The WSRC Team

Benefits Overview and General Information

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SRS®

INTRODUCTION

All benefit plans referred to in this Summary Plan Description are sponsored by Washington Savannah River Company and Bechtel Savannah River, Inc. (WSRC/BSRI).

This Summary Plan Description is divided into two sections. The first section, Benefits Overview, provides a brief summary of the employee benefits made available to eligible employees of the WSRC Team. The WSRC Team is comprised of Washington Savannah River Company LLC; Bechtel Savannah River, Inc.; BNG America Savannah River Corporation; BWXT Savannah River Company; and CH2 Savannah River Company. The second section, General Information, contains important legal and other information concerning the administration of the WSRC/BSRI employee benefit plans, including Plan Information and your rights to benefits from these plans. Also, procedures are outlined on the process of attempting to resolve a problem you might have with any of the plans.

The WSRC Team provides you with a competitive benefits program associated with your employment at the Savannah River Site. Eligibility for benefits should not be viewed as a guarantee of employment. While the WSRC Team intends to continue providing a comprehensive benefits program, the Company reserves the right to modify or terminate any of the benefit plans at any time. For more information on the procedures to modify or terminate benefit plans, refer to the General Information section of this Summary Plan Description.

This Summary Plan Description does not create an express or implied contract of employment.

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PART ONE

BENEFITS OVERVIEW

This section contains a brief description of your benefits. Detailed information is provided separately in the applicable Summary Plan Description. Additional Human Resources policies, practices and procedures are described in the 5B Human Resources Manual.

Health Choice options are the plans sponsored by WSRC/BSRI that help pay for your medical, dental and vision expenses. Other benefits include plans that assist with your future financial security, and programs that add value to your employment with the WSRC Team.

ELIGIBILITY FOR BENEFITS

The table on the next page provides a general glimpse of the various benefit plans and programs offered by the WSRC Team. This information is subject to change. Depending on your employment status and other factors, you may or may not be eligible for each individual plan checked under your listed category. Thus, it is important that you refer to the individual plan books, Summary Plan Descriptions and plan documents to determine your specific eligibility.

Important Notice about the Table

The table on the next page provides a general indication of benefits in which most persons affiliated with the WSRC Team may participate. It is not intended to outline the eligibility for benefits in any particular individual situation. That is because there are certain circumstances associated with a person's employment or other status within each broad category in the column headings. To avoid any possible misunderstanding or misinterpretation of your eligibility benefits, you must refer to the specific Summary Plan Description and Plan documents.

Benefit Plans and Programs

Benefit Plan, Policy or Program	Full Service WSRC Team Employees	DuPont Retiree Rehires	WSRC Team Retirees	Eligible Survivors	Long-Term Disability Recipients*	Option A Craft
Prime Choice Medical	●		●	●	●	●
Standard Choice Medical	●		●	●	●	●
BlueChoice HMO	●					●
Basic Choice Medical	●		●	●	●	●
Prime Choice Dental	●		●	●		
Standard Choice Dental	●		●	●		
Vision Care Choice	●	●				
Health Care Flexible Spending Account	●	●				●
Dependent Care Flexible Spending Account	●	●				●
Short-Term Disability Income	●	●				●
Long -Term Disability Income	●	●			●	●
Special Benefits for Occupational Related Disabilities	●	●				●
Non-Contributory Life Insurance	●		●		●	●
Non-Contributory Occupational Accidental Death Insurance	●	●				●
Contributory Life Insurance	●		●			●
Dependent Life Insurance	●	●				●
Accidental Death and Dismemberment Insurance	●	●				●
Pension Plan (Normal, Early, Optional or Incapability Retirement)	●	●	●			●
Savings and Investment Plan (SIP) **	●	●	●	●	●	●

* *Long-Term Disability Recipients (not receiving Incapability Retirement) are eligible for 2 years of medical coverage in lieu of COBRA continuation coverage.*

** *Only Active Employees can make contributions to the SIP.*

HEALTH CHOICE OPTIONS

Health Choice options include:

- Medical Care benefits
- Dental Care benefits
- Vision Care benefits
- Flexible Spending Accounts (FSAs).

If you do not make any changes to your Health Choice elections during the annual enrollment period, you will automatically be enrolled in the same Health Choice plans for you and your dependents for the upcoming Plan year.

If you are eligible for coverage under the Health Choice Medical, Vision and Flexible Spending Accounts, your coverage may begin on your first day of employment. Eligibility for Health Choice Dental begins after you have completed one year of eligibility service. Each individual Summary Plan Description contains information on eligibility, including dependent eligibility.

On your first day of employment, you will be asked to enroll for coverage by completing a "Health Choice Election Form." Your elected medical and vision plans will be effective on your first day of employment, and your Flexible Spending Account (FSA) elections will become effective on the first day of the following month, if you return your Election form within two weeks. If you fail to return your Election form within the first two weeks of employment, you will automatically be enrolled in Basic Choice Medical at the employee-only coverage level, with no vision coverage or participation in either FSA plan. As your one-year anniversary nears, you will be mailed a dental enrollment form to complete your dental coverage election.

The WSRC Health Choice Dental plan has an every other calendar year lock-in period. You will not be able to move out of the Dental plan, change your covered dependents, or change your level of coverage within the two-year enrollment period. Changes in covered dependents will only be allowed for an approved "Qualifying Change in Status" (see Page 7 for more details).

Health Choice Medical

WSRC/BSRI sponsors four options under Health Choice Medical.

- Prime Choice
- Standard Choice
- Basic Choice
- BlueChoice HMO

The plans are designed to help protect you and your family from the high cost of medical treatment. Two of the plans (Prime Choice and Standard Choice) provide a higher level of benefits when you choose treatment through a network of doctors and hospitals often referred to as the Preferred Provider Organization (PPO).

BlueChoice HMO is a Health Maintenance Organization in which your medical care is managed through your selected Primary Care Physician (PCP). Please note that no benefits are payable by the BlueChoice HMO plan if you use non-HMO providers, with the exception of emergency treatment.

Basic Choice is a traditional medical insurance plan with a high deductible, which you must satisfy before the plan will pay any benefit.

Read your Medical Care Summary Plan Description to understand the details of medical coverage provided under the Health Choice Medical options.

Health Choice Dental

WSRC/BSRI sponsors two options under Health Choice Dental.

- Prime Choice
- Standard Choice

Both options provide benefits for preventive care at 100% of the reasonable and customary (R&C) amount. Prime Choice and Standard Choice both cover minor and major restorative services, but there are differences in coverage and in how much is paid by the two options. An annual deductible of $25 per person ($50 maximum per family) is required under the Standard Choice Dental plan for non-preventive services.

Orthodontia treatment is covered by Prime Choice at 50% of R&C up to a lifetime maximum benefit of $1,500. Under Prime Choice, benefits for treatment of TMJ and other Temporomandibular Disorders are paid at 50% of R&C up to a maximum lifetime benefit of $500 for each covered person. Neither orthodontics nor treatment for TMJ/TMD is covered under Standard Choice.

Read your Dental Care Summary Plan Description to understand the details of dental coverage provided under the Health Choice Dental options.

Health Choice Vision

Vision Care Choice is designed to help you pay for vision care expenses. The plan covers routine eye exams, eyeglasses, and contact lenses. It does not cover the medical or surgical treatment of the eye, which may be covered by the Health Choice Medical options (refer to your Medical Care Summary Plan Description for medical coverage and exclusions).

Vision Care Choice pays a benefit when you use any licensed eye care provider, not just LensCrafters locations or eye doctors contracted by EyeMed. No licensed optometrist, ophthalmologist, or optician has been excluded from coverage under this plan.

Read your Vision Care Summary Plan Description to understand the details of coverage provided under the Health Choice Vision Care plan.

Flexible Spending Accounts (FSAs)

There are two Flexible Spending Accounts (FSAs). You may use either or both Accounts. Each serves a separate purpose, has a separate contribution limit and slightly different payment procedure.

The Health Care FSA allows you to set aside money that's not taxable to fund your estimated non-covered health care expenses, including deductibles, co-pays and certain non-covered expenses, then pays you back after you have incurred these expenses. You may contribute up to $4,000 per year if you elect the Health Care FSA. In addition, you can use this account for out-of-pocket health care expenses incurred by any of your legal dependents – as defined under Section 125 of the Internal Revenue Code of 1986, as amended – including those who are not covered by a health care plan.

The Dependent Care FSA covers expenses for the day care (not health care) expenses of your dependents so that you and your spouse can work. Dependent refers to a child under age 13 or a dependent of any age who is incapable of caring for him or herself, in accordance with federal tax regulations. You may contribute up to $5,000 per year if you elect the Dependent Care FSA (or up to $2,500 per year if you are married and file separately on your federal income tax return). The advantage of using a Dependent Care FSA is that you can avoid paying taxes on the money you spend for day care expenses.

