medical restrictions.

Treating Medical Physician means a person who is a legally qualified medical physician practitioner according to the laws and regulations of the governing jurisdiction who is performing tasks within the scope of his or her license and rendering care and treatment to you that is appropriate for your medical condition and locality. The term does not include you, your spouse, your immediate family (including parents, children, siblings, or spouses – whether the relationship is from blood or marriage) or a person living in your household.

You implies the eligible employee.

