Long-Term Disability Benefit

Summary Plan Description

BWX Technologies, Inc.

January 2017

Introduction

If something happens that prevents you from working, you may need additional financial protection. The benefits due to long-term disability described in this Summary Plan Description (the "*Long-Term Disability Benefits*") continue a percentage of your Predisability Earnings after a waiting period of 180 days if you are Disabled and unable to work due to an accidental injury, sickness or pregnancy.

The Long-Term Disability Benefits are offered under the BWXT Long-Term Disability Plan for Active Salaried and Non-Bargaining Hourly Employees sponsored by BWXT Investment Company (the "Company") for the benefit of eligible employees of the Company and its participating subsidiary and affiliated companies

The Plan is administered by the Claims Administrator.

Plan Highlights

This Plan Highlights section is a summary of your Long Term Disability Benefits and provisions. See the rest of the Summary Plan Description for more information.

It is important to read the rest of the Summary Plan Description. It describes your benefits as well as any exclusions and limitations that apply to these benefits. Please read it carefully. You should talk with your local Human Resources office if you have any questions.

You will notice that some of the terms used in the Summary Plan Description begin with capital letters. These terms have special meanings. They are explained elsewhere in the Summary Plan Description.

Employee Eligibility

Eligible Employee: All regular full-time employees (working at least 30 hours per week) of the Company, or any of the following participating subsidiary and affiliated companies:

- BWX Technologies, Inc.
- BWXT Nuclear Operations Group, Inc.
- BWXT Nuclear Energy, Inc.
- BWXT Technical Services Group, Inc.
- BWXT mPower, Inc.
- Intech, Inc.
- Nuclear Fuel Services, Inc.

You may request, in writing from the Corporate Benefits Department, information as to whether a particular subsidiary or affiliated company (or a location thereof) participates in the Plan, and, if so, the address of that subsidiary or affiliated company or location.

If you do not have regular work hours, you will be an Eligible Employee if you have worked at least an average of 30 hours per week during the preceding 12 calendar months (or during your period of employment if less than 12 months).

You are not an Eligible Employee if you are:

- A non-resident alien who has no U.S. source income (as defined in the U.S. tax code);
- Covered by a collective bargaining agreement that does not provide for participation in the Plan;
- Classified as a part-time or temporary, part-time casual or seasonal employee;
- A person who provides services to the Employer under an agreement with a leasing

organization; or

- Classified by the Employer as an independent contractor or consultant, regardless of whether you are subsequently re-classified as an employee by a court or governmental agency for any reason.

Eligibility Date: The employee becomes eligible for the Core LTD benefit on date of hire. The employee becomes eligible for the Buy Up, also known as "Optional" plan, of the first of the month coincident/following date of hire.

Long Term Disability Benefits

Monthly Benefit:

All eligible employees will be provided company paid Core Long-Term Disability (LTD) insurance covering 40% of the first $25,000 of Predisability Earnings, reduced by Other Income Benefits. Other Income Benefits are described in Reduction of Benefits - Other Income Benefits

All eligible employees are automatically enrolled in the Basic 40% LTD benefit, effective on date of hire

All eligible employees will be able to purchase additional LTD coverage under the 60% Buy Up option. This coverage will be paid by the employee.

Maximum Monthly Benefit: $10,000

Minimum Monthly Benefit: $100. The Minimum Monthly Benefit will not apply if you are in an Overpayment situation

Elimination Period: LTD benefits will begin the later of when short-term disability ends or 180 days.

Maximum Benefit Duration: The duration shown below:

Age on Date Disability Starts	Maximum Benefit Duration
Less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Work Incentive:

Work while Disabled: No offset for employment earnings during the first 24 months after you have satisfied your Elimination Period. However, your Monthly Benefit may be reduced if the total income you are receiving exceeds 100% of your Predisability Earnings or Indexed Predisability Earnings.

Survivors Benefit: A lump sum equal to 6 times the Monthly Benefit before reductions for Other Income Benefits.

Limitations

Limitation for Pre-existing Conditions: Coverage for Pre-existing Conditions begins 12 months after your Effective Date of coverage.

Limitation for Disability due to Mental or Nervous Disorders or Diseases: 24 Monthly Benefits in your lifetime, or the Maximum Benefit Duration, whichever is less. Benefits may be paid beyond 24 months as described in the provision, subject to certain requirements.

Contributions

You pay the full cost of your Buy-Up coverage through after-tax payroll deductions. Your cost for coverage is based on your pay and current age.

Benefits Checklist

In order to receive benefits under the Plan, you must provide to the Claims Administrator, at your expense and subject to the Claims Administrator's satisfaction, all of the following documents. These are further explained elsewhere in the Summary Plan Description. Initial submission of these documents should be made no later than the 12th week following your original date of disability.

- ✓ Proof of Disability.
- ✓ Evidence of continuing Disability.
- ✓ Proof that you are under the Appropriate Care and Treatment of a Doctor throughout your Disability.
- ✓ Information about Other Income Benefits.
- ✓ Any other material information related to your Disability which may be requested by the Claims Administrator.

Employee Eligibility

Active Employee

You are an Active Employee if you are an Eligible Employee working for the Employer doing all the material duties of your occupation at (i) your usual place of business; or (ii) some other location that your Employer's business requires you to be.

