



Summary Plan Description

Aflac Critical Illness and Accident Insurance

Savannah River Nuclear Solutions, LLC

Amended and Restated Effective January 1, 2025

Savannah River Nuclear Solutions, LLC Summary Plan Description

Aflac Critical Illness and Accident Insurance

Summary Plan Description

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Savannah River Nuclear Solutions, LLC (“Employer”) is pleased to make available to its employees the Critical Illness and Accident Aflac Group Supplemental Insurance Plan.

The Plan provides limited supplemental health and/or accident coverage through insurance policies issued by Continental American Insurance Company (“Aflac Group”).

The benefits available will vary depending upon which policies are offered by Employer and are described in detail in the individual Aflac Group policy certificates you will receive from your employer upon enrolling for such coverage.

The official policy certificate you receive (along with this booklet and any Riders) constitutes the formal Plan document and summary Plan description for the Aflac Group limited supplemental health, and/ or accident coverage in which you enroll.

If there is a disagreement between this booklet and the Aflac Group policy you receive, the insurance policy documents will always govern.

The benefit(s) described in this summary plan description are also governed by the terms of the SRNS Welfare Benefit Plan, referred to as a Wrap Plan.

Take time to review your Aflac Group policy certificate(s). If you have questions about your policy coverage, call Aflac Group at 800.433.3036 with questions. Please note, however, that information obtained during calls to Aflac Group, or your Employer do not waive any provision or limitation of your policy or the Plan.

To view this guide online, go to [www.srs.gov/general/ jobs/benefits/documents/Aflac_SPD.pdf](http://www.srs.gov/general/jobs/benefits/documents/Aflac_SPD.pdf)

Questions?

Claims

Online: www.aflacgroupinsurance.com

> Customer Service > File a Claim Email: groupclaimfiling@aflac.com Fax: 1.866.849.2970

Aflac Administrative Address:

P.O. Box 84075, Columbus, GA 31993

Aflac Group Customer Service

803.725.7772 or 800.368.7333

Service-Center@srs.gov

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

SRNS Service Center

Building 730-1B, Aiken SC 29808 803.725.7772 or 800.368.7333

Email: Service-center@srs.gov

Benefits, Eligibility and Enrollment

Types of benefits

Aflac Group supplemental health benefits generally pay a specified fixed amount for Critical Illness and certain specified diseases described in the policy certificate(s).

Accident coverage provides indemnity benefits for certain specified accidental occurrences. See your individual policy certificate for a comprehensive description of the Aflac Group supplemental benefits.

There are key limitations and exclusions under each policy. You must refer to your policy certificate to review these limitations and exclusions. All benefits available under the policy will be determined by Aflac Group, not Employer.

Post-tax benefit deduction

The Aflac Insured benefits, Critical Illness and Accident coverage, are premium amounts are paid on a post-tax basis. You should consult your tax advisor about the taxability of benefits under your Aflac Group policy.

Eligibility

Who is eligible?

You are eligible to apply to Aflac Group for the limited supplemental benefits:

- Full-Service employees are benefit eligible.
- Full-Service Employees must work a minimum of 20 hours per week.
- Waiting period: 1st of the month following date of hire or Qualifying Status Change
- Employees must be Actively-at-Work when electing coverage.
- Employees must be Actively-at-Work on the effective date of coverage.
- Actively-at-Work refers to an employee's ability to perform his regular employment duties for a full normal workday. The employee may perform these activities either at his employer's regular place of business or at a location where he is required to travel to perform the regular duties of his employment.

Note: Aflac has no restrictions on dual couple or dual dependent coverage. While this is not recommended, it is not restricted or monitored.

Are dependents eligible for coverage?

If you are an eligible employee, coverage may also be available for your eligible dependents.

The availability of dependent coverage (and definition of who is an eligible dependent) may be subject to underwriting by Aflac Group and may vary based on the Aflac Group coverage selected. Dependent coverage may be limited or denied in instances where a dependent or the employee has a pre-existing condition or has previously been diagnosed with a disease for which he or she now seeks coverage.

Refer to the Aflac Group policy certificates for more information.

Enrollment

When can I enroll?