Read your Flexible Spending Accounts Summary Plan Description to understand the details of the Health Care and Dependent Care FSAs.

A Word About Taxes

Federal and most state tax laws allow the use of pre-tax earnings to buy certain benefits. Because money used in this manner is redirected from your paycheck before it is legally considered part of your salary, you do not have to pay federal or state income taxes or FICA taxes on this money. By using pre-tax dollars from your earnings to buy benefits, you are able to reduce your taxable income.

The portion of your salary that you redirect to purchase pre-tax benefits will not appear on your annual W-2 form as part of your earned income for federal, state and Social Security tax purposes. However, your base salary (before the purchase of pre-tax benefits) will be used to determine all pay-related benefits.

Because of the pre-tax treatment of benefit costs, you may receive Social Security benefits at retirement that are somewhat less than they would be if all the program's benefit costs were paid using after-tax dollars. However, any reduction in Social Security benefits should be minimal — probably not enough to materially affect your future financial security. The benefits of saving taxes now will generally exceed any reduction in Social Security benefits later.

Special Rules for Dual Couples

Dual couples – employees (or retirees) who have a spouse who is also an employee (or retiree) of the WSRC Team or DuPont/SRP – present a special situation. Dual couples cannot be covered as both an employee and a dependent. So, in theory, everyone — employees and dependents alike — can only be covered once by the WSRC/BSRI Health Choice plans. So, what happens to dual couples? There are two possibilities:

- The obvious route: Only one person in the couple elects coverage – the other person waives coverage as an employee and is covered as a dependent for WSRC Team health care purposes.
- An alternate route: Each person elects employee-only coverage; or one person covers the children and the other person takes employee-only coverage. Both people would have coverage as an employee.

Which route is better depends on the level of coverage you need and the cost for that coverage. It also depends on your family's health and typical health care expenses. Remember, if you each have separate coverage (whereby neither employee is covered as a dependent by the other spouse); you also have separate plan deductibles and out-of-pocket maximums.

Qualifying Change in Status

Health Choice is a flexible benefits plan. The Internal Revenue Service (IRS) governs certain administrative procedures for flexible benefits plans. Normally, you are permitted to make Health Choice election changes only during the annual enrollment period, which will be effective beginning January 1 of the following year, and your Health Choice elections must stay in effect for the full calendar year (also known as the Plan Year). You cannot change your benefit elections during the calendar year unless you have an event that qualifies as a Change in Status for benefit coverage purposes. Certain rules specify the events under which you may change a benefit election during mid-year, effective with the date of the event through the remaining portion of the calendar year.

The benefit change you want to make must be consistent with the qualifying event. That is, the event must result in the employee, spouse or dependent child gaining or losing eligibility for coverage under either Health Choice or the spouse's or dependent child's employer's plan. The Medical Care, Dental Care, Vision Care and Flexible Spending Account Summary Plan Descriptions describe the specific election changes that are allowed to be made under the respective Health Choice plans, as a result of a qualifying Change in Status.

Changes in Status:

The following events may be considered qualifying if they result in a change in eligibility for health care.

- A change in Legal Marital Status – an event that changes an employee's legal marital status, including marriage, death of spouse, divorce, legal separation or annulment;
- A change in Number of Dependents – an event that changes an employee's number of dependent children, including birth, adoption, placement for adoption, death of a dependent child or the acquisition of a stepchild who will reside in your household;
- A change in Employment Status – the termination or commencement of employment by the employee, spouse or dependent child; commencement of or return from unpaid leave of absence;
- A change in Work Schedule – the permanent reduction or increase in hours of employment by the employee, spouse or dependent child (including a switch between part-time and full-time), a strike or lockout, or the commencement or return from an unpaid leave of absence;
- A change in which a Dependent Child Satisfies or Ceases to Satisfy the Plan's Eligibility Requirements for an Unmarried Child – an event that causes an employee's dependent child to satisfy or cease to satisfy the requirements for coverage due to attainment of maximum age under the plan, student status, marriage of dependent, or any similar circumstance under the plan that qualifies or disqualifies the child for coverage under the plan;
- A change in Residence or Worksite that impacts HMO provider accessibility – a change in the place of residence or work of the employee, spouse or dependent child enrolled in BlueChoice HMO to an area not served by a participating HMO; and
- A change due to Enrollment in Medicare or Medicaid – an employee, spouse or dependent child becomes entitled to and enrolls in Medicare (Part A or B) or Medicaid.

Special enrollment rights under HIPPA (Health Insurance Portability and Accountability Act of 1996)

If you have declined enrollment for yourself or your dependent (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that your request for enrollment is received within 60 days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that your request for enrollment is received within 60 days after the marriage, birth, adoption, or placement for adoption.

Requesting an Election Change

If you, your spouse or dependent child experiences an event that qualifies as a Change in Status for benefit plan purposes, you must notify the WSRC People Support Service Center, with the proper documentation within 60 days after the event occurs. Make your dependent changes and new elections (when available) using OSR Form 5-200 (available on ShRINE). Submit the form and supporting documentation to WSRC People Support Service Center, Aiken, SC 29808, or phone (803) 725-7772 locally or 1-800-368-7333 within 60 days after the event. You should be aware of certain limitations:

- With a qualifying Change in Status, you will only be able to change your level of coverage (employee, employee plus one or employee plus two or more dependents) under your medical, dental and vision care elections. You will not be able to change the option (Prime, Standard, HMO, Basic, No Coverage) you elected.
- You may enroll in, drop or change the amount you are contributing to your Dependent and Health Care Flexible Spending Accounts.

Any change you are able to make under the Health Choice plans must be consistent with your qualifying Change in Status.

The WSRC/BSRI Plan Administrator has the right to request, at any time, documentation as proof of a qualifying Change in Status and eligibility for benefits, and will have the final decision making authority regarding any allowable changes.

Even if you do not need to change your coverage status, you should notify The WSRC Team People Support Service Center immediately whenever you have any Change in Status that could possibly have an impact on your benefits. Accurate records are important to ensure proper coverage for you and your dependents.

Requests to change your benefit elections (outside the annual enrollment period) that are not received by the WSRC People Support Service Center within 60 days after the date of a qualifying event will not be recognized. You will be allowed to make changes during the next annual enrollment period, effective January 1 of the following year. However, if a dependent has become ineligible during the Plan year and you do not notify the WSRC People Support Service Center within 60 days after the qualifying event has occurred, then (1) your ineligible dependent will be removed retroactively from your coverage once the dependent's ineligibility is known, (2) you will not be refunded any premium contributions, (3) any claims paid after the dependent became ineligible will be recovered from the employee or the health care provider by the Claims Administrator and/or the WSRC Team, and (4) your ineligible dependent may not be eligible for COBRA continuation coverage.

OTHER BENEFITS

You have two types of other benefits — Company-Provided Programs and Optional Programs. You are eligible to participate in most of these plans on your first day of employment. You are automatically enrolled in the Company-Provided benefits summarized in the section below, but you will be required to complete certain beneficiary forms. You will, however, have to complete separate enrollment forms for the Optional Programs.

Company-Provided Benefits

You do not pay premium contributions for the following Company-Provided Programs:

- Disability Income Plans
- Non-Contributory Life Insurance Plans
- Pension Plan

Disability Income Plans

As a full service active employee of the WSRC Team, you may be eligible for disability benefits from various sources — Short-Term Disability, Long-Term Disability, and Special Benefits for Occupational Related Disabilities. In addition, an Incapability Retirement benefit is available to employees with at least 15 years of Eligibility Service. Your disability benefits are designed to financially protect you and in some instances your family if you cannot work due to a disabling illness or injury. Depending on your type of disability, your salary may either continue during the time you are considered to be disabled under the plan or up to a maximum payment period. (Refer to the Disability Summary Plan Description for details.)

Short-Term Disability Benefits: To qualify for Short-Term Disability benefits, you must be unable to perform your own job because of a non-occupational illness or injury. If you become sick or injured, this benefit can provide you with your full pay for up to 1,040 hours. If your illness or injury is job-related, your coverage may be provided by Workers' Compensation and/or Special Benefits for Occupational Related Disabilities.

Long-Term Disability Benefits: You must complete one year of Eligibility Service to be eligible to participate in the Long-Term Disability plan. To qualify for Long - Term Disability benefits, you must be disabled and unable to perform any type of work due to a qualifying illness or injury. The benefit you receive from this coverage, when combined with other sources of income, will provide you with 60% of your monthly/weekly base earnings to a maximum benefit of $7,500 a month. Your benefits begin after you have exhausted your Short-Term Disability benefits or Special Benefits for Occupational Related Disabilities and will continue to age 65 as long as you remain disabled. If you begin receiving Long-Term Disability after age 60, your benefit will continue as long as you remain disabled up to a maximum of five years.