You will be deemed an Active Employee if:

- you meet the above conditions; and

- you are absent from work solely due to vacation days, holidays, scheduled days off, or approved leaves of absence not due to Disability.

Effective Date of Coverage

You must apply for coverage under the Plan through the BWXT Enrollment Center. You may apply by using the Enrollment feature on the BWXT Enrollment website at www.bwxt.com/enrollment or you can call the BWXT Enrollment Center toll free at 1-844-708-1088.

If you apply for coverage no later than 31 days after your Eligibility Date and agree to have the required contributions deducted from your pay, you will be covered on the later of:

- your Eligibility Date as described in Plan Highlights;
- the date you meet the Active Employee requirements; or
- the date you apply for coverage.

If you are an Active Employee and apply for coverage more than 31 days after your Eligibility Date, you will be required to provide Evidence of Good Health satisfactory to the Claims Administrator. Your coverage will become effective on the later of:

- the date the Claims Administrator approves your Evidence of Good Health; or
- the date you meet the Active Employee requirements.

Each year, the Company conducts annual enrollment for the following Plan year. If you are an Active Employee and apply for coverage more than 31 days after your Eligibility Date and during the Company's annual enrollment period, you will be required to provide Evidence of Good Health satisfactory to the Claims Administrator. Your coverage will become effective on the later of:

- the date the Claims Administrator approves your Evidence of Good Health; or
- the January 1 following the annual enrollment period.

"*Evidence of Good Health*" is a statement providing your medical history. The Claims Administrator will use this statement to determine your insurability under the Plan. This statement must be provided to the Claims Administrator at your expense.

Changes in Amount of Monthly Benefit

The amount of your Monthly Benefit may change as a result of a change in your earnings or class. The new Monthly Benefit amount:

- will take effect on the date of the change; and
- will apply only to Disabilities commencing thereafter.

However, if you are not an Active Employee on the above date, the new Monthly Benefit amount will take effect on the date you are again an Active Employee.

If you are an Active Employee already enrolled for coverage, you may request a change to your coverage Option during the year. You must request a change in coverage by using the **Enrollment** feature on the BWXT Enrollment Website or by calling the BWXT Enrollment Center toll free at 1-844-708-1088.
You will be required to provide Evidence of Good Health satisfactory to the Claims Administrator if your coverage level is increased. Your new coverage level will become effective on the later of:

- the date the Claims Administrator approves your Evidence of Good Health (if required); or
- the first day of the month next following the date of your change request.

Long Term Disability Benefits

Monthly Benefit

You will be paid a Monthly Benefit, in accordance with Plan Highlights, if the Claims Administrator determines that:

- you are Disabled; and
- you became Disabled while covered under the Plan.

Benefits will begin to accrue on the date following the day you complete your Elimination Period. Payment of the Monthly Benefit will start on the date one month after completion of the Elimination Period. Subsequent payments will be made each month thereafter. Payment is based on the number of days you are Disabled during each one month period.

Contributions are not required for the time that Monthly Benefits are payable.

When Benefits End

Monthly Benefits will end on the earliest of the following dates:

- the end of the Maximum Benefit Duration;
- the end of the period specified in the Limitation for Disabilities Due to Particular Conditions;
- the date you are no longer Disabled;
- the date you fail to provide the Claims Administrator with any of the information listed in Plan Highlights under Benefits Checklist;
- the day you die;
- the date you cease or refuse to participate in a Rehabilitation Program as described in Work Incentive; or
- the date you fail to attend a medical examination requested by the Claims Administrator as described in Medical Examination.

Elimination Period

Your "*Elimination Period*" begins on the day you become Disabled. It is a period of time during which no benefits are payable. Your Elimination Period is shown in Plan Highlights. You must be under the continuous care of a Doctor during your Elimination Period. You may temporarily recover from your Disability during your Elimination Period. If you then become Disabled again due to the same or related condition, you may not have to begin a new Elimination Period.

Important Definitions

"*Disabled*" or "*Disability*" means that, due to sickness, pregnancy or accidental injury, you are receiving

Appropriate Care and Treatment from a Doctor on a continuing basis; and

- during your Elimination Period and the next 24 month period, you are unable to earn more than 80% of your Predisability Earnings or Indexed Predisability Earnings at your Own Occupation for any employer in your Local Economy; or

- after the 24 month period, you are unable to earn more than 60% of your Indexed Predisability Earnings from any employer in your Local Economy, and which provides you with substantially the same earning capacity as your former earning capacity prior to the start of your Disability.

Your loss of earnings must be a direct result of your sickness, pregnancy or accidental injury. Economic factors such as, but not limited to, recession, job obsolescence, pay cuts and job-sharing will not be considered in determining whether you meet the loss of earnings test.

For an employee whose occupation requires a license, "loss of license" for any reason does not, in itself, constitute Disability.

"*Appropriate Care and Treatment*" means medical care and treatment that meet all of the following:

- it is received from a Doctor whose medical training and clinical experience are suitable for treating your Disability;

- it is necessary to meet your basic health needs and is of demonstrable medical value;

- it is consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies;

- it is consistent with the diagnosis of your condition; and

- its purpose is maximizing your medical improvement.