You may apply for, or change, coverage elections during the following times:

- Annual Open Enrollment
- New Hire/Newly Eligible
- Within 60 days of certain valid Status Changes Refer to your policy certificate for details.

When does coverage begin?

Your policy will be effective on the date that Aflac Group issues a policy and/or such later date specified in the policy certificate as may apply to you.

The employee's effective date is the date his insurance takes effect. This date is:

- Annual Open Enrollment: January 1
- New Hire/Newly Eligible Employees: First of the month following date of hire or eligibility.
- Qualifying Life Event: First of the month following election date.

If you declined coverage this year and you do not enroll in coverage for next year during Annual Open Enrollment, you will not be able to apply for coverage for next year unless you have a valid Status Change event.

Changes in Coverage

Can I change my coverage?

You can change your elections during an Open Enrollment Period. Otherwise, federal tax laws generally require that, if you remain eligible for this benefit, the choices you make under the Plan remain in effect for the entire plan year. There are limited exceptions to this rule. Those exceptions are described in the summary plan description for the cafeteria plan and are called Status Change events.

If you wish to change your election based on a Status Change, you must establish that the revocation is on account of and corresponds with the Status Change. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and corresponds with a Status Change. Elections due to a Status Change must be filed within 60 days of the status change event.

Also, if you have changed marital status, or you or your spouse have changed your address, please notify Aflac Group and Savannah River Nuclear Solutions, LLC Service Center, at the address listed in your individual policy and Savannah River Nuclear Solutions, LLC Service Center.

Status Change Rules

1. Marriage

If the eligible employee (EE) is currently covered, can add spouse/ dependent child in accordance with underwriting rules applicable to newly eligible employees and dependents. Coverage amounts are based upon EE's current face amount. If EE wishes to increase their face amount at this time, they may do so. Must submit request within 60 days of event. If EE is not currently covered, can apply for coverage in accordance with underwriting rules applicable to newly eligible employees and dependents. Must submit request within 60 days of event. Verification will be required, and effective date of coverage will be the 1st of the month following approval, based on submission rules and platform capabilities.

2. Divorce, legal separation, annulment

If EE is currently covered, can add dependent child in accordance with underwriting rules applicable to newly eligible employees and dependents and/or cancel spouse. Coverage amounts are based upon EE's current face amount. If EE wishes to increase their face amount at this time, they may do so. Must submit request within 60 days of event.

If EE is not currently covered, can apply for coverage in accordance with underwriting rules applicable to newly eligible employees and dependents. Must submit request within 60 days of event. Verification will be required, and effective date of coverage will be the first of the month following approval, based on submission rules and platform capabilities.

3. Birth, adoption, or placement for adoption

If EE is currently covered, can apply for coverage in accordance with underwriting rules applicable to newly eligible employees and dependents. Coverage amounts are based upon EE's current face amount. If EE wishes to increase their face amount at this time, they may do so. Must submit request within 60 days of event. If EE is not currently covered, can add spouse/dependent child in accordance with underwriting rules applicable to newly eligible employees and dependents. Must submit request within 60 days of event. Verification will be required, and effective date of coverage will be the 1st of the month following approval, based on submission rules and platform capabilities.

4. Death of a spouse

May cancel spouse at any time. If EE is currently covered, can add dependent child(ren) without EOI within 60 days of event. Coverage amounts are based upon EE's current face amount. If EE wishes to increase their face amount at this time, they may do so. If EE is not currently covered, can apply for coverage in accordance with underwriting rules applicable to newly eligible employees and dependents. Must submit request within 60 days of event.

Verification will be required, and effective date of coverage will be the first of the month following approval, based on submission rules and platform capabilities.

5. Death of a dependent child

Can drop coverage any time.

6. Dependent child ceases to satisfy eligibility requirements

Coverage will drop for ineligible dependent. It is the employee's responsibility to notify Aflac.

7. Dependent child satisfies eligibility requirements

If EE is currently covered, can add spouse/dependent child without EOI. Coverage amounts are based upon EE's current face amount. If EE wishes to increase their face amount at this time, they may do so. Must submit request within 60 days of event. If EE is not currently covered, can apply for coverage in accordance with underwriting rules applicable to newly eligible employees and dependents. Must submit request within 60 days of eligibility being met.

