General Dynamics Corporation

Short-Term Disability (STD) Plan

Administered by Sedgwick Claims Management Services, Inc.

Summary Plan Description

For the following eligible employees:

- A Mission Systems full-time or part-time nonrepresented employee.

Effective January 1, 2016

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What You Should Know About This Plan

This plan does not pay benefits for every event and/or loss that you believe should be covered. This plan only pays benefits for those events or losses that are described in this Summary Plan Description (“SPD”). As such, it is incumbent on you to carefully consider whether you should participate in this plan if you have the option to enroll for coverage under this plan. In some cases, this plan may not provide you or your beneficiaries with any financial benefit or may not pay for an expense that is important to you. Only you can determine whether the coverage this plan provides will actually be beneficial to you and your family. Again, this plan only pays benefits for those events and losses that are described in this SPD or other official plan documents. It will not pay benefits for events or losses that are not covered. In addition, if for any reason a benefit is paid in error or is larger than the amount allowed by the plan, the plan has the right to recover that payment.

To ensure that you and your dependents (if applicable) receive the appropriate coverage, please review this SPD carefully.

Intentionally providing false information or enrolling a dependent you know to be ineligible or willfully falsifying the documentation needed to prove a relationship with your dependent constitutes fraud and may be considered grounds for rescission of coverage, termination of employment or other legal action. (For purposes of this plan, the use of the term “dependent” refers to those individuals who are eligible to participate based on the plan’s specific requirements and may not necessarily mean that the individual is your dependent for tax purposes.)

This SPD is updated from time-to-time. This SPD replaces all prior versions. If you are not certain that you have the most recent SPD, please call the General Dynamics Service Center at 1-888-GDBENEFITS (1-888-432-3633) to confirm whether you have the most up-to-date version.
# Table of Contents

Terms You Need to Know............................................................................................................. 1  
Who Is Eligible: Employee ........................................................................................................... 2  
Who Is Not Eligible ....................................................................................................................... 2  
Cost of the Plan ............................................................................................................................ 2  
When Coverage Begins ................................................................................................................ 3  
How the Plan Works ..................................................................................................................... 3  
Benefits Chart ............................................................................................................................... 4  
State Coordination Rules ............................................................................................................ 10  
Applying for Benefits/Filing a Claim ............................................................................................ 10  
Qualifying for Disability Payments .............................................................................................. 11  
Using Paid Time Off .................................................................................................................... 12  
Partial Disability .......................................................................................................................... 12  
Subrogation ................................................................................................................................... 13  
Appealing a Denied Claim or Any Other Adverse Benefit Determination ................................... 15  
Plan Administration ...................................................................................................................... 20  
When Coverage Ends ................................................................................................................... 20  
Continuation of Coverage for Employees in the Uniformed Services ......................................... 20  
Family and Medical Leave Act (FMLA) ....................................................................................... 20  
Your Rights Under ERISA ........................................................................................................... 21  
Plan Financing ............................................................................................................................. 22  
Official Plan Document ............................................................................................................... 22  
The Company’s Right to Change (Amend) or Terminate This Plan............................................. 23  
Limitation on Assignment ............................................................................................................ 23  
Unclaimed Benefits ..................................................................................................................... 23  
Your Employment ......................................................................................................................... 23  
Collective Bargaining Agreement ................................................................................................. 23  
Life Events Matrix ....................................................................................................................... 24  
Disclaimer ................................................................................................................................... 24
Terms You Need to Know

Here are important terms you need to know. These terms have the specified meaning when capitalized throughout this summary plan description.

- **Actively-at-Work Requirement**: You must satisfy this requirement both for your plan coverage and your benefits coverage. Plan coverage begins on the date you become an eligible employee under the plan, provided that you have been actively at work for some or all of your regularly scheduled work hours or using an approved paid absence day as of that date. For a disability-related absence to be covered by plan benefits, you must be actively at work for some or all of your regularly scheduled work hours or using an approved paid absence day as of the last regularly scheduled workday preceding the start of the Elimination Period.

- **Benefits**: Payments of Disability or Partial Disability benefits that are approved by the Claims Administrator under the terms of this plan.

- **Company**: This term refers to General Dynamics Corporation, and in any employment context, and elsewhere as appropriate, the subsidiary or affiliate of General Dynamics Corporation that is the employing unit of those eligible to participate in the plan.

- **Elective**: Elective procedures include the following (see the row "What is Not Covered" in the section titled Benefits Chart):
  - Cosmetic surgery or treatment primarily to change appearance;
  - Sex-change surgery;
  - Sterilization procedures including reversal of sterilization;
  - Abortion (voluntary or involuntary);
  - Liposuction;
  - Cosmetic dentistry;
  - Visual correction surgery; and
  - In vitro fertilization; embryo transfer procedure; or artificial insemination.

- **Elimination Period**: The time during which you must be disabled as defined by the plan before your Benefits will begin. You must be disabled during the entire Elimination Period in order to qualify for Benefits. The Elimination Period is counted toward the Maximum Duration. For an employee who cannot satisfy the Elimination Period due to the intermittent nature of his/her disability and who is otherwise eligible for benefits under this plan, consideration will be given to modifying the consecutive nature of the Elimination Period.


- **FMLA**: Family and Medical Leave Act of 1993.

- **Maximum Duration**: The longest time you can receive disability payments under this plan.

Who Is Eligible: Employee

You are eligible to participate in this plan if you are a Mission Systems full-time or part-time nonrepresented employee.

For the purposes of benefits eligibility, you are considered a full-time employee if you are regularly scheduled to work 30 or more hours per week. For the purposes of benefits eligibility, you are considered a part-time employee if you are regularly scheduled to work at least 20 but less than 30 hours per week.

If you are in a location that offers this plan to other categories of employees, your Benefits Office will provide you with details.