"*Doctor*" means a person who: (i) is legally licensed to practice medicine; and (ii) is not related to you. A licensed medical practitioner will be considered a Doctor:

- if applicable state law requires that such practitioners be recognized for the purposes of certification of disability; and

- the care and treatment provided by the practitioner is within the scope of his or her license.

"*Own Occupation*" means the activity that you regularly perform and that serves as your source of income. It is not limited to the specific position you held with your Employer. It may be a similar activity that could be performed with your Employer or any other employer.

"*Local Economy*" means the geographic area surrounding your place of residence which offers reasonable employment opportunities. It is an area within which it would not be unreasonable for you to travel to secure employment. If you move from the place you resided on the date you became Disabled, the Claims Administrator may look at both that former place of residence and your current place of residence to determine local economy.

Work Incentive

While you are Disabled, you are encouraged to work or participate in a Rehabilitation Program during your Elimination Period or while Monthly Benefits are being paid to you.

When you work while Disabled, you will receive the sum of the following amounts:

- your Monthly Benefit
- the amount of your earnings for working while Disabled.

During the 24 month period following your Elimination Period, your Monthly Benefit will be reduced if the total amount you receive from the above sources and Other Income Benefits exceeds 100% of your Predisability Earnings or Indexed Predisability Earnings. Your Monthly Benefit will be reduced by that portion of the amount you receive which exceeds 100% of your Predisability Earnings or Indexed Predisability Earnings.

After the 24 month period described above, your Monthly Benefit will be reduced by 50% of your earnings from working while Disabled. Your Monthly Benefit will be further reduced if the total amount you receive from the above sources and Other Income Benefits exceeds 100% of your Indexed Predisability Earnings. Your Monthly Benefit will be reduced by that portion of the amount you receive which exceeds 100% of your Indexed Predisability Earnings.

Monthly Benefit payments will cease on the date you refuse to participate in a Rehabilitation Program in which the Claims Administrator determines you are able to participate. "*Rehabilitation Program*" means:

- a return to active employment by you on either a part-time or full-time basis in an attempt to enable you to resume gainful employment or service in an occupation for which you are reasonably qualified taking into account your training, education, experience and past earnings; or
- participating in vocational training or physical therapy. This must be deemed by one of the Claims Administrator's rehabilitation coordinators to be appropriate.

Predisability Earnings

"*Predisability Earnings*" means the amount of your gross salary or wages from your Employer as of the day before your Disability began. This is calculated on a monthly basis.

Predisability Earnings may include contributions you make on a pre-tax basis through a salary reduction agreement with your Employer or the Company to any of the following:

- an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement, such as the BWXT Thrift Plan;
- an executive nonqualified deferred compensation arrangement; and
- amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC Section 125 plan (for example, your pre-tax contributions to the BWXT programs).

Predisability Earnings do not include:

- awards, commissions and/or bonuses;
- overtime pay;
- your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan; or
- any other compensation.

If you do not have regular work hours, your Predisability Earnings are based on the average number of hours you worked per month during the preceding 12 calendar months (or during your period of employment if less than 12 months). In no event will the number of hours be more than 173 hours.

Indexed Predisability Earnings

After 12 Monthly Benefits are payable, your Indexed Pre-disability Earnings are your Covered Earnings plus an increase applied on each anniversary of the date Monthly Benefits became payable. The amount of each increase will be the lesser of:

1. 10% of your Indexed Pre-disability Earnings during your preceding year of Disability; or
2. the rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

Reduction of Benefits - Other Income Benefits

Your Monthly Benefit is reduced by Other Income Benefits shown below. The Monthly Benefit payable to you:

- will not be less than the amount shown in Plan Highlights under Minimum Monthly Benefit (except in the case of an Overpayment);
- will not be further reduced due to cost-of-living increases payable under Other Income Benefits after the correct reduction has been determined;
- will not be reduced by any reasonable attorney fees included in any award or settlement; and
- will not be reduced by any sources other than those shown below.

If you receive Other Income Benefits in a lump sum instead of in monthly payments, you must provide to the Claims Administrator satisfactory proof of the breakdown of: (i) the amount attributable to lost income; and (ii) the time period for which the lump sum is applicable. If you do not provide this information to the Claims Administrator, the Plan may reduce your Monthly Benefit by an amount equal to the Monthly Benefit otherwise payable. Your Monthly Benefit will be reduced each month until the lump sum has been exhausted. However, if the Claims Administrator is given proof of the time period and amount attributable to lost income, the Plan will make a retroactive adjustment.

List of Sources of Other Income Benefits

1. Federal Social Security Act, Railroad Retirement Act, Canada Pension Plan, or any provincial pension or disability plan, or the Canada Old Age Security Act

a. benefits that you receive, are entitled to receive or would have been eligible to receive upon making timely application because of your disability or retirement will be counted; and

b. benefits available with respect to your spouse and dependents (regardless of marital status or their place of residence) because of your disability or retirement will be counted. If you are divorced or legally separated, benefits paid directly to your dependents and not taken into constructive receipt by you will not be counted.

Estimating Social Security Benefits

The Plan reserves the right to reduce your Monthly Benefit by estimating the Social Security disability benefits you may be eligible to receive.