Verification will be required, and effective date of coverage will be the first of the month following approval, based on submission rules and platform capabilities.

8. Loss of spouse's employment or decrease in hours that causes loss of coverage.

If EE is currently covered, can add spouse/dependent child without EOI. Coverage amounts are based upon EE's current face amount.

If EE wishes to increase their face amount at this time, they may do so. Must submit request within 60 days of event. If EE is not currently covered, can apply for coverage in accordance with underwriting rules applicable to newly eligible employees and dependents. Must submit request within 60 days of event. Verification will be required, and effective date of coverage will be the first of the month following approval, based on submission rules and platform capabilities.

9. Commencement of spouse's employment or increase in hours that includes gain of coverage

Can drop coverage within 60 days of event.

10. Change in Work Assignment which results in a change in eligibility

If EE is currently covered, can add spouse/dependent child without EOI. Coverage amounts are based upon EE's current face amount. If EE wishes to increase their face amount at this time, they may do so. Must submit request within 60 days of event. If EE is not currently covered, can apply for coverage in accordance with underwriting rules applicable to newly eligible employees and dependents. Must submit request within 60 days of event. Verification will be required, and effective date of coverage will be the first of the month following approval, based on submission rules and platform capabilities.

11. Death of Employee

For Critical Illness: If the employee has spouse coverage and the employee dies, the spouse can keep their benefit amount at the same. (There is no re-rating.) If the employee has no spouse coverage, the spouse and/or dependents cannot port/convert the employee's benefit to themselves or elect new coverage.

For Accident: If spouse coverage is in force at the time of the employee's death, the surviving spouse may elect to continue coverage. Coverage would continue according to the existing plan (and rates) and would also include any dependent child coverage in force at the time. A new certificate would be issued.

Please contact Aflac to discuss the option to continue coverage. Premiums will be paid directly to Aflac.

Rehired employees and Leaves of Absence

You may continue your coverage while on any leave of absence by making payments directly to Aflac Group during your leave. If you stop making payments during your leave, you may have the coverage under the group plan policy reinstated (subject to the plan's guidelines and to Aflac Group underwriting). See the policy for details. However, your policy certificate will not cover events that occurred during the time that the policy had lapsed.

If you did not continue to make payments on your policy and return to work, you must make a new election and satisfy any new waiting period.

If you are on leave of absence governed by the Family and Medical Leave Act, or military leave, you may be entitled to have your coverage reinstated upon your return to work to the extent required by applicable federal law.

In the event of beginning unpaid leave the employee should contact Aflac. Upon notification of an employee's unpaid leave starting, Aflac will mail a letter to the employee notifying them of their option to remit premium directly.

If the employee maintains their premium while on leave, coverage will continue with no interruption. Once the employee returns to work, normal premium payroll deductions will continue.

If premiums are not maintained while on leave, and the employee returns within 90 days from the approved leave date, payroll deductions should resume, and coverage will be placed back in force on the 1st of the month following their return date. There will be a gap in coverage for the time period that the employee was on leave. This gap of coverage is a period where coverage is not in force. During this gap no premium would be due, and no claims would be payable. Aflac will notify the employer of any gap in coverage.

If premiums are not maintained while on leave and the employee does not return within 90 days from the approved leave date, their coverage will terminate on the 91st day. Aflac will notify the employer of the termination.

- If the employee returns after 90 days, then they must wait until the next annual open enrollment to re-apply for coverage.
- If the employee is on military leave and returns within 5 years, their coverage can be reinstated.

Termination of plan participation

When does coverage end?

Your coverage and your dependents' coverage will end on the earliest of:

- When you fail to make the required premium contribution;
- With respect to your covered dependent(s), when they no longer qualify as eligible dependents as defined in the policy(ies); or
- Any other earlier termination date specified in the Aflac Group policy(ies).
- If you terminate your employment coverage ends on the termination date. You may be able to continue your coverage. Please contact Aflac to discuss the Portability option to continue coverage.

Portability

Insureds who have terminated employment or are no longer benefit eligible have the option to continue their coverage with the same benefits and the same premiums. The only difference is that instead of having premiums payroll deducted, payments would be made directly to Aflac. Upon notification of the employee's termination, Aflac will mail a letter to the employee notifying them of their option to port their plan(s). Employees will be required to call the Aflac customer service center within 45 days of their termination date to request to continue their coverage on a direct-bill basis.