Who Is Not Eligible

- Any individual classified by the Company as an independent contractor.
- Any individual who is classified by the Company as an intern and who is employed by the Company for less than 90 days.
- Any individual whose compensation for services to the Company is reported on IRS Form 1099.
- Any individual whose compensation for services to the Company is paid from a payroll or other account of another employer under contract with the Company.
- Any individual who is not paid from the Company’s payroll account or with respect to whom the Company does not issue an IRS Form W-2 (or any replacement form).
- The above exclusions shall not be affected by the Company’s misclassification of the individual’s employment status, or a determination by a court, government agency, arbitrator, or other authority that the individual is or was a common-law employee of the Company, or that the Company is or was a common-law employer, joint employer, single employer, or co-employer of the individual.

For example, workers commonly referred to as contract employees, job-shoppers, independent contractors, consultants, and leased employees (including “leased employees” as that term is used in Code Section 414(n) regardless of whether such leased employees have completed the 12-month waiting period described in Code Section 414(n)) are excluded from participation in the plan.

- Any employee represented by a collective bargaining agent, unless the applicable collective bargaining agreement specifically allows for participation.

Cost of the Plan

The Company pays the full cost of coverage.

Information about the cost of your coverage (if applicable) is available on the General Dynamics Service Center web site at www.gdbenefits.com. It can also be found in the enrollment materials posted on your work intranet or that you receive from your General Dynamics business unit (by mail or delivered at work). If you don’t have access to the enrollment
When Coverage Begins

Your coverage begins on your date of hire or on the day after you complete your waiting period, if applicable (see the section titled Who Is Eligible: Employee for information about waiting periods), provided you satisfy the Actively-at-Work Requirement as of that date.

How the Plan Works

The plan pays a benefit if you become disabled as defined by the plan due to a non-work-related illness or injury. You will receive a disability benefit for a specific amount of time. That benefit is reduced for benefits you receive from other sources, such as Social Security.
## Benefits Chart

<table>
<thead>
<tr>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Identifying Information</strong></td>
</tr>
<tr>
<td>Plan Design Group: Mission Systems Nonrepresented</td>
</tr>
<tr>
<td>Flex Status Codes: DSISAL, C4SSAL, AISFT, AISPT, AISFT and AISPT (plus Company Code H13)</td>
</tr>
<tr>
<td>Type of Service: ASO with FMLA, Self Funded</td>
</tr>
<tr>
<td>Plan Year: 2016</td>
</tr>
<tr>
<td>Account Structure:</td>
</tr>
</tbody>
</table>

### Plan Facts

<table>
<thead>
<tr>
<th>Details</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Services</td>
<td>1-800-416-1808</td>
</tr>
<tr>
<td>Web Site</td>
<td><a href="http://www.gdbenefits.com">www.gdbenefits.com</a></td>
</tr>
<tr>
<td>Claims Fiduciary</td>
<td>Sedgwick CMS</td>
</tr>
<tr>
<td>Claims Payor</td>
<td>General Dynamics Corporation</td>
</tr>
<tr>
<td>Claims Administrator</td>
<td>Sedgwick CMS</td>
</tr>
<tr>
<td>Insurer</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