Your Monthly Benefit will not be reduced by estimated Social Security disability benefits during the first 24 months of Monthly Benefit payments if, prior to the end of the 6 month period following the

date you became disabled:

i. you provide proof that you have applied for Social Security disability benefits;

ii. you have signed the "*Reimbursement Agreement*", prescribed by the Claims Administrator, which confirms that you will repay all Overpayments; and

iii. you have signed the form prescribed by the Claims Administrator which authorizes the Social Security Administration to release information on awards directly to the Claims Administrator.

In any case, when you do receive approval or final denial of your claim from the Social Security Administration:

i. your Monthly Benefit will be adjusted; and

ii. you must promptly refund to the Plan an amount equal to all Overpayments. If you do not promptly make such a refund to the Plan through the Claims Administrator, the Plan may, at the Claims Administrator's discretion, reduce or offset against any future Plan benefits payable to you, including the Minimum Monthly Benefit.

2. Group Insurance Policies

Group insurance policies will be counted if the Employer or Company contributes towards them or makes payroll deduction for any of the following:

a. other group health insurance policies will be counted to the extent that they provide benefits for loss of time from work due to disability; and

b. a group life policy that provides installment payments for permanent total disability will be counted.

3. Work Earnings will not be used to reduce your Monthly Benefit except as described in Return to Work Incentive.

4. Employer's Retirement Plan

Benefits for disability and/or retirement that you receive under the Retirement Plan (defined below) will be counted to the extent they are attributable to the Employer's or Company's contributions.

Benefits under the Retirement Plan that are payable for disability is money which:

a. is payable under the Retirement Plan due to a disability as defined in the Retirement Plan; and

b. does not reduce the amount of money which would have been paid as retirement benefits at the normal retirement age under the Retirement Plan if the disability had not occurred. (If the payment does cause such a reduction it will be deemed a retirement benefit as defined below.)

Benefits under the Retirement Plan that are payable upon retirement is money which:

a. is payable under the Retirement Plan either in a lump sum or in the form of periodic payments;

b. is payable upon:

i. the later of age 62 or normal retirement age as defined in the Retirement Plan;

ii. early retirement age as defined in the Retirement Plan (you must have voluntarily elected to receive payments prior to your normal retirement age); or

iii. disability as defined in the Retirement Plan (you must have voluntarily elected to receive payment prior to your normal retirement age and such payment does reduce the amount of money which would have been paid at the normal retirement age under the Retirement Plan if the disability had not occurred); and

NOTE: You will be considered to have voluntarily elected to receive payments if you file an application for benefits with the Retirement Plan and request the start of payments prior to your normal retirement age.

c. does not represent contributions made by you. Payments which represent your contributions are deemed to be received over your expected remaining life regardless of when such payments are actually received.

The "*Retirement Plan*" is a plan sponsored by the Employer or the Company which provides retirement benefits to Employees and which is not funded wholly by Employee contributions. The term shall not include the following, regardless of the source of contributions:

a. profit sharing plans;

b. thrift or savings plans;

c. non-qualified plans of deferred compensation;

d. plans under IRC Section 401(k) or 457;

e. individual retirement accounts (IRA);

f. tax sheltered annuities (TSA) under IRC Section 403(b);

g. stock ownership plans; or

h. Keogh (HR-10) plans.

5. No-fault Auto Laws

Only the basic reparations portion for loss of income of a law providing for payments without determining fault in connection with automobile accidents will be counted. Supplemental disability benefits you buy under a no-fault auto law will not be counted.

6. Other Programs or Plans including:

a. a compulsory benefit program of any government which provides payment for loss of time from your job because of your disability will be counted;

b. any other group disability income plan, fund, or other arrangement, no matter what called, if the Employer or Company contributes toward it or makes payroll deductions for it, will be counted.

7. Workers' Compensation or a Similar Law

Periodic benefits and substitutes and exchanges for periodic benefits will be counted.

8. Occupational Disease Laws

9. Maritime Maintenance & Cure

10. Third Party Recovery

The amount of recovery you receive for loss of income as a result of claims against a third party by judgment, settlement or otherwise.

11. Unemployment Insurance Law or Program

Exceptions to Other Income Benefits

Other Income Benefits will not include:

1. group credit or mortgage disability insurance benefits; or

2. early retirement benefits not taken into constructive receipt; or

3. individual insurance policies.

Supplemental Benefits

Survivors Benefit

If you die while you are receiving benefit payments under the Plan, your spouse or unmarried children under age 21 may be eligible for a lump sum Survivors Benefit.

The amount of the Survivors Benefit is equal to 6 times the Monthly Benefit before reductions for Other Income Benefits. The amount of Survivors Benefit payable is reduced by any Overpayment which the Plan is entitled to recover.

The Plan will pay the Survivors Benefit to your Eligible Survivor, if the following conditions are met:

- you have completed your Elimination Period;
- you are eligible to receive a Monthly Benefit at the time of death;
- you have an Eligible Survivor; and
- proof of your death is provided to the Claims Administrator.

An Eligible Survivor is one of the following:

- your surviving spouse; or
- if there is no surviving spouse, your unmarried children or your spouse's unmarried children under age 21. The term children also includes adopted children and children placed for adoption until legal adoption. Payment will be divided into equal shares among the eligible children.