Special Benefits for Occupational Related Disabilities: To qualify for Special Benefits for Occupational Related Disabilities, your disability must be due to a job-related illness or injury and, as a result of that illness or injury; you will be entitled to receive Workers' Compensation benefits. The benefit you receive will be an amount established that when added to your Workers' Compensation benefit will keep your net take home pay approximately the same as of the time of the illness or injury. The benefit is payable for up to 1,040 hours.

Incapability Retirement Benefit: To qualify for the Incapability Retirement benefit, you must have 15 years of Eligibility Service and your disability must prevent you from performing your own job. The Incapability Retirement benefit provided by the WSRC/BSRI Pension Plan pays you an unreduced pension benefit equal to the benefit you earned at the time your employment ends.

Non-Contributory Life Insurance Plans

Plans sponsored by WSRC/BSRI help safeguard your family's financial security through two Company-provided life insurance plans — Non-Contributory Life Insurance and Non-Contributory Occupational Accidental Death Insurance. Refer to the Life Insurance Summary Plan Description for details.

A requirement of the life insurance plans is that you must name a beneficiary. You may name the same person as the beneficiary for all of your life insurance benefits or you can name different individuals for each plan. If you do not name someone as a beneficiary, your non-contributory life insurance death benefits will be paid to your estate.

Non-Contributory Life Insurance: This plan provides you with life insurance protection equal to one times your Life Insurance Pay (LIP) to a maximum benefit of $500,000 if you die, subject to certain exclusions while you are a full service employee or retiree of the WSRC Team. Between ages 65 and 75, the plan's death benefit gradually reduces to one-fourth of one times your LIP. LIP is your base pay and does not include occasional ad-hoc overtime or temporary variations from normal working hours, awards under incentive or special compensation plans or payments for relocation or severance. LIP for employees permanently assigned to premium pay shifts will be calculated using estimated projected earnings for a particular shift.

- ***Tax on Imputed Income:*** *The Internal Revenue Code of 1986, as amended (IRC), states that employer-provided group term life insurance can be provided tax-free up to $50,000 of coverage. The value of the amount of noncontributory life insurance in excess of $50,000 will be considered taxable income to you, in accordance with Table I of IRC Section 79(c). This excess value is called "imputed income," and is calculated according to your specific age bracket and the uniform premium cost per $1,000 of protection as established by IRS. The taxable amount is included on your pay stub and your W-2 form as additional income.*

Non-Contributory Occupational Accidental Death Insurance: This plan provides you an additional life insurance benefit if your death is the result of a job-related accident. If you die within 365 days as a direct result of a job-related accident, your beneficiary will receive a life insurance benefit equal to three times your Life Insurance Pay (LIP) to a maximum benefit of $750,000, in addition to the benefit of one times your LIP under the regular Non-Contributory Life Insurance Plan.

- *LIP is your base pay and does not include occasional ad-hoc overtime or temporary variations from normal working hours, awards under incentive or special compensation plans or payments for relocation or severance. LIP for employees permanently assigned to premium pay shifts will be calculated using estimated projected earnings for a particular shift.*

Pension Plan

The Pension Plan provides you with income during your retirement years. Under the Pension Plan, there are a variety of ways for you to receive a benefit. The following descriptions provide a brief explanation of each benefit payment method and its eligibility requirements.

Normal Retirement: You become eligible to receive a Normal Retirement benefit after you have reached age 65 and have completed at least 15 years of Eligibility Service with the WSRC Team.

Early Retirement (Unreduced): The earliest you become eligible to receive an unreduced Early Retirement benefit is age 58 with at least 27 years of Eligibility Service. Between age 58 and age 65, your age plus Eligibility Service must total at least 85 in order to be eligible to receive an unreduced Early Retirement benefit.

Early Retirement (Reduced): You become eligible to receive a reduced Early Retirement benefit after you have reached age 50 and you have at least 15 years of Eligibility Service.

Optional Retirement: You become eligible to receive an Optional Retirement benefit if you have been involuntarily terminated for a reason other than gross misconduct and you are age 50 or over with at least 15 years of Eligibility Service. You may also be eligible to receive a benefit if you are at least age 45 with 25 years of Eligibility Service when your employment with the WSRC Team is involuntarily terminated due to lack of work.

Incapability Retirement: You become eligible for an Incapability Retirement benefit if you are a full service employee with at least 15 years of Eligibility Service. To receive an Incapability Retirement benefit, you must be incapable of performing the duties of your own job.

Deferred Vested Pension Benefit: You become eligible for a Deferred Vested Pension benefit if you have at least five years of Eligibility Service. This means that if you leave the Company after you are vested but before you retire, you may receive a deferred pension benefit. "Deferred" means a postponed benefit payment. The pension payment is postponed until you are eligible to receive benefits and you apply for them. Even if you are eligible when you leave, you will not receive a pension payment until you apply for a benefit. When you receive a Deferred Vested Pension benefit depends on your age, Eligibility Service and whether you want a reduced or unreduced pension benefit. However, if the value of your deferred pension benefit is $1,000 or less at the time of your termination, there will be an automatic cash-out of your pension benefit.

Employer Paid Survivor Benefit: The Employer Paid Survivor Benefit provides a monthly payment to your eligible survivors. In order for your survivors to receive the Employer Paid Survivor Benefit at the time of your death, you must have at least 15 years of Eligibility Service as an active employee. Eligible survivors include your spouse, minor children under age 21 or one of your parents or stepparents.

Optional Programs

Participation in the Optional Programs is voluntary. This means you make the decision to participate in any of the Optional Programs by enrolling in the plan(s) and making the required contributions. Your contributions will be deducted from your pay on an after-tax basis, except for the Savings and Investment Plan (SIP) where you can choose to make either before-tax or after-tax contributions or both. You are eligible to enroll in the plans on your first day of employment. The following provides a brief description of your Optional Programs. For detailed information, read each individual Summary Plan Description (Life Insurance or Savings and Investment Plan).

Contributory Life Insurance

You may purchase Contributory Life Insurance if you wish to provide your family with greater financial protection than provided by Non-Contributory Life Insurance.

You can choose one, two or three times your Life Insurance Pay (LIP) to a maximum benefit of $550,000. Cost of the coverage is based upon your age. Between ages 65 and 75, the plan's death benefit gradually reduces to one-half of one times your LIP. LIP is your base pay and does not include occasional ad-hoc overtime or temporary variations from normal working hours, awards under incentive or special compensation plans or payments for relocation or severance. LIP for employees permanently assigned to premium pay shifts will be calculated using estimated projected earnings for a particular shift.

Dependent Life Insurance

Dependent Life Insurance provides a benefit payable to you in case one of your dependents dies. Dependents are defined in the Life Insurance Summary Plan Description. There are two different coverage amounts to choose from:

- *$5,000 for your spouse; $1,000 for each child, or*
- *$10,000 for your spouse; $2,000 for each child.*

You do not have to purchase Contributory Life Insurance to be able to purchase Dependent Life Insurance.

Accidental Death and Dismemberment Insurance

Accidental Death and Dismemberment (AD&D) Insurance provides a benefit if you or one of your dependents dies, loses permanent use of a limb or suffers a permanent loss of vision, as the result of an accident. The death or loss must occur within 365 days of the accident.

You have two coverage options: (1) You can purchase insurance coverage for yourself (in the event of your death or dismemberment) and/or (2) you can purchase coverage for your dependents. There are limitations as to the maximum amount of coverage you can purchase. For yourself, the maximum coverage is five times your Life Insurance Pay up to $300,000. For your dependents, you may purchase coverage up to $100,000 for your spouse and $20,000 for each child – in increments of $10,000. You are automatically the beneficiary of your dependent's AD&D coverage.

Savings and Investment Plan (SIP)

The Savings and Investment Plan (SIP) provides you with another way to save for the future and retirement. Moreover, because the WSRC Team feels it is important for you to save for the future, the Company will match $0.50 for every $1.00 of pay you contribute, up to 6%.

You are eligible to enroll in the SIP on your first day of employment and begin making contributions ranging from 1% to 16% of your pay as of the first eligible payroll. Then, after you have completed one year of Eligibility Service, the Company will begin to match your contributions (50 cents for every $1.00 you contribute up to 6%).

If you are a transfer from an affiliated entity of the WSRC Team and you have at least one year of recognized Eligibility Service, then you are eligible to immediately receive matching contributions in the WSRC/BSRI SIP.