### Plan Design Structure: Short Term Disability

<table>
<thead>
<tr>
<th>Details</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who pays for coverage?</td>
<td>General Dynamics Corporation pays the cost of the plan</td>
</tr>
<tr>
<td>Benefit Amount</td>
<td>70% of Base Pay weeks 2-26.</td>
</tr>
<tr>
<td>Pre-Existing Condition Limitation</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Maximum Duration</td>
<td>26 weeks, including Elimination Period</td>
</tr>
<tr>
<td><strong>Coverage</strong></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td><strong>Definition of Disabled and Disability</strong></td>
<td><strong>Disabled:</strong> You are considered to have a &quot;Disability&quot; or be 'Disabled&quot; under the Plan if, (1) as a result of a health condition that is not due to a work-related illness or injury, you are continuously unable to perform the essential duties of your regular occupation in substantially the same manner as you did immediately before the start of the applicable Elimination Period; and (2) you are in an active treatment program which is a scheduled plan that provides ongoing consultation with a physician within the scope of the specialty for the diagnosed illness or injury. &quot;Substantially the same manner&quot; means with any adjustments that the Company makes to those responsibilities. The loss of a professional or occupational license or certification does not, in itself, constitute a Disability for purposes of this Plan. A determination of &quot; Disabled&quot; status under this Plan does not constitute a determination that an individual is disabled for any other purpose. <strong>Disability:</strong> The physical or mental condition for which benefits under this plan are approved by the Claims Administrator in accordance with the plan's terms and the definition of the term &quot;Disabled.&quot; A determination of &quot;Disability&quot; under this plan does not constitute a determination that an individual has a disability for any other purpose.</td>
</tr>
<tr>
<td><strong>Definition of Base Pay</strong></td>
<td><strong>Base Pay</strong> (for purposes of this plan): For employees paid on a salaried basis, it is the amount of your salary in effect as of the start of the Elimination Period. For hourly employees paid on an hourly basis, it is your straight-time hourly rate of pay multiplied by your regularly scheduled weekly hours as of the start of the Elimination Period. &quot;Base Pay&quot; does not include bonuses, commissions, premium pay, overtime, shift differentials, or any other form of compensation other than amounts directed to the Company's 401(k) plans and Section 125 plans.</td>
</tr>
<tr>
<td><strong>Elimination Period</strong></td>
<td>The Elimination Period is seven consecutive calendar days. An Eligible Employee must be continuously Disabled for the entire Elimination Period to be eligible for Benefits. If you are ill or disabled for fewer than seven consecutive calendar days, contact your supervisor to authorize the time off. You may be eligible for pay during the Elimination Period. For an employee who cannot satisfy the Elimination Period due to the intermittent nature of his/her disability and who is otherwise eligible for benefits under this plan, consideration will be given to modifying the consecutive nature of the Elimination Period.</td>
</tr>
<tr>
<td><strong>When Benefits Begin</strong></td>
<td>Benefits begin on the first scheduled workday of absence following the Elimination Period, provided that the Claims Administrator first determines you are Disabled under the plan.</td>
</tr>
<tr>
<td><strong>Salary Increases that Impact Benefit Amount</strong></td>
<td>Increases in salary that would have otherwise been implemented if you were actively at work will be delayed until your return to work and will not be reflected in your STD benefit. Increases upon your return to active employment will follow the personnel policies set forth by your business unit or location.</td>
</tr>
<tr>
<td><strong>Coverage</strong></td>
<td></td>
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<tr>
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<tr>
<td><strong>Benefit Reductions</strong></td>
<td></td>
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<tr>
<td>STD benefits are offset by:</td>
<td></td>
</tr>
<tr>
<td>1. Any state or federal disability benefits except for veterans’ benefits, including any state-required disability program (such as those required by California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico)</td>
<td></td>
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<tr>
<td>2. Primary and family Social Security benefits due to your disability</td>
<td></td>
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<tr>
<td>3. Wage or salary for work performed</td>
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<td>4. Railroad Retirement Act benefits</td>
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<tr>
<td>5. Benefits payable under any group disability income plan</td>
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<tr>
<td>6. Benefits you voluntarily elect to receive as retirement or early retirement payments under your Employer’s retirement plan</td>
<td></td>
</tr>
<tr>
<td>Benefit reductions (offsets) are based on the gross (before-tax) amount of any payment received.</td>
<td></td>
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<tr>
<td><strong>Return to Work</strong></td>
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<tr>
<td>When you are medically able to return to work with or without medical restrictions, the Company will engage in an interactive process with you to identify any reasonable accommodations that may be necessary to return you to work in an occupation compatible with your medical restrictions. If you do not accept an offer to return to work in a position you are able to safely perform and for which you are qualified, your employment and any remaining benefits may end. The Claims Administrator has the right to have you evaluated for participation in an approved rehabilitation program and has the right to require your participation in such a program. The plan will stop paying for the program if the Claims Administrator withdraws its approval or if you no longer meet the definition of Disabled under the plan.</td>
<td></td>
</tr>
<tr>
<td><strong>Partial Disability</strong></td>
<td></td>
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<tr>
<td>Partially Disabled: You are considered to have a &quot;Partial Disability&quot; or be &quot;Partially Disabled&quot; under the plan if you satisfy the definition of &quot;Disabled&quot; with the sole exception that the Claims Administrator has determined your Disability permits you to perform some or all of the essential duties of your regular occupation (subject to adjustments by the Company) for at least a part of each week without a substantial risk of harm to your health.</td>
<td></td>
</tr>
<tr>
<td>Partial Disability: The physical or mental condition for which benefits under this Plan are approved by the Claims Administrator in accordance with the Plan's terms and the definition of the term &quot;Partially Disabled.&quot;</td>
<td></td>
</tr>
<tr>
<td>Pay for Partial Disability: For time you are actually able to work, you will be paid 100% of your Base Pay, plus for approved STD time, you will be paid at the STD percentage of your Base Pay applicable to that workweek for the portion of the workweek not worked. (See the row &quot;Benefit Amount.&quot;);</td>
<td></td>
</tr>
<tr>
<td><strong>Coverage</strong></td>
<td></td>
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<tr>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td><strong>Successive Disability Rule</strong></td>
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<tr>
<td>If a new Disability begins during an existing period of Disability under the plan, Benefits can be extended to cover the new Disability, without requiring you to re-satisfy the Actively-At-Work requirement for the new Disability, as long as your original Disabled status is continuous and approved.</td>
<td></td>
</tr>
<tr>
<td>If you return to active status and become Disabled due to the same sickness or injury within a 30 calendar-day period, you will continue to use Disability days under your initial period of Disability. If you return to active status and more than 30 calendar days pass before you become Disabled again, you will begin a new period of Disability. If you return to active status and become Disabled due to a different sickness or injury within a 30-calendar day period, you will begin a new period of Disability.</td>
<td></td>
</tr>
<tr>
<td><strong>When Benefits End</strong></td>
<td></td>
</tr>
<tr>
<td>Benefits end on the earlier of the date when</td>
<td></td>
</tr>
<tr>
<td>~ You are no longer Disabled or Partially Disabled as defined by the plan.</td>
<td></td>
</tr>
<tr>
<td>~ You fail to remain under the appropriate regular care and treatment of a physician.</td>
<td></td>
</tr>
<tr>
<td>~ You have received Benefits for the Maximum Duration.</td>
<td></td>
</tr>
<tr>
<td><strong>Coverage During Leave</strong></td>
<td></td>
</tr>
<tr>
<td>Plan coverage is suspended while you are on any unpaid leave of absence, including leave covered by USERRA (paid or unpaid) or FMLA.</td>
<td></td>
</tr>
<tr>
<td><strong>Coordination with FMLA</strong></td>
<td></td>
</tr>
<tr>
<td>Approval of medical documentation supporting a request for FMLA coverage due to an employee's serious health condition does not constitute a determination of benefits under the STD plan. However, periods of absence for which STD benefits are approved are treated and recorded as FMLA leave to the extent that the employee is otherwise eligible for FMLA leave.</td>
<td></td>
</tr>
<tr>
<td><strong>Taxes</strong></td>
<td></td>
</tr>
<tr>
<td>Benefit payments are subject to state and federal income taxes, FICA, and Medicare taxes.</td>
<td></td>
</tr>
</tbody>
</table>
## Coverage

The STD Plan does not cover disabilities that are caused or contributed to by:

1. Illness or injury that is work-related
2. Intentionally self-inflicted injury while sane or insane
3. Your active participation in an insurrection or a rebellion or your taking part in a riot or civil commotion
4. Your committing or attempting to commit an assault, battery, or felony.

In addition, STD benefits will not be paid for:

1. Absences due to illnesses or injuries that begin during a leave of absence not covered by Benefits under this plan
2. Absences for Elective procedures (other than surgery to donate an organ).