The Plan will pay a Survivors Benefit to your Eligible Survivor on the date one month after the last Monthly Benefit payment was made before your death. If there is no Eligible Survivor, payment will be made to your estate.
Payment to a minor child may be made to an adult who submits proof satisfactory to the Claims

Administrator that he/she has assumed custody and support of the child.

Temporary Recovery

Once benefits become payable under the Plan, you may experience a Temporary Recovery from your Disability. If you become Disabled again due to the same or related condition, you may not have to begin a new Elimination Period.

Once you have satisfied your Elimination Period, a period of Temporary Recovery is your return to work for less than 6 months for each Temporary Recovery.

During the Temporary Recovery you will not qualify for any change in coverage caused by a change in any of the following:

- the rate of earnings used to determine your Predisability Earnings; or
- the terms, provisions, or conditions shown in the Summary Plan Description.

If your recovery lasts longer than the Temporary Recovery period allowed, when you become Disabled again you will have to begin a new Elimination Period.

Concurrent Disability

If a new Disability occurs while Monthly Benefits are payable, it will be treated as part of the same period of Disability. Monthly Benefits will continue while you remain Disabled. They will be subject to both of the following:

- the Maximum Benefit Duration; and
- Limitations and Exclusions that apply to the new cause of Disability.

Limitations

Limitation For Employer-Paid Sick Leave and Salary Continuance

No benefits are payable for any period during which you are eligible to receive Employer-paid sick leave or salary continuance.

Limitation For Pre-existing Conditions

You may be Disabled due to a Pre-existing Condition. No benefits are payable under the Plan in connection with that Disability unless your Elimination Period starts after you have been an Active Employee under the Plan for 12 consecutive months.

A "*Pre-existing Condition*" is an injury, sickness, or pregnancy for which you in the 3 months before your Effective Date:

- received medical treatment, consultation, care, or services;
- took prescription medications or had medications prescribed; or
- had symptoms or conditions which would cause a reasonably prudent person to seek diagnosis, care, or treatment.

Limitation For Disabilities Due to Particular Conditions

Monthly Benefits are limited to 24 months during your lifetime if you are Disabled due one of the following conditions:

- Anxiety disorders
- Delusional (paranoid) disorders
- Depressive disorders
- Eating disorders
- Mental illness
- Somatoform disorders (psychosomatic illness)

If, before reaching your lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against your lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above.

"*Hospital or Institution*" means a facility licensed to provide care and treatment for your condition. Rest homes, nursing homes, convalescent homes, homes for the aged, and facilities primarily affording custodial, educational, or rehabilitative care are not acceptable as hospitals or institutions under the Plan.

In no event will Monthly Benefits be payable longer than the Maximum Benefit Duration shown in the Plan Highlights.

Exclusions

The Plan does not cover any Disability which results from or is caused or contributed to by:

- war, insurrection, or rebellion;
- active participation in a riot;
- intentionally self-inflicted injuries or attempted suicide; or
- committing a felony.

Termination of Coverage

You will cease to be covered under the Plan on the earliest of the following dates:

- the date the Plan terminates; or
- the date you terminate employment or otherwise cease to be an Eligible Employee; or
- the date you transfer to an affiliated company which does not participate in the Plan; or
- the date your employer ceases to be a participating Employer in the Plan; or
- the first day of the month for which you fail to make the required contributions.

If you are Disabled when any of the above events occur, you may contact the Claims Administrator to discuss options for continuing your coverage outside the Plan.

Approved Leave of Absence

You may be entitled to continue your coverage during a leave of absence, depending on the type of leave you take. If you are entitled to continue your coverage during your leave of absence, coverage will be

provided in accordance with the Employer's leave of absence policy, but the period of coverage will not exceed 6 months. Contact your local Human Resources office for more information about your coverage during leaves of absence.

Continuation of Coverage During Family and Medical Leave (FMLA)

The Family and Medical Leave Act of 1993 ("*FMLA*") requires employers to provide up to a total of 12 weeks of unpaid, job-protected leave during any 12-month period to eligible employees for certain family and medical reasons. Effective January 28, 2008, the National Defense Authorization Act of 2008 ("*NDAA*") amended the FMLA to require employers to provide up to 26 weeks of leave to employees to care for certain family members who sustained serious injury or illness while serving in the armed forces. Coverage under the Plan will be administered as required for compliance with the FMLA and NDAA, and in accordance with procedures issued by the Plan Administrator for that purpose.

If you qualify for an FMLA leave, you may continue your coverage by continuing to pay the required contributions while you are on leave. For more information, contact your local Human Resources office.

If You Take a Military Leave of Absence

If you are absent from employment due to service in the uniformed services ("*Military Service*") under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("*USERRA*"), you may be entitled to certain continuation of coverage and reinstatement rights related to your absence. Coverage under the Plan will be administered as required for compliance with USERRA and in accordance with procedures issued by the Plan Administrator for that purpose.

If you fail to give advance notice to the Employer of your Military Service as prescribed by USERRA (and your failure is unexcused), or you do not timely elect to continue paying for coverage while absent due to Military Service, your coverage ends on the earlier to occur of the following:

- The first day of the month for which you fail to make the required contributions
- The date that you no longer meet the eligibility requirements.

Important Note: Your rights under USERRA with respect to the Plan will be lost if you:

- Are discharged from the uniformed services for "other than honorable" conditions; or
- Provide written notice to the Employer that you will not be returning to work.