When you enroll, you must decide:

- How much you are going to contribute — 1% to 16% of your pay
- Whether your contributions are going to be deducted on a before-tax or after-tax basis or both
- How you want to invest your contributions.

When you save on a before-tax basis, you will immediately pay less in federal and most state income taxes. However, federal and state income taxes will be applied to your contributions and investment earnings when you start withdrawing from your savings account. If your contributions are deducted on an after-tax basis, federal and state income taxes are only applied to the investment earnings upon withdrawal. All contributions are subject to federal tax limits.

You can choose to invest your contributions and the Company Matching Contribution among the investment funds the plan offers. A number of funds are available, ranging from a low-risk fixed income fund to riskier equity funds.

Although the plan is designed for retirement savings, you may be able to apply for a loan or withdrawal of the money in your account for other important purposes, such as helping to fund your child's college education. Contact the SIP Service Center at 1-800-360-2747 for details. You can also access detailed personalized information about your SIP account through the internet at http://resources.hewitt.com/wsrc.

WHAT HAPPENS IF . . .

The following charts provide a quick view of certain situations and things you should do to ensure you receive the highest level of benefits. It is intended only as an easy reference guide. Each specialized Summary Plan Description will have more complete information.

If You Need Medical Care and...	Then...
You are enrolled in Prime Choice or Standard Choice Medical and want to select PPO Network Providers in order to receive the highest level of benefits	Refer to the BlueCross & BlueShield PPO Provider Directory and call the provider to verify current PPO participation status or call 1-800-325-6596 for S.C. providers or 1-800-810-2583 for providers outside S.C, or use your computer with the following Internet address: http://www.bluecard.com.
You are enrolled in BlueChoice HMO	You must utilize BlueChoice HMO Network Providers in order to receive benefits (for non-emergency care); and you must have all your medical care coordinated by your BlueChoice HMO Primary Care Physician (PCP).
You are going to be admitted to the hospital for an overnight stay, and you are enrolled in Prime, Standard or Basic Choice Medical	Make sure your provider has pre-certified your hospital confinement as soon as possible (preferably at least two weeks before you are admitted) by calling 1-800-327-3238 in S.C. or 1-800-334-7287 outside S.C.
Your doctor recommends elective surgery	You might want to get a Second Surgical Opinion.
You are injured or seriously ill	Go to the nearest qualified Emergency Room (either a Network or Non-Network facility) if your condition is life threatening or you need acute or urgent care.
You need treatment for a mental health problem, alcohol abuse and/or substance abuse	You must call ValueOptions at 1-800-333-6557 (accessible 7 days per week, 24 hours per day) for assistance and to ensure that benefits will be provided. If you do not call, then no benefits will be provided under the Health Choice Medical options (except for very limited outpatient mental health services).
Your emergency leads to a hospital admission	You must certify the admission within 1 business day by calling 1-800-327-3238 in S.C. or 1-800-334-7287 outside S.C for Prime, Standard, and Basic. If you are enrolled in the HMO you must notify your Primary Care Physician within 48 hours of seeking emergency room care.
You would like to have a routine periodic exam or other preventive care service	Check to see whether the routine exam and/or tests are covered by the medical plan you are enrolled in for your age group, and use Network providers to ensure coverage.

If you need Dental Care and...	Then...
You want the highest level of benefits available under the dental plan	You may use any licensed dentist since a dental network is not available, but you may want to shop around since dentists' charges vary widely.
Your dentist estimates the total charges may exceed $200	It is strongly advised that you have your dentist file a pre-treatment plan to BlueCross & BlueShield of S.C. You and your dentist will be mailed a Pre-Determination of Benefits.
Your dentist recommends that your child be fitted with braces	Have your dentist file a pre-treatment plan. The Prime Choice Dental Plan covers orthodontia with limitations.

If you need Vision Care Services and...	Then...
You go to a LensCrafters location or participating EyeMed optometrist or ophthalmologist	Pay your copay for eye exam and the cost for any services not covered by the plan or above the plan's limits.
You go to another eye care provider	Obtain an out of network claim form from ShRINE (OSR 3-352), WSRC People Support Service Center or from EyeMed Vision Care by calling 1-800-521-3606. Pay your eye care provider for services rendered, and then submit the claim with receipts to EyeMed Vision Care.

If you die while employed and...	Your beneficiary will receive...
Your Beneficiary is eligible for certain benefits.	• Company-Provided Non-Contributory Life Insurance equal to one times your Life Insurance Pay. • Contributory Life Insurance, if elected. • Health Choice Benefits, either under the Survivor Benefits policy or through COBRA continuation coverage. • Spousal Benefits from the pension plan, based on age, Eligibility Service and your choices. • Full payment from your Savings and Investment Account, if enrolled.

If you plan to retire from active service...	You may be eligible to receive...
And meet the age and service requirements for retirement; you may be eligible for certain benefits. You should contact Retirement Services section of WSRC Benefits Administration as soon as you know you will be retiring.	• Monthly Pension benefit payment. • Health Choice Medical and Dental coverage. • Vision Care Choice through COBRA continuation coverage, if enrolled at retirement. • Company provided Non-Contributory Life Insurance at one times your Life Insurance Pay (LIP) amount until you are age 65; then your benefit amount will be periodically reduced to one-fourth your LIP amount until you are age 75 at which time it will remain at one-fourth your LIP amount until your death. • Contributory Life Insurance, if elected, at the same amount (either 1, 2 or 3 times your LIP amount) until you are age 65; then your benefit amount will be periodically reduced to one-half of ONE times your LIP amount until you are age 75 at which time it will remain at one-half of ONE times your LIP amount until your death. Your insurance premiums will be deducted from your Pension checks.) • Full lump sum payment or monthly installments from Savings and Investment Plan, if enrolled.

If you are on an approved unpaid leave of absence...	You will be eligible to continue...
You are eligible to continue certain benefits and should contact WSRC People Support Service Center as soon as you know you will be taking a leave of absence.	Your medical, dental, vision, Health Care Flexible Spending Account, and all your life insurance coverage as long as you pay the required premiums. Generally, you will not receive service credit for leaves of absence greater than 30 days.

If you are laid off...	You will receive...
You may be eligible for certain benefits and will be provided instructions at the time you are notified.	• Any special benefits established (at the time of your lay-off) for employees who are laid off. Any such extended benefits are in lieu of coverage continuation through COBRA. • Your Health Choice benefits through COBRA Continuation Coverage. • Special extended life insurance coverage based on your years of Eligibility Service if you are eligible for this provision and it is available at the time of your lay-off. Moreover, you may be able to convert to an individual policy. • Full payment from your Savings and Investment Account, if enrolled. • Optional Retirement, if you meet the age and service requirements.

If you terminate your employment...	Then...
You and/or your dependents are eligible for certain benefits.	• Your Health Choice Benefits can be continued through COBRA Continuation Coverage. • Your Company-Provided Non-Contributory Life Insurance, Contributory Life Insurance and Dependent Life Insurance can be converted to an individual policy. • You may be eligible for a pension if you meet certain eligibility requirements. • You may be required to take a full distribution of your Savings and Investment Plan, if enrolled.

II

PART TWO

GENERAL INFORMATION

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

- Your rights under Employee Retirement Income Security Act (ERISA)
- How to contact the Plan Administrator or Plan Trustee
- What happens if you or a dependent loses coverage under the Health Choice options (Medical, Dental, Vision, and FSA plans)
- Additional information on rights that you may have as a plan participant.
- Refer to each individual Summary Plan Description to determine what benefits are available to you and how to file a claim.

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

You may not be eligible to participate in every plan and program mentioned in this section. The Overview section of this Summary Plan Description includes an easy-to-follow table listing the various WSRC/BSRI benefit plans, along with a general indication of eligibility. Each individual Summary Plan Description contains specific eligibility information.

PLAN INFORMATION

Employer Identification Numbers of The WSRC Team

The identification numbers assigned by the Internal Revenue Service are:

- Washington Savannah River Company LLC (WSRC): 82-0510443
- Bechtel Savannah River, Inc. (BSRI): 94-3077224
- BNG America Savannah River Corporation: 54-1813446
- BWXT Savannah River Company: 54-1804131
- CH2 Savannah River Company: 02-0693747

The Plan Directory located at the end of this Summary Plan Description will provide you with plan-specific information, such as Plan Name, Plan Administrator, and Insurance Company.