For purposes of this plan, a physician does not include a naturopath, iridologist, herbalist, licensed social worker, physiologist, chiropractor, nurse practitioner, physician's assistant or midwife. A chiropractor is considered a physician for purposes of this plan if you have a verified referral for the chiropractor from a doctor of medicine or doctor of osteopathy.

Notwithstanding any other provision of this plan, benefits will not be provided to the extent that they would cause an employee to be paid at a rate more than 100% of his/her Base Rate for any period of time covered by this plan.

## Proof of Good Health

Not required

## Administrative Information

### Plan Records

Plan records are kept on a calendar-year basis: January 1 - December 31

### Plan Sponsor and Plan Administrator

General Dynamics Corporation  
2941 Fairview Park Drive, Suite 100  
Falls Church, VA 22042-4513  
1-703-876-3000

### Employer Identification Number (EIN)

13-1673581

### DOL Plan Name (Number)

General Dynamics Corporation Subsidiary Health and Welfare Plan (561)

### Plan Type

Welfare plan providing short-term disability benefits

### Administration Type (Contract or Insured)

Contract

### Funding Type (Self-Funded or Insured)

Self-funded by General Dynamics Corporation

### Agent for Service of Legal Process

General Dynamics Corporation  
2941 Fairview Park Drive, Suite 100  
Falls Church, VA 22042-4513  
1-703-876-3000
<table>
<thead>
<tr>
<th><strong>Important Addresses</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage</strong></td>
</tr>
<tr>
<td><strong>Claims Filing Address</strong></td>
</tr>
<tr>
<td>Call Member Services at 1-800-416-1808.</td>
</tr>
<tr>
<td><strong>Appeals Filing Address</strong></td>
</tr>
<tr>
<td>Sedgwick Claims Management Services, Inc.</td>
</tr>
<tr>
<td>Appeals Unit</td>
</tr>
<tr>
<td>P.O. Box 14446</td>
</tr>
<tr>
<td>Lexington, KY 40512-4575</td>
</tr>
<tr>
<td>1-888-777-7039</td>
</tr>
<tr>
<td><strong>Corporate Address: Claims Administrator</strong></td>
</tr>
<tr>
<td>Sedgwick Claims Management Services, Inc.</td>
</tr>
<tr>
<td>1100 Ridgeway Loop Road</td>
</tr>
<tr>
<td>Memphis, TN 38120</td>
</tr>
<tr>
<td>1-901-415-7400</td>
</tr>
</tbody>
</table>
State Coordination Rules

The amount and duration of benefit payments from the plan will not be less than required by any state disability program (such as those required by California, Hawaii, New Jersey, New York, and Rhode Island). If you work for General Dynamics Corporation in one of the following states, special provisions may apply to you:

■ **California and Rhode Island** — If you work in California or Rhode Island, you will be required to apply for state disability insurance benefits before you can receive any Benefits under this plan. The Claims Administrator presumes maximum benefits will be received from the state, and therefore Benefits payable under the plan will be reduced by benefits paid to you by the state disability plan for a total amount of benefits not to exceed 100% of Base Pay. If maximum benefits are not received from the state, you may provide documentation from the state to the Claims Administrator and receive a supplemental payment from this plan.

■ **Hawaii, New Jersey and New York** — You will receive either the Benefits payable by the plan or the state-required disability benefits, whichever is higher.

Applying for Benefits/Filing a Claim

You must contact your manager immediately when you are absent from work.

If you expect to be absent from work for longer than the Elimination Period, you must do the following:

■ Call the Claims Administrator’s Member Services to apply for benefits (see the section titled Benefits Chart for contact information). Claims should be reported as soon as you are aware your absence will meet the Elimination Period as defined by your plan but always within 90 days. If you fail to file a claim for benefits within 90 days from your first day of absence, the Claims Administrator will determine whether circumstances warrant extension beyond 90 days. Past time charges into the time-keeping system cannot be reclassified solely to meet the 90-day limit (e.g., changing vacation time to sick or disabled time).

When you call the Claims Administrator, you will speak with a claims intake specialist who will:

— Check your eligibility for benefits,
— Ask you about your illness or injury,
— Ask you to describe your occupation,
— Begin the claims process.

A case manager will later call you to evaluate and certify your disability. You may be referred to a nurse consultant who will gather more information, as appropriate. In addition, the case manager may contact your Human Resources/Benefits Office to learn more about your occupational requirements (what you do on your job).

■ Provide medical proof of your disability as requested by the Claims Administrator. The Claims Administrator may contact your physician directly for proof of disability (in this case, you may be asked to sign an authorization to release medical records).
Remain under the regular care of a qualified physician and in an active treatment program. Regular care of a physician means you are attended by a physician:

— Who is not you or related to you,
— Who is practicing within the scope of his or her license,
— Who has medical training and clinical expertise suitable to treat your disabling condition,
— Who specializes in psychiatry, if your disability is caused, to any extent, by a mental health or psychiatric condition, and
— Whose treatment is consistent with the diagnosis of the disabling condition; and according to guidelines established by medical, research, and rehabilitative organizations; and administered as often as needed.
— For purposes of this plan, a physician does not include a naturopath, iridologist, herbalist, licensed social worker, physiologist, chiropractor, nurse practitioner, physician's assistant or midwife. A chiropractor is considered a physician for purposes of this plan if you have a verified referral for the chiropractor from a doctor of medicine or doctor of osteopathy.

Be receiving psychiatric care from a psychiatrist within 30 days of your first day of disability for any condition with a mental health/emotional diagnosis. Psychiatric care must involve direct treatment by a psychiatrist or treatment by a licensed, registered psychologist who is working under the supervision of a psychiatrist or your treating physician.

Comply with the Claims Administrator’s requests about your disability.