Benefits at a Glance

To view a summary of benefits for Accident and Critical Illness insurance, click on the appropriate link below.

[Aflac : Employee View](#)

Plan Rates for Accident and Critical Illness

Aflac Accident Plan Rates

Monthly premiums are shown. Weekly deductions will be taken in four equal installments.

Low Plan Option: Premium Rates

Coverage	Premium
Employee	\$4.57
Employee + 1	\$7.69
Family	\$10.68

High Plan Option: Premium Rates

Coverage	Premium
Employee	\$8.80
Employee + 1	\$14.60
Family	\$20.39

Accident Low/High

Rate structure is tiered. This rate structure is a composite rate set on the following coverage options:

- Employee Only
- Employee + 1 (Employee and 1 spouse or 1 dependent child)
- Family (Employee and 2 or more dependent children or 1 child + spouse)

Issue Ages: Age is based on the date the employee elects coverage.

- Employee 18+, no age maximum
- Spouse 18+, no age maximum
- Children ages 0-25, cannot enroll after age 25*

**However, Aflac will continue coverage for Dependent Children insured under the plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical handicap and are chiefly dependent on a parent for support and maintenance.*

Certification

Employees will be required to read and acknowledge the following Certification for both Accident and Critical Illness.

If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill. You should contact your insurance carrier for an explanation of your options for both continuation or cancellation of your existing coverage.

If a covered child reaches a limiting age as specified in the certificate or a rider, it is your responsibility to notify the company.

Coverage will not become effective unless you are actively at work on the Certificate Effective Date. If you are not actively at work on that date, coverage will become effective on the date you return to an active work status.

CERTIFICATION: I have read the completed Employee Application and the statements and answers that pertain to me and my spouse and my children. I acknowledge that these statements and answers are true and complete to the best of my knowledge and belief, and that the statements and answers will be used by the insurance company to determine insurability. I realize any false statement or misrepresentation in the Employee Application may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Employee Application is approved and the necessary premium is paid.

- I understand and agree that the coverage that I am applying for may have pre-existing condition exclusion.
- I acknowledge that I am actively at work.
- I acknowledge that I have accurately disclosed my usage of tobacco products in the past 12 months.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situated in California, group coverage is underwritten by Continental American Life Insurance Company. For groups situated in New York, coverage is underwritten by American Family Life Assurance Company of New York.

Critical Illness

The Critical Illness rate is age banded and Tobacco-Rated. That means your rates may increase on the Policy Anniversary Date. The age band is determined by

the employee's age even when electing spousal coverage. The Tobacco-Rated premium is determined based on the employee's certification only.

Issue Ages – see below for when age is determined:

- Employee 18+, no age maximum
- Spouse 18+, no age maximum
- Children ages 0-25*

**Dependent Children are automatically covered at 50% of the employee election at no additional cost. No election data is required for Dependent Children on the Critical Illness plan.*

Rate Structure

- Age Banded: Five-year age bands.
- Attained Age: Rates should be calculated off the group's plan year.
 - Open Enrollment, premium will be based on the age of the employee as of January 1, 2020.
- New Hires premium will be based on the current plan year anniversary.
 - Example: Current plan year begins January 1, 2020, and the insured's coverage effective date is July 1, you will calculate their age as of January 1, 2020.
- Employees will have their age recalculated on each plan year anniversary.
- Spouse's age is based upon the employee's age.
- Tobacco Distinct
 - The employee's tobacco status will determine if premiums are Tobacco- or Non-Tobacco-rated.
 - Spouse's tobacco status is based upon the employee's status Tobacco Status:
- Tobacco: Employee has used any tobacco products in past 12 months.
- Non-Tobacco: Employee has not used any tobacco products in past 12 months.

Definition of Tobacco use: Employee has used any tobacco products in the past 12 months Spouse's tobacco status is based upon the employee's Tobacco products include: Cigarettes, electronic cigarettes (e-cigarettes), pipes, cigars, chewing tobacco, smokeless tobacco or other tobacco products. Non-Tobacco = Employee has not used any tobacco products in the past 12 months.