Plan Sponsor

All ERISA-covered benefit plans referred to in this Summary Plan Description are sponsored by Washington Savannah River Company LLC and Bechtel Savannah River, Inc. (WSRC/BSRI). The term "ERISA" is described in the section of this Summary Plan Description titled "Your Rights Under ERISA." The address for the Plan Sponsor is:

Washington Savannah River Company LLC
Benefits Administration
Aiken, SC 29808
(803) 725-7772

Plan Administrator

The Plan Administrator is responsible for maintaining the records related to and administration of ERISA-covered benefit plans. The Plan Administrator also has the express discretionary authority to interpret the terms of the plans and to make final determinations on questions that may affect your eligibility for benefits. The Plan Administrator reserves the right to request, at any time, documents to determine eligibility for benefits and to resolve appeals. The Plan Administrator for the retirement plans and self-insured welfare plans is designated by the WSRC/BSRI Benefits Committee. Correspondence to the Plan Administrator, unless otherwise indicated in the Plan Directory table located at the end of this Summary Plan Description should be sent to:

Benefits Administration – Plan Administrator
Washington Savannah River Company LLC
Aiken, SC 29808
(803) 725-7772

Plan Numbers

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

Plan Year

All plans are administered on a calendar-year basis beginning January 1 of each year and ending December 31, unless otherwise indicated.

Plan Documents

Each individual Summary Plan Description summarizes the provisions of the applicable plan. However, the official plan documents, insurance company contracts and trust agreements legally govern the operation of the plans.

If any question should arise which is not covered by a Summary Plan Description, or in case a Summary Plan Description should appear to conflict with the official plan documents, the text of the official plan document will control how the question will be resolved. Copies of plan documents, together with Plan annual reports and descriptions are available for review by any plan member, spouse or beneficiary. If you would like to review a copy of these documents, contact your Plan Administrator.

Plan Financing and Administration

Many of the plans are financed by Company contributions. The following sections provide you with funding and administrative information for the WSRC/ BSRI Welfare and Retirement Plans.

Welfare Plans

The following plans are termed "welfare" plans by ERISA.

Health Choice Options

The Health Choice Medical and Dental options are self-insured and funded through Company contributions and participant premium contributions. The Health Choice Prime, Standard and Basic Choice Medical and Prime and Standard Choice Dental options are administered under a contract with Blue Cross and Blue Shield of South Carolina (BCBS-SC). The Health Choice BlueChoice HMO Medical option is administered under a contract with Blue Cross and Blue Shield Healthcare Plan of Georgia (BCBSHP). The mental health and chemical dependency treatment benefits under each of the Health Choice Medical options are administered under a contract with ValueOptions. Participants who are entitled to receive benefits from these plans will receive payment from the respective Claims Administrator.

The Health Choice Flexible Spending Accounts (FSAs) are funded through employee contributions. Any amount remaining in your Flexible Spending Account, after all eligible expenses have been paid for the Plan Year, is forfeited subject to applicable law and regulations. Any forfeitures shall revert to the Plan Sponsor as indicated in the Plan

Directory located at the end of this Summary Plan Description. The Health Choice Flexible Spending Accounts are administered under a contract with Blue Cross and Blue Shield of South Carolina (BCBS-SC).

The Health Choice Vision Care option is insured and administered by EyeMed Vision Care, LLC, under a contract with WSRC. Effective January 1, 2005, the Health Choice Vision will be underwritten by Fidelity Security Life Insurance Company, which has partnered with EyeMed. This plan is funded with before-tax employee premium contributions. Participants who are entitled to receive benefits from this plan will receive benefits from EyeMed Vision Care. Benefits are available for services provided by a provider contracted with EyeMed Vision Care, a LensCrafters location or doctor of optometry located next to LensCrafters, or any other licensed eye care provider.

Remember that your Flexible Spending Account can be used only for eligible expenses for services incurred during the Plan Year in which you are a participant and make FSA contributions. You have until April 15 following the Plan Year to file a claim for FSA reimbursement. Any amount remaining in your account will be forfeited.

Other Welfare Plans

The Non-Contributory Life Insurance and Occupational Accidental Death Plans are insured and funded with premium payments made to the Life Insurance Company of North America.

The Contributory Life Plan, Dependent Life Plan and Accidental Death and Dismemberment Insurance Plan are insured and funded with your after-tax payroll contributions. These premium contributions are paid to Life Insurance Company of North America.

Refunds from the Contributory Life Insurance Plan, due to favorable claims experience, are held in the WSRC/BSRI Employee Benefits Trust Fund, a Voluntary Employees' Beneficiary Association (VEBA). This trust fund is for use in purchasing and stabilizing the premiums of the Contributory Life Insurance Plan. The Trustee for the VEBA fund is:

State Street
P.O. Box 351
Boston, MA 02101-0351

The above-named life insurance plans are administered under contract with Life Insurance Company of North America. Participants and survivors who are entitled to receive benefits from these plans will receive payment from Life Insurance Company of North America.

The Disability Income Plan (Short-Term Disability, Long-Term Disability and Special Benefits for Occupational Related Disabilities) is self-insured, self-administered and funded by the Company.

Retirement Plans

The following plans are termed "pension" plans by the ERISA. They may provide you with retirement income when you retire from The WSRC Team or one of its affiliates.

The WSRC/BSRI Pension Plan is funded through contributions to a trust fund, which is held by the trustee, Mellon Bank Trust. The contributions to the fund are determined in accordance with actuarial principles for the funding of pension plans.

The WSRC/BSRI Savings and Investment Plan is funded through Company-matching contributions, employee before-tax salary contributions and/or employee after-tax salary contributions to a trust fund. The trust fund is held by the trustee, State Street, and investment of the funds in which participants choose to place their money is made by the respective investment managers of the funds.

The trust funds have been set up for the exclusive benefit of the plan participants and their beneficiaries. Participants and survivors who are entitled to receive benefits from the Pension Plan and/or Savings and Investment Plan will receive payment from the trustee on directions from the Plan Administrator. The trustee is also required to provide an annual report to the Plan Administrator.

Legal Limits

Federal law limits the total annual amount that can be paid to you from the Pension Plan. Federal law also limits the amount that can be contributed by you and the Company to the Savings and Investment Plan. These limitations are subject to periodic change by the IRS. The Plan Administrator will communicate changes in these limitations.

Under federal law, certain provisions of the Pension Plan or Savings and Investment Plan will take effect if either or both plans become "top-heavy." A plan becomes "top heavy" if either 60% of the benefits are payable to "key employees" or more than 60% of its total assets are held in the accounts of "key employees," as defined under federal law and regulations. In the unlikely event that either plan becomes "top-heavy," the special provisions that will take effect are designed to protect the rights of "non-key" employees. If either plan becomes "top-heavy," you will receive a detailed description of these provisions.

Pension Benefit Guaranty Corporation (PBGC)

If the Pension Plan is terminated or partially terminated, you have certain guarantees. You would be fully vested in the pension benefits you earned as of the date of termination to the extent that the Pension Plan is funded, or to the extent that pension benefits are guaranteed by the Pension Benefit Guaranty Corporation (PBGC), whichever is greater.

The PBGC is a government corporation established by the Employee Retirement Income Security Act of 1974 (ERISA) to insure certain benefits. Generally, the PBGC guarantees most normal, early and vested pensions earned before the date of termination, and survivor benefits that are being paid at the time of termination. The PBGC does not, however,

guarantee all types of benefits under covered plans. The amount of benefit protection, by law, is subject to certain limitations. For example, the PBGC does not guarantee benefits for employees who were not vested immediately before the date of termination.

The PBGC guarantees benefits, which were vested immediately before the date of termination, at the level then in effect. If, however, a plan has been in effect less than five years before it terminates, or if benefits have been increased within five years before plan termination, the entire amount of vested benefits that otherwise would be guaranteed or the benefit increase may not be insured. In addition, there is a periodically adjusted ceiling on the dollar amount of the monthly benefit that the PBGC guarantees. If there are not enough plan assets, vested benefits not covered by plan assets or PBGC guarantees will not be payable by the plan, the PBGC or the Company.

You can get more information on PBGC insurance protection and its limitations from the Plan Administrator, or you can write to the Pension Benefit Guaranty Corporation, 1200 K Street NW, Washington, DC 20005-4026. The PBGC's Internet address is http://www.pbgc.gov. The PBGC does not insure benefits under any other plan described in this Summary Plan Description, since PBGC protection only applies to defined benefit pension plans, like the WSRC/BSRI Pension Plan.

Future of the Plans

While the WSRC Team expects to continue the plans for an indefinite period of time, the Company - by action of its Board of Directors or the WSRC/BSRI Benefits Committee reserves the right at any time and from time to time to modify or amend in whole or in part any or all of the provisions of the plans. When such plan modification or termination occurs, plan participants will receive written notification of plan modification or termination changes, and their rights under any plan that is terminated.