After contacting the Claims Administrator, you and your local Human Resources/Benefits Office will receive a written notification stating your approved period of disability (if any), or the reason for a denial. The Company will be sent a notification that explains when you are expected to return to work. If the Claims Administrator certifies (i.e., approves) your disability, you will begin receiving benefit payments as provided by this plan.

If you do not submit a claim or the requested information, you may be denied benefits. Any costs associated with releasing medical information are your responsibility.

**Qualifying for Disability Payments**

To qualify to receive disability benefits, you must:

— Be under the regular care of a physician,
— Be unable to perform regular duties of your occupation,
— Not be engaged in any substantial and gainful employment,
— Be disabled as defined by the plan for the entire Elimination Period, and
— Provide documentation from your physician certifying your disability.
In order to continue receiving plan benefits, you must:

- Provide the Claims Administrator with information from your physician that:
  - Verifies your disability and
  - Explains the nature and extent of your disability.

- Submit to an exam by a physician selected by the Claims Administrator or the Plan Administrator, if requested.

- Comply with the Claims Administrator’s request for additional information about your disability and your other income.

- Cooperate with a rehabilitation program recommended by either the Claims Administrator or the Plan Administrator.

- Remain under the proper care of an appropriate treatment provider and follow the provider’s prescribed/directed treatment plan. Unless approved by your treating provider, non-compliance with your treatment plan may result in your benefits being denied or terminated.

**Using Paid Time Off**

Consult with Mission Systems Human Resources regarding usage of PTO.

**Partial Disability**

**Approved Rehabilitation Program**

Recovery from disability can be extremely difficult in some situations. The rehabilitation program can help. It is a program of physical, mental, or vocational rehabilitation that is expected to result in increasing your employability and is approved in writing by the Claims Administrator.

The Claims Administrator retains the right to have you evaluated for participation in an approved rehabilitation program, and can require you to participate in a program if the Claims Administrator determines it would be beneficial.

The plan will stop paying for the program if the Claims Administrator withdraws its approval or if you no longer meet the definition of Disabled under the plan.

**About the Partial Disability Benefit**

If you are disabled and return to work under a rehabilitation program approved by the Claims Administrator, you may be eligible for partial disability benefit.
**Benefit for Partial Disability**

If you return to work under a rehabilitation program approved by the Claims Administrator, it means you are not working on a full-time basis and may be eligible to receive a benefit for the time you are not working. Here's how it works:

- You will be paid at your Base Pay rate for your time worked.

PLUS

- You will be paid the applicable percentage of your Base Pay for your time not worked (see the row titled “Benefit Amount” in the section titled *Benefits Chart*).

Let's look at an example. Assume you work 8 hours per day and 40 hours per week. Under the rehabilitation program, you are only able to work half-time (four hours per day). Here’s how it would work during the weeks of your disability when you receive less than 100% of Base Pay for your STD benefit. If you work 4 hours and are disabled 4 hours you received 100% of pay for 4 hours worked and your applicable STD Pay for 4 hours off from work (i.e., 60%, 70%, etc.).

In any event, you will not receive more than what you would have received if you were working and not disabled.

**Subrogation**

The plan does not cover the following:

- Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your eligible dependent (see the section titled *Who Is Eligible: Dependents*), or

- Expenses to the extent they are covered under the terms of any automobile liability, medical payments, automobile no-fault, personal injury protection, uninsured or underinsured motorist, homeowner’s, umbrella, workers compensation, government insurance other than Medicaid, or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your eligible dependent (see the section titled *Who Is Eligible: Dependents*).

If you or your eligible dependent incurs health care expenses as described above, the plan is entitled to recover the full extent of any payment made by the plan and is entitled to all rights of recovery that you or your eligible dependent have from or with respect to any person or under any insurance policy or plan of benefits that would be obligated to pay benefits to you for any injury and/or illness, and shall automatically have a lien upon the proceeds of any such recovery by or on behalf of you or your eligible dependent. If you or your eligible dependent dies as a result of your injuries and a wrongful death or survivor claim is asserted against any third party, the plan’s subrogation and recovery rights will still apply.

You, your eligible dependent or their representative shall do nothing after loss due to such injury and/or illness to prejudice the plan's rights and shall do everything necessary to secure such rights, including but not limited to providing the Plan Administrator with notice within 30 days of any and all claims made by you or your eligible dependent for such injury and/or illness and executing any documents as may be required to secure the plan's rights, and, if requested by the Plan Administrator, any agreement of reimbursement to the plan in such form determined by
the Plan Administrator. An agreement for reimbursement shall provide that any amounts recovered belong to the plan (to the extent of benefits paid by the plan), and that you will refrain from dissipating any such amounts but will rather hold them in trust for the plan until paid to the plan. This agreement for reimbursement will create separate contractual obligations on you that are in addition to those set forth in the plan.

Except as otherwise provided in a separate agreement of reimbursement with the Plan Administrator, the conditions described in the following paragraph shall apply. Any and all amounts recovered by you (whether by lawsuit, settlement, or otherwise), regardless of designation of said recovery, shall be held in trust for the benefit of the plan. You shall not make any settlement which specifically excludes or attempts to exclude the medical expenses paid by the plan. Any amount recovered shall not be dissipated until the plan receives reimbursement. Amounts recovered shall be apportioned as follows: The Plan Administrator shall be reimbursed first to the full extent of its payment under the plan. If any balance then remains from such recovery, it shall be applied to reimburse you and any other plan providing benefits to you as the interest may appear. The plan's right of recovery shall not be defeated nor reduced by the application of any so-called "Make-Whole Doctrine," "Rimes Doctrine" or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages. You shall not incur any expenses on behalf of the plan in pursuit of the plan's rights. Specifically, no court costs or attorney's fees may be deducted from the plan's recovery without the prior expressly written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" or any other similar doctrine. These doctrines have no application under this plan, since the plan's refund rights apply to the first dollars payable by a third party. Under no circumstances will the plan be obligated to pay a fee or costs to your attorney.