Reinstatement of Coverage Following Break in Service or Loss of Eligibility

If your coverage ends due to termination of employment or loss of eligibility for other than leave of absence, you may become covered again as an Eligible Employee. Coverage is subject to the following:

1. If your coverage ends because you cease to be an Eligible Employee (for other than termination of employment or leave of absence), and you become an Eligible Employee again, you will be required to reenroll in order to become covered again and will otherwise be subject to the Plan's requirements for new enrollment.

2. If your coverage ends because your employment ends, and you become an Eligible Employee again within 1 month following the date your employment ends, you will not be required to reenroll for coverage or provide Evidence of Good Health. Your coverage will take effect on the later of the date you again become an Eligible Employee, or the date you meet the Active Employee requirements.

3. If your coverage ends because your employment ends, and you become an Eligible Employee

again after 1 month, following the date your employment ends, you will be required to reenroll for coverage and provide Evidence of Good Health satisfactory to the Claims Administrator. Your coverage will take effect on the latest of the date you again become an Eligible Employee, the date the Claims Administrator approves your Evidence of Good Health, or the date you meet the Active Employee requirements.

4. In all other cases, if your coverage ends because you fail to make the required contribution, you will be required to reenroll in order to become covered again and will otherwise be subject to the Plan's requirements for new enrollment.

5. If you become covered again as described in 1 or 2 above, the Pre-existing Condition Limitation will be applied as if there had been no gap in coverage.

Claims

Filing a Claim

If you experience a Disability, you or your beneficiary or an authorized representative on your behalf (each referred to in this Section as "you") must file proof of your Disability with the Claims Administrator within 3 months after the end of your Elimination Period.

No benefits are payable for claims submitted more than one year after the date of Disability. However, you can request that benefits be paid for late claims if you can show that:

- it was not reasonably possible to give written proof of Disability during the one year period; and
- proof of Disability satisfactory to the Claims Administrator was given to the Claims Administrator as soon as was reasonably possible.

Claim forms are available:

- By calling the calling the BWXT Enrollment Center toll free at 1-844-708-1088.
- Under Forms on the BWXT Enrollment Web site at www.bwxt.com/enrollment; or
- From your local Human Resources office.

Along with your claim form, you will be required to submit, at your own expense, supporting documentation of your Disability including:

- Proof of your Disability (includes date, cause and prognosis of your Disability);
- Satisfactory evidence of continuing Disability;
- Proof that you are under the appropriate care and treatment of a Doctor throughout your Disability;
- Information requested about Other Income Benefits. If you do not provide proof you have applied, or are not eligible, for Other Income Benefits, the Claims Administrator may reduce your Monthly Benefit. The reduction will be based on the Claims Administrator's estimate of what you would be eligible to receive through proper and timely pursuit;
- Proof that you applied for Social Security disability benefits until denied at the Administrative Law Judge level;
- Proof you have applied for Workers' Compensation benefits or benefits under a similar law. If

you do not provide proof that you have applied for these benefits, the Claims Administrator may reduce your Monthly Benefit. The reduction will be based on the Claims Administrator's estimate of what you would be eligible to receive through proper and timely pursuit; and

- Any other material information related to your Disability which may be requested by the Claims Administrator.

You will be required to authorize the Claims Administrator to obtain and release any relevant medical and financial information to the extent necessary to support your disability claim.

If you would like assistance in filing for Social Security disability benefits, you may contact the Claims Administrator.

Claims Fiduciary

The Claims Administrator is the fiduciary responsible for deciding claims under the Plan, including initial claim reviews and all claim appeals.

Your claim will be treated as filed when it is submitted to, and received by, the Claims Administrator in accordance with the Plan's claims review and appeal procedures. The timeframe for the Claims Administrator to decide claims and provide related notices to you begins when your claim is filed.

Timeframe for Initial Benefit Determination

The Claims Administrator will make a determination on your claim within a reasonable period of time, but not later than 45 days after your claim was filed. However, under some special circumstances, the Claims Administrator may extend its decision on your claim by an additional 30 days where the Claims Administrator determines an extension is necessary due to matters beyond the Plan's control. In such a case, written notice of the extension will be furnished to you prior to the end of the initial 45-day period, explaining the special circumstances which required the extension and the date by which the Claims Administrator expects to make the benefit determination.

If, prior to the end of that first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a determination cannot be made within the first 30-day extension period, a second 30-day extension may be taken. The Claims Administrator will notify you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the second extension and the date by which it expects to make its decision. Any notice of extension by the Claims Administrator will explain the standards which will be used to determine your entitlement to a benefit, the unresolved issues that prevent a decision on your claim, and the additional information needed to resolve those issues.

If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the number of days from the date of the Claims Administrator's notice of extension to you until the Claims Administrator receives the requested information will not count toward the Claims Administrator's timeframe for making a determination on your claim, as described above. You will be given 45 days within which to provide the needed information.

If a Claim is Approved

If the Claims Administrator determines you are Disabled and that your claim is payable:

- Monthly Benefits are paid one month after you qualify for them. Such benefits will be paid on a monthly basis thereafter.

- Benefits will be paid to you. However, benefits unpaid at your death will be paid to:

    - your spouse, if living; otherwise

- your children, if living, divided equally; otherwise
- your estate.