The Critical Illness plan is Guaranteed Issue, and no evidence of insurability is required.

Benefit Amounts

- Employee: \$10,000 or \$20,000
- Spouse: \$5,000 or \$10,000
 - Spouse is eligible up to 50% of the employee benefit amount.
- Eligible Dependent Children are automatically covered at 50% of the employee election at no additional cost.

Coverage Options

- Employee Only
- Employee + Spouse

Aflac Critical Illness Rates

Monthly premiums are shown. Weekly deductions will be taken in four equal installments.

Employee Non-Tobacco Monthly Premiums

Age	\$10,000	\$20,000
18-25	\$3.93	\$6.34
26-30	\$5.00	\$8.48
31-35	\$5.69	\$9.86
36-40	\$7.22	\$12.91
41-45	\$8.59	\$15.66
46-50	\$10.14	\$18.76
51-55	\$15.36	\$29.20
56-60	\$14.98	\$28.43
61-65	\$30.26	\$50.01
66+	\$53.09	\$104.66

Spouse Non-Tobacco Monthly Premiums

Age	\$5,000	\$10,000
18-25	\$2.73	\$3.93
26-30	\$3.26	\$5.00
31-35	\$3.60	\$5.69
36-40	\$4.37	\$7.22
41-45	\$5.05	\$8.59
46-50	\$5.83	\$10.14
51-55	\$8.44	\$15.36
56-60	\$8.25	\$14.98
61-65	\$15.89	\$30.26
66+	\$27.30	

Employee Tobacco Monthly Premiums

Age	\$10,000	\$20,000
18-25	\$5.05	\$8.59
26-30	\$6.52	\$11.52
31-35	\$8.00	\$14.47
36-40	\$10.63	\$19.73
41-45	\$12.69	\$23.85
46-50	\$15.06	\$28.61
51-55	\$23.43	\$43.35
56-60	\$23.67	\$45.82
61-65	\$46.82	\$92.13
66+	\$80.45	\$159.39

Spouse Tobacco Monthly Premiums

Age	\$5,000	\$10,000
18-25	\$3.29	\$5.05
26-30	\$4.02	\$6.52
31-35	\$4.76	\$8.00
36-40	\$6.07	\$10.63
41-45	\$7.10	\$12.69
46-50	\$8.29	\$15.06
51-55	\$12.48	\$23.43
56-60	\$12.60	\$23.67
61-65	\$24.17	\$46.82
66+	\$40.99	\$80.45

Claims and Appeals

How do I file a claim?

Claims must be filed directly with Aflac Group. Specific instructions for filing your claim with Aflac Group are included in each Aflac Group supplemental benefit policy in which you enroll.

How do I appeal a denial of a claim?

Any denial of a claim for benefits will be provided by Aflac Group in accordance with the policy certificate provisions. You will receive notice of a denial as soon as reasonably possible but no later than 30 days (for medical) or 45 days (for disability claims) after Aflac Group receives the claim (filed in accordance with the Aflac Group supplemental policy).

In special circumstances, an extension of time may be needed to decide (e.g., we may need additional information). In that case, Aflac Group may take a 15-day extension (for medical claims) or two 30-day extensions (for disability claims). You will receive written notice of the extension before the end of the 30/45-day period (whichever is applicable).

Generally, your denial will consist of a written explanation which will include (i) the specific reasons for the denial, (ii) reference to the specific provisions upon which the denial is based, (iii) a description of any additional information you might be required to provide and explanation of why it is needed, and (iv) an explanation of the claim review procedure.

You, your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to Aflac Group.

You may also submit with your appeal any comments, documents, records and issues that you believe support our claim (even if you have not previously submitted such documentation).

You may have representation throughout the review procedure. An appeal must be filed with Aflac Group in accordance with the claim filing procedures described in your denial letter within 180 days of receipt of the written notice of denial of a claim.

The full, fair and independent review will be held, and a decision rendered by the Claims Administrator, no later than 60 days (if for a medical claim) or 45 days (if for a disability claim) after receipt of your written appeal. In addition, the Claims Administrator may take a 45-day extension for any disability claims for reasons beyond the Claims Administrator's control.