You must agree to notify the plan of any events that may affect the Plan Administrator's rights of recovery, such as injury resulting from an automobile accident, or job-related injuries that may be covered by workers compensation. Also, you must cooperate with the plan by giving the Plan Administrator information and signing documents to help the Plan Administrator get reimbursed. In addition, you must agree to authorize the Plan Administrator to investigate, request, and release information that is necessary to carry out the purpose of this section.

If you or your attorney fail to comply with any of the requirements in this section, it may result in a forfeiture of payment of future medical benefits, and any funds or benefits otherwise payable under the plan may be withheld until all obligations are satisfied.

**Recovery and Offset of Benefit Overpayments**

The plan is obligated to take whatever reasonable steps are legally permissible in order to recover any overpayments of benefits discovered through the plan's eligibility verification process or otherwise. The plan is also granted a right of reimbursement from the proceeds of any settlement, judgment or other payment obtained by you. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted above, but only to the extent of the benefits paid by the plan. If reimbursement attempts are unsuccessful, the plan may withhold any reimbursement otherwise due you or your eligible dependent under the plan and offset that amount against the amount you owe the plan. As soon as the plan has recovered the entire amount that you owe, your plan benefits will once again be processed and paid in the normal manner.
The plan has the right to recover any overpayments based on fraud, intentional misrepresentation, or claims processing errors. You must reimburse the plan in full. The plan will determine the method by which the repayment is to be made. The plan may not recover more than the amount paid to you.

When an overpayment has been made by the plan, the plan will have the right at any time to:

- Recover that overpayment from the person to whom or on whose behalf it was made, or
- Offset the amount of that overpayment from a future claim payment.

**Substantiation**

From time to time, you may be asked to provide information in support of your claims or payments. As a participant in the plan, you are obligated and required to provide substantiation when requested. In the event of a misstatement of any fact affecting your coverage under this plan, the true facts will be used to determine the coverage in force, and the Plan Administrator has the right to recover from you any overpayments that resulted from such misstatement. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit may be subject to prosecution to the full extent of the law, as well as termination of employment from the Company or other disciplinary action.

**Appealing a Denied Claim or Any Other Adverse Benefit Determination**

This section describes the generally applicable timeframe for deciding a claim and the appeals process that applies if your claim is denied or you receive any other adverse benefit determination. The section also describes limits that apply to the appeals process. For specifics about this plan's appeals process for adverse benefit determinations, contact the Claims Administrator at the address and phone number listed in the section titled *Benefits Chart*.

An adverse benefit determination is any denial, reduction or termination of a benefit or any failure to provide (in whole or in part) a benefit. Adverse benefit determinations include any denial, reduction, termination or failure that is based on a participant's or beneficiary's eligibility to participate in this plan.

You have the right to appoint an authorized representative to act on your behalf. Your properly appointed authorized representative can take all actions you are allowed to take. For example, a properly appointed authorized representative could file a claim or file an appeal of an adverse benefit determination on your behalf. For information about how you can appoint an authorized representative, contact the Claims Administrator.

If your claim for benefits relates to your enrollment in the plan or your eligibility to participate in the plan, see the section below titled *Special Provisions Applicable to Claims for Enrollment or Plan Eligibility* for special rules.

**Timeframe for Initial Claim Determination**

Ordinarily the Claims Administrator will notify you of an adverse benefit determination within 45 days of receiving your claim. However, the Claims Administrator is allowed to extend the
time for review by two 30-day periods, provided it determines that an extension is necessary due to matters beyond the plan’s control.

If the Claims Administrator requires the first 30-day extension, you will be notified in writing within the initial 45-day period. If the Claims Administrator requires the second extension, you will be notified in writing during the first 30-day extension period. The notice will state the reasons an extension is required and the date the Claims Administrator expects to provide a decision on your claim.

If an extension is necessary due to your failure to submit necessary information, you will have at least 45 days to provide the additional information requested by the extension notice. The plan’s period for making a benefit determination is suspended from the date the Claims Administrator sends you an extension notice until the earlier of (a) the date you respond to the request for additional information or (b) the end of this 45-day period.

All extension notices for reviewing disability claims must explain:

- The standards used in determining whether a participant is entitled to a benefit,
- The unresolved issues that prevent a decision on the claim, and
- The additional information needed from you, if any, to resolve those issues.

If You Receive an Adverse Benefit Determination

The Claims Administrator will provide you with a notification of any adverse benefit determination which will set forth:

- The specific reasons for the adverse benefit determination.
- References to the specific plan provisions on which the benefit determination is based, if applicable.
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary.
- A description of the plan’s appeal procedures and the time limits applicable to those procedures, including a statement about your right to bring a civil action under Section 502(a) of ERISA.
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided to you free of charge upon request.
- If the adverse benefit determination was based on medical necessity or an experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your health care circumstances, or a statement that such explanation will be provided free of charge upon request.

How to Appeal an Adverse Benefit Determination

If you receive an adverse benefit determination, you have the right to two levels of appeal. Your first appeal (Level 1 appeal) must be sent to the Claims Administrator within 180 days of receipt
of such a determination. If your Level 1 appeal is denied, your second appeal (Level 2 appeal) must be sent to the Claims Administrator within 180 days of receipt of the denial of your Level 1 appeal. As described in more detail below, you must complete a Level 1 appeal before you can bring a lawsuit. In contrast, a Level 2 appeal is voluntary. Additional information about a voluntary Level 2 appeal is provided below. To initiate either appeal, send the Claims Administrator a letter stating why you disagree with its determination. All appeals must include a list of all the specific issues to be considered on appeal. The Claims Administrator's address is listed in the section titled Benefits Chart.

With each appeal, you have the right to:

■ Be informed of specific review procedures applicable to your appeal, including any need to file an affidavit about the facts relevant to your claim.

■ Submit written comments, documents, records and other information relating to the claim for benefits.

■ Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as “relevant” to your claim if it:
  — Was relied upon in making the benefit determination,
  — Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination,
  — Demonstrates compliance with the administrative processes and safeguards required in making the benefits determination, or
  — Constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.