- Monthly Benefits due for a period of less than a month will be paid at a daily rate of 1/30th of the Monthly Benefit payable.

If a Claim is Denied

If your claim is denied, you will receive a written notice from the Claims Administrator within the timeframe for initial benefit determination, above, explaining:

- The specific reasons for the denial;
- Reference to the specific Plan provision on which the denial is based;
- The additional information or materials needed to support your claim and explanation of why such information is necessary;
- What steps you can take to have your claim reevaluated under the Plan's appeal procedures and the related time limits;
- A description of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("*ERISA*") following the denial of an appeal;
- A statement disclosing any internal rule, guideline, protocol, or similar criterion relied on in denying the claim (or a statement that such information will be provided free of charge upon request); and
- If the denial is based on application of an exclusion that involves scientific or clinical judgment, an explanation of such judgment for the claim denial (or a statement that such explanation will be provided free of charge upon request).

Appeal Procedure for Denied Claims

If the Claims Administrator denies your claim, you may appeal the decision. Upon your written request, the Claims Administrator will provide you, free of charge, with copies of documents, records, and other information ("*Appeal Documents*") relevant to your claim.

To appeal your claim, you must send a written request for appeal within 180 days after your claim is denied to the Claims Administrator at:

Cigna Group Insurance
P.O. Box 16491
Pittsburgh, PA 15242

Appeals must be in writing and must include the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision

- A description of appropriate issues, comments and reasons why you believe your claim should not have been denied.

Your request must set forth all facts and include all documents and other information you feel support your appeal. The review of your appeal will take into account any information you submit, even if not submitted or considered as part of the initial determination, and will afford no deference to the initial benefit determination. Someone on behalf of the Claims Administrator other than an individual who made the initial benefit determination, or a subordinate of that individual, will conduct the review of your appeal.

If your claim was denied based on a medical judgment, the Claims Administrator will consult with a health professional with appropriate training and experience in the pertinent field of medicine. The health care professional consulted for the appeal will not be the professional (if any) consulted during the initial determination or a subordinate of such professional. The Claims Administrator also will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination, even if the advice was not relied upon in making the initial determination.

Notification of Decision on Appeal

Within a reasonable period of time, but not later than 45 days after the Claims Administrator receives your request for a review, you will receive a written notice of the Claims Administrator's final decision on appeal, unless the Claims Administrator determines that special circumstances require an extension of time for processing the review. In such a case, the extension will not be longer than 45 days from the end of the initial 45-day review period, and written notice of the extension will be furnished to you prior to the end of the initial 45-day period, explaining the special circumstances requiring the extension and the date by which the Claims Administrator expects to make its determination on review.

If an extension is needed because you did not provide sufficient information, the number of days from the date of the Claims Administrator's notice of extension to you until the Claims Administrator receives the requested information will not count toward the Claims Administrator's timeframe for making a final determination on your appeal, as described above.

If your appeal is denied, the notice from the Claims Administrator will include:

- The specific reasons for the denial;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to or copies of all Appeal Documents relevant to the claim;
- A statement of your right to bring civil action under Section 502(a) of ERISA;
- A statement disclosing any internal rule, guideline, protocol, or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- If the denial on appeal is based on application of an exclusion that involves scientific or clinical judgment, an explanation of such judgment for the denial on appeal, applying the Plan terms to your disability circumstances (or a statement that such explanation will be provided free of charge upon request).

Decision on Appeal to be Final

The Claims Administrator makes the final determination on your claim and any appeal. The decision by the Claims Administrator on appeal will be final, binding and conclusive and will be afforded the maximum deference permitted by law. The Plan's claims review and appeal procedures for the Long-Term Disability

Benefit must be exhausted before you will be entitled to bring a civil action to recover benefits.

Right To Recover Overpayments

The Plan has the right to recover from you any amount determined by the Claims Administrator to be an Overpayment. You have the obligation to refund to the Plan any such Overpayment amount. The Plan's rights and your obligations in this regard are also set forth in the "Reimbursement Agreement", prescribed by the Claims Administrator, which you are required to sign when you become eligible for Monthly Benefits under the Plan. The Reimbursement Agreement: (i) confirms that you will repay all Overpayments; and (ii) authorizes the Claims Administrator to obtain any information relating to Other Income Benefits.

An "*Overpayment*" occurs when the Claims Administrator determines that the total amount paid by the Plan on your claim is more than the total of the benefits due under the Plan. This includes any Overpayments resulting from:

- retroactive awards received from sources shown in the List of Sources of Other Income Benefits;
- fraud; or
- any error the Claims Administrator makes in processing your claim.

The Overpayment equals the amount the Plan paid in excess of the amount due under the Plan. In the case of a recovery from a source other than the Plan, the Plan's Overpayment recovery will not be more than the amount of the recovery.

You have the right to appeal any Overpayment recovery. You must contact the Claims Administrator for the applicable appeal procedures to follow.

An Overpayment also occurs when payment is made by the Plan that should have been made under another group plan. In that case, the Plan may recover the payment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

The Plan may, in the discretion of the Claims Administrator, recover the Overpayment by:

- reducing or offsetting against any future benefits payable to you or your survivors, as permitted by law;
- stopping future benefit payments (including Minimum Monthly Benefits) which would otherwise be due under the Plan. Payments may continue when the Overpayment has been recovered; or
- demanding an immediate refund of the Overpayment.