The decision after your review will be in writing and will include information like that which was included in your first denial letter. You may request, free of charge, and at any time during the appeal process, all documents that are relevant (as defined by ERISA) to your claim. If your claim is denied, you have the right to bring an action in federal court in accordance with ERISA 502(a). You cannot take any legal action until you have exhausted the claims review procedures described above.

If you wish to have a third-party file the appeal on your behalf, you must have them submit with the written appeal a written authorization executed by you. If the third party is an individual other than your treating provider, then the authorization must comply with the applicable terms of the Health Insurance Portability and Accountability Act ("HIPAA").

All claims decisions are made solely by Aflac Group, not Employer.

ERISA

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office, all Plan documents, including insurance contracts and copies of all documents filed by the Plan Administrator with the U.S. Department of Labor or the Internal Revenue Service such as detailed annual reports.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator, which may make a reasonable charge for the materials.
3. Receive a summary of the Plan's annual financial report; if it files an annual report, the Plan Administrator is required by law to furnish each Plan Participant with a copy of the summary annual report.

In addition to creating rights of Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These persons are referred to as "fiduciaries" of the Plan. Fiduciaries must act solely in the interests of Plan Participants, and they must exercise prudence in the performance of their Plan duties.

Your employer must not discharge you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under this Plan or exercising your rights under ERISA. If your claim for benefits is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the claim reviewed and your claim reconsidered. If your claim for benefits is denied in whole or in part after a final review, or if your claim is ignored, you may file suit in a state or federal court.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials in writing from the Plan Administrator and do not receive them within 30 days, you may file a suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials, pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If fiduciaries are misusing the Plan's money, or if you are discriminated against for asserting your rights, you have a right to file suit in a federal court or request assistance from the U.S. Department of Labor. The court will decide who should pay court costs and legal fees. If you are successful in your lawsuit, the court may, if it so decides, require the other party to pay your legal costs, including attorneys' fees. If you lose, the court may order you to pay the costs and fees - for example, if it finds your claim frivolous. If you have any questions about this statement or your rights under ERISA, you should contact the Plan Administrator or the nearest area office of the Department of Labor (listed in your telephone directory) or the Division of Technical Assistance and Inquiries, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.

Plan information

Plan Name	Savannah River Nuclear Solutions, LLC Aflac Accident and Critical Illness
Plan Number	525
Policy Number	Aflac Group Policy Number 25615
Plan Sponsor	Savannah River Nuclear Solutions, LLC
Plan Sponsor Employer Identification Number	26-0240191
Type of Plan	An employee welfare benefit plan providing to employee's individual insurance policies with supplemental limited benefit accident, critical illness, health coverage and/or other specific disease coverage according to a rider attached to such individual insurance policies. All coverages are underwritten by Aflac Group.
Plan Year	January 1 - December 31
Plan Administrator:	SRNS Health and Welfare Plan Administrator Savannah River Nuclear Solutions, LLC SRNS Benefits Administration Savannah River Site, Bldg. 730-1B Aiken, SC 29808 Phone: 803.725.7772 or 803.368.7333
Type of Administration	Insurer Administration
Agent for Service of Legal Process	Corporation Service Company 1703 Laurel St., Columbia, SC 29201 800.927-980
Insurer/ Claims Administrator	Continental American Insurance Company 1.800.433.3036

See your Aflac Group policy certificates for information concerning where to submit claims.

Sources and methods of contributions to the Plan

Insurance premiums for employee and family coverage are paid 100% by employees who enroll for coverage.

Funding: This Plan is fully insured. Benefits are provided under insurance contracts between you and Aflac Group. Claims for benefits are sent to Aflac Group. Benefits are payable only as determined by Aflac Group in accordance with your individual insurance policy. Aflac Group (not Employer) is solely responsible for paying claims and determining which benefits are payable.

Although Employer presently intends to continue this Plan, it reserves the right to amend or terminate the Plan at its sole discretion at any time. Certificate holders may be able to continue coverage on a direct-pay basis with Aflac Group as set forth in the applicable policy. Changes to coverage under the Aflac Group insurance policies may be made by Aflac Group in accordance with such policies.

Certificates

To view Accident and Critical Illness insurance certificates and riders, click on the appropriate link below.

[Aflac : Employee View](#)

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

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