■ A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered previously.

■ A review that does not defer to the initial adverse benefit determination or, if applicable, denial of your Level 1 appeal.

■ A review that is not conducted by the individual who made the adverse determination or, if applicable, denial of your Level 1 appeal or who is a subordinate of that person.

■ If the appeal involves an adverse benefit determination based in whole or in part on a medical judgment, a review in which the Claims Administrator consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional must not have been consulted in connection with the initial adverse benefit determination or, if applicable, denial of your Level 1 appeal, or be the subordinate of a person who was consulted.

■ The identification of health care or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.
The Claims Administrator ordinarily will notify you of its decision on your Level 1 and Level 2 appeals within 45 days. The Claims Administrator’s notice of an adverse benefit determination on appeal will be forwarded to you in writing and will contain all of the following information:

- The specific reasons for the adverse benefit determination.
- References to the specific plan provisions on which the benefit determination is based, if applicable.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- A statement describing any voluntary level of appeal and appeal procedures offered by the plan and your right to obtain information about such procedures, and a statement about your right to bring an action under ERISA.
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided to you free of charge upon request.
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

**Special Provisions Applicable to Claims for Enrollment or Plan Eligibility**

If your claim for benefits relates to your enrollment in the plan or your eligibility to participate in the plan (as opposed to what benefits you are eligible for as a participant in the plan), you must contact the General Dynamics Service Center and request a claim initiation form to begin the internal claim and appeal process. Complete the claim initiation form and submit it, together with any documentation that you feel supports your claim, to:

General Dynamics Service Center  
PO Box 770003  
Cincinnati, OH 45277-1060

The Plan Administrator or its designee will respond to your claim and appeal in the manner and within the time limits provided in the section *Appealing a Denied Claim or Any Other Adverse Benefit Determination*, where applicable. If your claim for benefits relates to enrollment or eligibility for the plan, you will not have the opportunity for any voluntary Level 2 appeal after the initial claim and appeal process.

**Limits on the Appeals Process**

No interest is payable on any benefits that are delayed or paid late unless required by federal or state regulations.

In the event the Claims Administrator or Plan Administrator is unable to provide a response during the timeframes outlined in the plan, you will be treated as having exhausted your administrative remedies with respect to that step of the process and may move on to the next
step. Please note, however, this does not preclude the Claims Administrator or Plan Administrator from providing a response within a reasonable time.

Before you can bring a lawsuit against the plan in state or federal court, you must timely use and exhaust your right to a Level 1 appeal under the plan’s claims and appeals procedures. If your Level 1 appeal is denied, you may bring a lawsuit. If your Level 1 appeal is denied by the Claims Administrator, you also have the right to a voluntary Level 2 appeal. You are not required to initiate a Level 2 appeal before filing a lawsuit. The plan waives any right to assert that you have failed to exhaust administrative remedies because you do not elect to submit any benefit dispute to a voluntary Level 2 appeal. There are no fees or costs associated with a Level 2 appeal. Your rights to any other benefits under the plan are not affected by the fact that you file a Level 2 appeal. If you do file a voluntary Level 2 appeal, any statute of limitations or any other defense based on timeliness is suspended during the time your Level 2 appeal is pending. Your right to bring an action under ERISA is not affected by a Level 2 appeal.

No legal action, including a lawsuit, may be brought more than one year after a final decision is rendered on a claim. In addition to the one-year deadline that applies to filing a lawsuit after the claims and appeals procedures are exhausted, there is a general time limitation that applies to all lawsuits involving all types of plan issues. You must commence any such lawsuit involving plan claims no later than three years after the deadline for filing a claim (90 days from your first day of absence). Although any period of time when your claim is in the claims procedure described above (i.e., the time between when you file a claim for benefits and the time you receive a final determination letter) does not count against the three-year period, once the claims procedure process is completed, the three-year period will continue running where it left off.

The Claims Administrator will provide to you, upon request, sufficient information relating to a Level 2 appeal to enable you to make an informed judgment about whether to submit a benefit dispute to this voluntary level of appeal. You may request information about the rules applicable to a Level 2 appeal, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process. Your decision as to whether or not to submit a benefit dispute to a Level 2 appeal will neither affect your rights to any other benefits under the plan nor your right to representation.

During the appeals process you must raise all issues and legal theories you wish to have considered at any time during the administrative claims review process or any subsequent lawsuit.

The Claims Administrator and the Plan Administrator have absolute authority and sole discretion to interpret and apply plan provisions and determine facts, benefits, and eligibility. All interpretations, decisions, and determinations of the Claims Administrator and the Plan Administrator are intended to be final, conclusive, and binding on all parties having an interest in the plan.
Plan Administration

The plan shall be administered by General Dynamics Corporation, which shall have the absolute and sole discretionary authority to:

- Construe and interpret the provisions of the plan, plan documents, summary plan description, as well as any communications related to the plan,
- Make factual determinations thereunder, including determining the rights or eligibility of employees or participants and any other persons, and the amounts of their benefits under the plan, and
- Remedy ambiguities, inconsistencies, or omissions.

Such determinations shall be binding on all parties. Benefits will only be paid if General Dynamics Corporation, in its sole discretion, determines that the participant or beneficiary is entitled to them.

General Dynamics Corporation has the authority to delegate any of its powers under this plan (including, without limitation, its power to administer claims and appeals) to any other person, persons, or committee in the administration of this plan. This person, persons, or committee may further delegate its reserved powers to another person, persons, or committee as they see fit. Any delegation or subsequent delegation shall include the same sole discretionary and final authority that General Dynamics Corporation has listed herein, and any decisions, actions, or interpretations made by any delegate shall have the same ultimate binding effect as if made by General Dynamics Corporation.

When Coverage Ends

Your coverage under the plan will end on the day the first of one of the following occurs:

- You no longer meet the eligibility requirements.
- You cease active employment with the Company.
- You stop active work with the Company for any reason other than becoming totally disabled.
- You retire.
- The plan ends.