Welfare Plans

If the Health Choice Medical, Dental or Vision Care options, or the Life Insurance Plans are changed or terminated, any claim for benefits incurred by you, your eligible dependents or beneficiaries prior to the date of change or termination will be considered liabilities of the plans.

If the Health Care and/or Dependent Care Flexible Spending Accounts are terminated, you will be reimbursed for any eligible expenses incurred during the Plan Year that do not exceed the balance of your Account, up to the date of termination of the Accounts.

Once any of these welfare plans is terminated, you have no further rights to benefits (other than payment of covered expenses incurred during the time you were covered). You are not vested in any of these plan benefits.

Retirement Plans

The WSRC/BSRI Pension Plan and WSRC/BSRI Savings and Investment Plan are subject to continuing approval by the Internal Revenue Service that makes possible certain tax advantages to you and the Company. If the plans are changed to maintain IRS approval, you will be notified of the changes.

If the Pension Plan is terminated, you will have a vested or non-forfeitable right to your accrued benefits as of the date the plan is terminated. The amount of your pension, if any, will depend on the plan assets, terms of the plan and the benefit guarantees of the Pension Benefit Guaranty Corporation. (See the description in this Summary Plan Description titled "Pension Benefit Guaranty Corporation (PBGC).")

If the Savings and Investment Plan is terminated, you will have a vested or non-forfeitable right to your account balance as of the date of the termination of the plan.

CLAIMS AND APPEALS

Claims Filing

You do not receive benefits automatically from the following plans. You or your beneficiary must apply for benefits from these plans:

- Health Choice Medical
- Health Choice Dental
- Health Choice Vision Care
- Health Care Flexible Spending Account (FSA)
- Dependent Care Flexible Spending Account (FSA)
- Disability Income Plans
- Non-Contributory Life Insurance
- Occupational Accidental Death (OAD) Insurance
- Contributory Life Insurance
- Dependent Life Insurance
- Accidental Death and Dismemberment (AD&D) Insurance
- Savings and Investment Plan
- Pension Plan.

The claim process is different for each plan. You should refer to each individual Summary Plan Description to determine how to apply for benefits. Claim forms may be obtained electronically on SRS computers through ShRINE, the respective Claims Administrator or from People Support Service Center.

If Your Claim Is Denied

If your claim (or your beneficiary's claim if you are deceased) for benefits under any plan is denied in whole or in part, and you have exhausted the claims appeal process with the appropriate Claims Administrator, you can appeal the denial through the Plan Administrator. (Refer to the Plan Directory for the name, address and phone number of the appropriate Plan Administrator.) The Plan will not accept any documents for review dated and/or received after the Plan Administrator's final decision. Refer to each individual Summary Plan Description for the appeal process with the exception of Pension and SIP. The Pension and SIP appeals process begins on the next page.

If Your Pension or Savings and Investment Plan claim is denied

You have the right to appeal any denied claim. To begin the appeal process, you or your beneficiary must write to the Plan Administrator within 60 days of denial of the claim. Your request for review must state the reason for appealing the claim denial and the basis upon which the review is requested, including but not limited to, pertinent plan provisions, prior decisions and/or statements of facts or circumstances in your possession, which are pertinent to your claim. You should identify the plan by using the Plan Name and Plan Number found in the Plan Directory located at the end of this Summary Plan Description.

As part of the review procedure:

- You will be able to review all plan documents and other documents that affect your claim
- You may have someone act as your representative in the review procedure as long as you notify the Plan Administrator of your authorization in writing
- You may submit issues or comments in writing.

Within 60 days after receiving your appeal, the Plan Administrator will provide you or your beneficiary with a written decision. If more time is needed to review your appeal, the Plan Administrator may utilize one 60-day extension. If this additional time is needed, you will be notified in writing.

The Plan Administrator and those persons acting on the Plan Administrator's behalf are vested with full power and sole discretion to interpret all the terms of the plan and will make the final determination based solely on the applicable facts and evidence. All decisions of the Plan Administrator are final and binding and the Plan will not accept any documents for review dated and/or received after the Plan Administrator's final decision.

ADDITIONAL INFORMATION

Assignment of Benefits

As part of divorce proceedings, you may be ordered to provide coverage under certain plans for your spouse, former spouse, child or other dependents. (See Qualified Domestic Relations Order, below.)

Qualified Domestic Relations Order

Under the Retirement Equity Act of 1984, your benefits may be assigned to an alternate payee if a Qualified Domestic Relations Order exists.

A Qualified Domestic Relations Order is a legal judgment, decree or order, which is qualified by the Plan Administrator and recognizes the rights of an alternate payee under your Pension Plan and/or Savings and Investment Plan with respect to dependent support, alimony or division of marital property rights, and otherwise meets federal law.

In other words, if you become divorced, a portion of your benefits under the Pension Plan and/or Savings and Investment Plan may be assigned to someone else to satisfy a legal obligation you may have to a spouse, former spouse, child or other dependent.

There are specific IRS requirements that the Qualified Domestic Relations Order must meet to be recognized by the Plan Administrator, and specific procedures regarding the amount and timing of payments. Procedures may be obtained without charge from the Plan Administrator.

Overpayments

If, for any reason, an overpayment is erroneously made under any of these plans, the participant shall be responsible for refunding the amount to the plan. The repayment shall be made pursuant to the method established by the Plan Administrator.

Legal Service

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

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

Corporate Service Company
5000 Thurmond Mall Blvd.
Columbia, SC 29201
Phone: 800-927-9800

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal law enacted in 1986, if you or an eligible dependent loses coverage under any of the Health Choice Medical, Dental or Vision Care options or the Health Care Flexible Spending Account, you may be entitled to continue Medical, Dental, Vision and/or Health Care Flexible Spending Account coverage for a limited period of time. This is called COBRA continuation coverage.

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a covered employee becomes entitled to Medicare benefits (under Part A, Part B or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Administrative Solutions, P.O. Box 100136, Columbia, SC 29202-3136, phone (800) 325-6596 (select Option 5), or (800) 991-3801, of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the I8-month period of continuation coverage.

You must notify Administration Solutions, P.O. Box 100136, Columbia, SC 29202-3136, phone (800) 325-6596 (select Option 5) of your disability status within 60 days of the SSA determination and prior to the end of the 18 month period of continuation coverage. You will be required to submit a copy of the letter from the SSA notifying you of your disability status. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of him or her qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Administrative Solutions of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan.

These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify Administrative Solutions within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

COBRA continuation coverage is available in the event you and/or your Dependent's coverage terminates due to certain qualifying events described below. The Company will provide you or your dependents with COBRA information for these qualifying events:

- Termination of your employment for any reason, including retirement, voluntary termination, etc., other than for gross misconduct;
- A reduction in your work hours of work causing ineligibility for coverage.
- Your death.

It is your or your Dependent's responsibility to notify the WSRC People Support Service Center within 60 days of the following qualifying events:

- Your dependent child no longer meets the eligibility requirements for coverage;
- Your divorce or legal separation;
- You become entitled to Medicare benefits.

If you desire to exercise your right to continuation of coverage under COBRA, you must do so within 60 days following the date of the event that terminated your coverage. To remove a Dependent from your coverage you should complete an OSR 5-200 Health Care Enrollment Change form and submit it to the WSRC People Support Service Center no later than 60 days from the date of the qualifying event or loss of coverage. You may be required to provide official documentation supporting your request such as a copy of your divorce decree.

The following is the address and phone number for the submission of requests for COBRA continuation coverage:

WSRC People Support Service Center
Aiken, SC 29808
Phone (800) 368-7333 / (803) 725-7772

Administrative Solutions will send you an election form in the mail to your address of record. To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 62-day gap in health coverage,

and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under' federal law.

You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

You pay 102% of the full cost of COBRA continuation coverage. The premium includes actuarially calculated Plan costs, in addition to the cost of administering COBRA. COBRA continuation coverage is available in the event your and/or your dependents' coverage terminates due to certain qualifying events.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage: If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked.) If you do not make your first payment for continuation coverage in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact

Administrative Solutions
P.O. Box 100136
Columbia, SC 29202-3136
Phone (800) 325-6596 (select Option 5) or (800) 991-3801

Periodic payments for continuation coverage: After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is provided to you during enrollment. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for periodic payments: Although periodic payments are due on the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

Administrative Solutions
P.O. Box 100136
Columbia, SC 29202-3136

For more information

If you have any questions concerning the information or your rights to coverage, you should contact

WSRC People Support Service Center
Aiken, SC 29808
Phone: (803) 725-7772 or (800) 368-7333

or

Administrative Solutions
P.O. Box 100136
Columbia, SC 29202-3136
Phone: (800) 991-3801

Absent from employment due to military service

Continuation of Coverage (Federal Law – USERRA): Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Employee may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under the Plan, and if the Employee becomes absent from work due to military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the Plan. In order to be eligible for coverage during the period that the Employee is absent from work on military leave, the Employee must give reasonable notice to the Employer of his or her military leave.

The Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her dependents can elect to continue coverage under the Plan up to 24 months from the date the military leave commences, or the length of uniformed service, whichever is shorter.

An employee returning from military leave is guaranteed the right to reinstatement in the health plan without any waiting periods. During military leave, the Employee can be required to pay the Employer for the entire cost of such coverage, including any elected dependents' coverage for employees who are on military leave for 31 or more days.

Conversion Privilege in Lieu of COBRA

If you or your eligible dependents do not wish to elect COBRA continuation coverage, you may apply for conversion to an individual non-group Blue Cross and Blue Shield medical policy. This conversion privilege is only available for Health Choice Medical. You cannot convert your Health Choice Dental, Health Choice Vision Care plan or Health Care Flexible Spending Account.

If you elected COBRA continuation coverage, you may apply for conversion to an individual non-group Blue Cross and Blue Shield medical policy within 30 days of the end of your COBRA continuation coverage period. The conversion privilege is only available for Health Choice Medical.

HIPAA (Health Insurance Portability and Accountability Act)

The WSRC/BSRI Health Choice Medical and Dental options do not deny coverage to employees or dependents because of pre-existing medical conditions. However, should you leave the WSRC Team and go work for another company; your medical coverage may be affected by your new company's restrictions relative to pre-existing conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which medical insurance coverage may be excluded for medical conditions that were present before you enrolled in your new company's medical benefits plan. Under HIPAA, a pre-existing condition exclusion in another company's plan generally may not be imposed for more than 12 months (18 months for a late enrollee). The exclusion period is reduced by the amount of your prior health coverage under the WSRC/BSRI Health Choice Medical plan.

When you leave employment with the WSRC Team, you are entitled to a "Certificate of Group Health Plan Coverage" which will be automatically provided to you by Benefits Administration. The Certificate will show evidence of your prior medical coverage under the WSRC/BSRI Health Choice options, including the beginning date if less than 18 months before the date the coverage ended and ending dates of your medical, dental and vision care coverages. You should provide this Certificate to your new employer. If you decide to buy health insurance other than through an employer group health plan, the Certificate showing prior coverage may help you obtain coverage without a pre-existing condition clause.

Privacy of Protected Health Information

WSRC/BSRI's Certification or Compliance

Neither the Health Choice Benefit Plan (the "Plan") nor any third party business associate servicing the Health Choice Benefit Plan will disclose plan participants' Protected Health Information (PHI) to WSRC/BSRI unless WSRC/BSRI certifies that the Plan documents have been amended to incorporate this section and agrees to abide by this section.

- WSRC/BSRI will neither use nor further disclose PHI received from the Health Choice Benefit Plan, except as permitted or required by the Health Choice Benefit Plan documents, as amended, or required by law.
- WSRC/BSRI will ensure that any agent, including any subcontractor, to whom it provides PHI obtained from the Plan, agrees to the restrictions and conditions of the Health Choice Benefit Plan documents, including this section.
- WSRC/BSRI will not use or disclose a participants' PHI obtained from the Plan for employment-related actions or decisions or in connection with any other nongroup health benefit or employee benefit plan of WSRC/BSRI.
- WSRC/BSRI will report to the Health Choice Benefit Plan any use or disclosure of PHI obtained from the Plan that is inconsistent with the uses and disclosures allowed under this section upon learning of such inconsistent use or disclosure.
- WSRC/BSRI will make PHI obtained from the Plan available to the plan participant .
- WSRC/BSRI will track disclosures it may make of PHI obtained from the Plan so that it can make available the information required for the Health Choice Benefit Plan to provide an accounting of disclosures in accordance with applicable law or regulation.
- WSRC/BSRI will make its internal practices, Summary Plan Descriptions, and records, relating to its use and disclosure of PHI obtained from the Plan to the Health Choice Benefit Plan and to the Secretary of Health and Human Services for audit purposes.

WSRC/BSRI will, if feasible, return or destroy all PHI WSRC/BSRI received from the Plan that WSRC/BSRI maintains in whatever form and including copies of any such information, when the plan participants' PHI is no longer needed for the plan administration functions for which the disclosure was made.

Purpose or Disclosure to WSRC/BSRI

- The Health Choice Benefit Plan and any third party business associate servicing the Health Choice Benefit Plan will disclose PHI obtained from the Plan to WSRC/BSRI only to permit WSRC/BSRI to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996. Any disclosure to and use by WSRC/BSRI of PHI obtained from the Plan will be subject to and consistent with the provisions of this section.

- Neither the Health Choice Benefit Plan nor any third party business associate servicing the Health Choice Benefit Plan will disclose PHI obtained from the Plan to WSRC/BSRI unless the disclosures are explained in the Notice of Privacy Practices distributed to the plan participants.

Adequate Separation Between WSRC/BSRI and The Health Choice Benefit Plan

- WSRC Benefits Administration, WSRC People Support Service Center, WSRC Payroll, WSRC Internal Audit, WSRC General Counsel or WSRC Medical Department employees may be given access to plan participants' PHI received from the Health Choice Benefit Plan or a health insurance issuer or business associate servicing the Health Choice Benefit Plan.
- These employees will have access to plan participants' PHI only to perform the plan administration functions that WSRC/BSRI provides for the Health Choice Benefit Plan.
- These employees will be subject to disciplinary action, for any use or disclosure of plan participants' PHI in breach or violation of or noncompliance with the provisions of this section to the Health Choice Benefit Plan documents. WSRC/BSRI will report such breach, violation or noncompliance to the Plan and will cooperate with the Health Choice Benefit Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any participant, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires that you be specifically informed that you are covered by the WSRC/BSRI Health Choice Medical options (Prime, Standard, Basic and BlueChoice HMO) for certain medical services following a mastectomy. The WSRC/BSRI Medical options provide coverage for the following services subsequent to a mastectomy:

- Elective reconstructive surgery of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Such coverage is subject to normal plan rules (such as coinsurance provisions). Questions concerning breast reconstruction following a mastectomy should be directed to the appropriate Claims Administrator (BlueCross and BlueShield of South Carolina if you are enrolled in the Prime, Standard or Basic Choice Medical Plan; or HMO Georgia, Inc. if you are enrolled in the BlueChoice HMO Plan).

Your Rights Under ERISA

Although the Employee Retirement Income Security Act (ERISA) of 1974, as amended, does not require that an employer provide benefits, it does set standards on how a plan is run, and requires that you be kept informed of your rights and benefits.

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

ERISA provides that you may:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as your personnel office, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, Pension and Welfare Benefits Administration, such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- 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 financial report, also called "Summary Annual Report" or SAR.
- Obtain a statement telling you whether you have a right to receive a benefit under the Pension Plan and Savings and Investment Plan and, if so, what your benefit is under either plan if you stop working now. If you do not have a right to a benefit, the statement will tell you how many more years you have to work to receive a right to a benefit (of course, you are always fully vested in your own contributions to the plan). The statement must be requested in writing and is not required to be given more than once a year. The plan must provide this statement free of charge.

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

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your application for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your application.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from a plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have an application for benefits which you believe was improperly denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, Pension and Welfare Benefits Administration, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and/or fees. If you lose, the court may order you to pay these costs and/or fees (for example, if it finds your claim frivolous or without reasonable cause).