Legal Actions

No legal action of any kind may be filed against the Claims Administrator:

- within the 60 days after proof of Disability has been given; or
- more than three years after proof of Disability must be filed. This will not apply if the applicable law in the area where you live allows a longer period of time to file proof of Disability.

Medical Examinations

The Claims Administrator will have the right to have you examined at reasonable intervals by medical specialists of its choice. The examination will be at the Claims Administrator's expense. Failure to attend a medical examination or cooperate with the medical examiner may be cause for denial or suspension of your benefits under the Plan.

Incontestability of Coverage

The Claims Administrator may not use Evidence of Good Health presented by any person for coverage to declare his or her coverage invalid if that person has been covered under the Plan for at least 2 years. In order to use Evidence of Good Health to deny coverage before the end of 2 years, the Evidence of Good Health must have been signed by the person. A copy of the signed Evidence of Good Health must be given to the person or the person's beneficiary.

Assignment

You may not assign your benefits under the Plan. This means that you may not give or transfer your benefits to anyone else.

Important Plan Information

The following information provides details about the way the Plan is administered. If you have questions about the Plan that are not answered in this Summary Plan Description, please contact your local Human Resources office. The existence of benefits, benefit plans or this benefits information is not intended as an employment contract or a guarantee of future employment.

Plan Administration

The Plan Administrator has appointed the Claims Administrator as the claims fiduciary for adjudicating benefit claims under the Plan and for deciding any appeals of denied claims. In its capacity as claims fiduciary, the Claims Administrator has the right to carry out responsibilities and use maximum discretionary authority permitted by law. These rights and responsibilities include, but are not limited to, the following:

- Interpret, construe and administer the Plan
- Make determinations regarding participation, enrollment and eligibility for benefits under the Plan
- Evaluate and determine the validity of benefit claims
- Resolve any and all claims and disputes regarding the rights and entitlements of individuals to participate in the Plan and to receive benefits and payments pursuant to the Plan.

The decisions of the Claims Administrator regarding benefit claims and appeals are final and binding.

With respect to matters other than claims payment and administration, the Plan Administrator has the authority to control, administer and manage the operation of the Plan. Those rights and responsibilities include, but are not limited to, making and enforcing such rules, regulations, and procedures as it may deem necessary or proper for the orderly and efficient administration of the Plan.

Plan Documents

This Summary Plan Description provides a summary of the benefits available to Eligible Employees. Full details of the Plan are contained in the official Plan documents and insurance contracts underlying the Plan. If a provision described in this Summary Plan Description differs from the provisions of the applicable Plan document and/or insurance contract, the Plan document and/or insurance contract

prevails.

Copies of official Plan documents are available from the Plan Administrator. You may be asked to pay reasonable costs for copying the document.

Your ERISA Rights

As an Eligible Employee with Plan coverage (also referred to as a "participant"), you are entitled to certain rights and protections under 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 any 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 any collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and 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 those people responsible for the operation of employee benefit plans. The people who operate the 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.

Enforcing Your Rights

If your claim for a benefit is denied or ignored, 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 example, 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, and you have exhausted the Plan's claims review and appeal procedures, you may file suit in a state or federal court. You may also file suit in a federal court if you disagree with the Plan's decision, or lack of a decision, concerning the qualified status of a domestic relations order. If a Plan fiduciary misuses the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds 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:

Employee Benefits Security Administration
U.S. Department of Labor
(listed in your telephone directory)
or
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave., N. W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration) listed in your telephone directory.

The information provided to you in this Summary Plan Description describes eligibility, loss of eligibility, how you may submit a claim for Long-Term Disability Benefits and how to appeal any denial of a claim and other pertinent information, as required by ERISA. Technical information, including the Plan Sponsor, Plan number and Plan Administrator can be located in the following chart:

Plan Details	
Official Plan Name	BWXT Long-Term Disability Plan Active Salaried and Non Bargaining Hourly Employees
Plan Sponsor/ Plan Administrator	BWXT Investment Company 800 Main Street Lynchburg, VA 24504 1-434-522-3800
Claims Administrator/ Insurance Company	Cigna Group Insurance P.O. Box 16491 Pittsburgh, PA 15242
Type of Administration	This benefit is administered under contract with the Claims Administrator.
Employer Identification Number (EIN)	72-11727054
Plan ID Number	507
Plan Type	Welfare benefit plan
Plan Year	January 1 through December 31
Plan Funding	This benefit is fully insured with premiums paid solely by employee contributions.

Agent for Service of Legal Process	CT Corporation Systems 8550 United Plaza Boulevard Suite 504 Baton Rouge, LA 70809 Service of legal process may also be made on the Plan Administrator.

This Summary Plan Description contains general information about the Plan benefits available to Eligible Employees. Full details of the Plan are contained in the official Plan documents and/or insurance contracts. If a provision described in this Summary Plan Description differs from the provisions of the applicable Plan document and/or insurance contract, the Plan document and/or insurance contract prevails.

This description of the Plan is not intended as an employment contract or a guarantee of current or future employment. **The Plan Sponsor reserves the right to modify, amend, suspend or terminate the Plan at any time**.