See the section titled *Life Events Matrix* for information about how coverage continues while you are not Actively-at-Work.

Continuation of Coverage for Employees in the Uniformed Services

Not applicable.

Family and Medical Leave Act (FMLA)

FMLA leave runs concurrently with an STD leave. STD plan coverage is suspended while you are on an unpaid FMLA leave that is not related to your own disability.
Your Rights Under 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:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, 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.

Enforce Your Rights

If your claim for a benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court, but only after you have exhausted the plan’s claims and appeals procedure. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a
federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the party you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if the court finds that your claim is frivolous).

**Assistance With Your Questions**

If you have any questions about the plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor. The EBSA can be reached at:

Employee Benefits Security Administration
U.S. Department of Labor
Public Disclosure Room,
Suite N-1513
200 Constitution Avenue N.W.
Washington, D.C. 20210
1-202-693-8673

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA publications hotline.

**Plan Financing**

Benefits under the plan are paid from the general assets of the Company.

**Plan Expenses**

To the extent a Company-sponsored plan is funded by a trust, the Company reserves the right, according to applicable law, to pay for all reasonable and proper expenses incurred in the administration of the plan from any funds held in trust; provided, however, that the Company may pay any such expenses or reimburse the trust for any payment, or the trust may reimburse the Company for any such expenses the Company has paid.

**Official Plan Document**

For a self-funded plan, this booklet and any future summaries of material modifications (SMMs) serve as both the summary plan description and the official plan document for the plan.

For a fully insured plan, this booklet and the detailed benefits information and/or any applicable insurance contract provided by the carrier together serve as both the summary plan description and the official plan document for the plan. If the plan has an insurance contract, complete details about the plan are in the insurance contract, which is the legal document governing the fully insured plan. If there is a discrepancy between this booklet and the insurance contract, the insurance contract governs. Copies of the insurance contract and annual financial reports of the plan are available for review during normal business hours in the General Dynamics Service Center.
Because terms of the plan may change from time to time throughout the plan year, before taking any actions in reliance on the provisions in this SPD, please call the General Dynamics Service Center at 1-888-GDBENEFITS (1-888-432-3633) to confirm that you have received the latest materials. The materials will be sent to you free of charge. Even though the latest materials will be provided to you as the plan is changed, it is important that you seek the most up-to-date version of the SPD by contacting the General Dynamics Service Center.

The Company’s Right to Change (Amend) or Terminate This Plan

You should know that the Company reserves to itself the absolute and unfettered right to terminate this plan (and the benefits it provides) at any time (including at any time during the plan year) without any prior notice to you or your beneficiaries. The Company also reserves to itself the absolute and unfettered right to amend this plan in any manner whatsoever (including in a manner that is financially adverse to you and your beneficiaries) at any time (including at any time during the plan year) and for any reason at all without prior notice to you or your beneficiaries. Participation in this plan confers no rights (legal, equitable, or otherwise) on you or your beneficiaries that are not otherwise conferred by law or applicable collective bargaining agreement. No one has a vested right to benefits under this plan; you may not rely on any statement or promise to the contrary.

If the plan is terminated, you and/or your beneficiaries will not be vested in any plan benefits or have any rights (other than payment of claims incurred before the plan’s termination), subject to applicable law.

Limitation on Assignment

Your rights and benefits under the plan cannot be assigned, sold, transferred, or pledged by you or reached by your creditors or anyone else, subject to applicable law.

Unclaimed Benefits

If you receive a benefit payment from the plan and do not claim that payment within a reasonable period of time, the payment may be forfeited and the funds will be used to pay for benefits provided under the plan or to pay plan expenses. Prior to any forfeiture, the Plan Administrator or Claims Administrator will exercise due and proper care in attempting to contact you. If your benefit is forfeited and you later request reimbursement, you must make a proper claim through the plan’s claim and appeal process.

Your Employment

Eligibility for a benefit or the right to a benefit from the plan is not considered a contract or guarantee of employment with the Company. Nothing in the plan, this summary plan description, or any benefit communication shall be deemed to give any person any right to remain in the employ of the Company or to affect the Company’s right to terminate the employment of any person at any time without cause. The Company reserves the right to terminate your employment at any time for any reason.

Collective Bargaining Agreement

Not applicable.
Life Events Matrix

The handout titled “Life Events Matrix” gives details about how coverage continues while you are not Actively-at-Work. A copy of the current handout is available online or from the General Dynamics Service Center at 1-888-GDBENEFITS (1-888-432-3633).

Disclaimer

As a matter of prudent business planning, the Company is continually reviewing and evaluating various proposals for changes to this plan. When the Company is acting in this manner, it is not acting in its capacity as fiduciary or the Plan Administrator, but as the settlor of the plan. When acting in its capacity as the settlor of the plan, the Company has no fiduciary obligations to the plan or to any participant or beneficiary of the plan. You should understand that in some cases while performing its settlor responsibilities, the Company's interests and actions will be adverse to the continuation of this plan and to the financial interests of you (as well as to any beneficiary). In acting as settlor of the plan, the Company will indemnify its officers and employees from any and all personal liability arising out of any actions taken by them in good faith and in the course and scope of their employment and responsibilities with respect to the plan.

Because of the need for confidentiality, decisions regarding changes in the plan are not discussed or evaluated below the highest levels of management. Until a plan amendment is actually adopted by the Company, lower-level managers and other employees of the Company (as well as third-party service providers) do not know whether the Company will change the plan and are not in any position to advise any employee about possible changes. Any such speculation or statements about future changes should be disregarded and may not be relied upon by you. Unless and until changes in the plan are formally announced by the Company, no one is authorized to give you assurance that a change will or will not occur.

In the event of a discrepancy between any statements (written or oral) given to you and the legal documents comprising the plan, the plan documents as interpreted within the sole discretion of the Plan Administrator will control.