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

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

PLAN DIRECTORY

Plan Name	Plan Administrator	Plan Sponsor	Policy or Contract Number
Health Choice Medical (Prime, Standard, and Basic Options)	Plan Administrator – Medical Plan Washington Savannah River Company LLC Aiken, SC 29808	Washington Savannah River Company LLC Bechtel Savannah River Inc. Aiken, SC 29808	71-5210
Health Choice Medical BlueChoice HMO	Plan Administrator – Medical Plan Washington Savannah River Company LLC Aiken, SC 29808	Washington Savannah River Company LLC Bechtel Savannah River Inc. Aiken, SC 29808	WSRC 024 101
Health Choice Mental Health (All Medical Options)	Plan Administrator – Medical Plan Washington Savannah River Company LLC Aiken, SC 29808	Washington Savannah River Company LLC Bechtel Savannah River Inc. Aiken, SC 29808	NA
Health Choice Dental (Prime and Standard Options)	Plan Administrator – Dental Plan Washington Savannah River Company LLC Aiken, SC 29808	Washington Savannah River Company LLC Bechtel Savannah River Inc. Aiken, SC 29808	71-5210
Health Choice Vision Care	EyeMed Vision Care, LLC Washington Plan 4000 Luxottica Place Mason, OH 45040	Washington Savannah River Company LLC Bechtel Savannah River Inc. Building 703-47A Aiken, SC 29808	VC-19
Health Care Flexible Spending Account	Plan Administrator – HC-FSA Washington Savannah River Company LLC Aiken, SC 29808	Washington Savannah River Company LLC Bechtel Savannah River Inc. Aiken, SC 29808	71-5210
Dependent Care Flexible Spending Account	Plan Administrator – DC-FSA Washington Savannah River Company LLC Aiken, SC 29808	Washington Savannah River Company LLC Bechtel Savannah River Inc. Building 703-47A Aiken, SC 29808	71-5210
Disability Income Plan	Plan Administrator – Disability Plan Washington Savannah River Company LLC Aiken, SC 29808	Washington Savannah River Company LLC Bechtel Savannah River Inc. Aiken, SC 29808	NA
Employee Basic Life, Voluntary Employee Life, and Voluntary Dependent Life	Plan Administrator – Life Insurance Washington Savannah River Company LLC Bechtel Savannah River Inc. Aiken, SC 29808 Plan Fiduciary for final review of claims Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235	Washington Savannah River Company LLC Bechtel Savannah River Inc. Aiken, SC 29808	FLX52108

Plan Name	Plan Administrator	Plan Sponsor	Policy or Contract Number
Employee Only Basic Occupational Accidental Death, Family Voluntary AD&D, and Employee Voluntary AD&D	Plan Administrator – Life Insurance Washington Savannah River Company LLC Bechtel Savannah River Inc. Aiken, SC 29808 Plan Fiduciary for final review of claims Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235	Washington Savannah River Company LLC Bechtel Savannah River Inc. Aiken, SC 29808	OK817090
Pension Plan	Plan Administrator – Pension Plan Washington Savannah River Company LLC Aiken, SC 29808	Washington Savannah River Company LLC Bechtel Savannah River Inc. Aiken, SC 29808	NA
Savings and Investment Plan	Plan Administrator – SIP Washington Savannah River Company LLC Aiken, SC 29808	Washington Savannah River Company LLC Bechtel Savannah River Inc. Aiken, SC 29808	NA

Plan Name	Insurance Company, Claims Administrator, Trustee	Plan Number	Funding and Type of Plan
Health Choice Medical (Prime, Standard, and Basic Options)	Blue Cross Blue Shield of SC I-20 Alpine Rd Columbia, SC 29219 Customer Service 1-800-325-6596	501	Self-Insured Welfare Plan
Health Choice Medical BlueChoice HMO	Customer Service Department P.O. Box 7368 Columbus, GA 31908 Phone 1-800-354-6928	501	Self-Insured Welfare Plan
Health Choice Medical Mental Health	ValueOptions 5001 S. Miami Blvd., Suite 200 Durham, NC 27709 WSRC Toll Free number 800-333-6557	501	Self-Insured Welfare Plan
Health Choice Dental (Prime and Standard Options)	Blue Cross Blue Shield of SC I-20 Alpine Rd Columbia, SC 29219 Customer Service 1-800-325-6596	501	Self-Insured Welfare Plan

Plan Name	Insurance Company, Claims Administrator, Trustee	Plan Number	Funding and Type of Plan
Health Choice Vision Care	EyeMed Vision Care, LLC 4000 Luxottica Place Mason, OH 45040 Customer Service: 800-521-3606	501	Fully insured Welfare Plan
Health Care Flexible Spending Account	Blue Cross Blue Shield of SC FSA Administration P.O. Box 100237 Columbia, SC 29202 Customer Service 1-800-325-6596	506	Self-Insured Welfare Plan
Dependent Care Flexible Spending Account	Blue Cross Blue Shield of SC FSA Administration P.O. Box 100237 Columbia, SC 29202 Customer Service 1-800-325-6596	507	Self-Insured Welfare Plan
Disability Income Plan	Washington Savannah River Company LLC Bechtel Savannah River Inc. Building 703-47A Aiken, SC 29808	503	Self-Insured Welfare Plan
Contributory Employee Basic Life	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235 Medical Underwriting 1-800-732-1603 Conversion Policies 1-800-759-0101	508	Experience Rated Fully-Insured Welfare Plan
Noncontributory Employee Life, Occupational Accidental Death, Dependent Life, AD&D	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235 Medical Underwriting 1-800-732-1603	505	Experience Rated Fully-Insured Welfare Plan
Pension Plan	Plan Trustee: Mellon Bank Trust	333	Defined Benefit Pension Plan
Savings and Investment Plan	Plan Trustee: State Street	334	Defined Contribution Pension Plan

Eligibility for benefits should not be viewed as a guarantee of employment. Also, while the Company intends to continue providing a comprehensive benefits program, the Company reserves the right to modify or terminate any of the benefit plans at any time. For more information on the procedures to modify or terminate benefit plans, refer to the section titled "Future of the Plans" in this Summary Plan Description.

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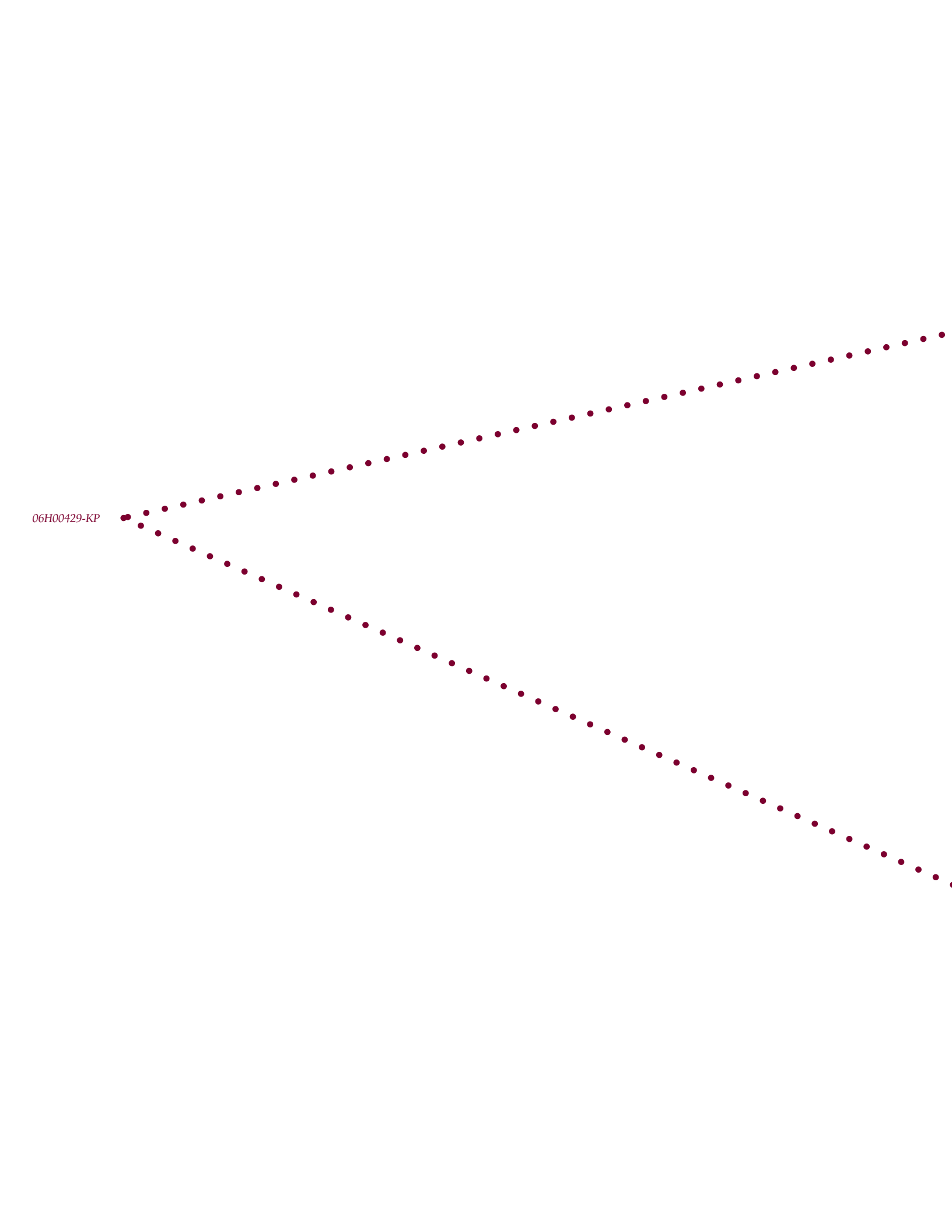
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