SUMMARY PLAN DESCRIPTION
FOR EMPLOYEES OF WACO, INC.

GENERAL INFORMATION

NAME OF PLAN - **Employees Hospitalization Plan of Waco, Inc.**

PLAN SPONSOR - The Plan is sponsored by:

Waco, Inc.
5450 Lewis Road
Sandston, VA 23150
Phone: 804/222-8440
Fax: 804/226-3241

EMPLOYER AND PLAN IDENTIFICATION NUMBER - Some information about the Plan is filed with the Internal Revenue Service and the Department of Labor. Should you wish to contact either agency, you must refer to both numbers:

Employer Identification Number: 54-0720555
Plan Number: 501

TYPE OF WELFARE PLAN - The Plan provides medical insurance benefits.

PLAN ADMINISTRATOR - The Plan Administrator is:

Waco, Inc.
5450 Lewis Road
Sandston, VA 23150
Phone: 804/222-8440
Fax: 804/226-3241

PLAN TRUSTEE - If you have any questions about the Plan, you should contact the Plan Trustee, who is Daniel M. Walker, at the above address and phone number of the Plan Sponsor.

SERVICE OF LEGAL PROCESS - Service of Legal Process may be made upon the Plan Trustee.

The Plan is fully insured through certain insurance policies and HMOs (for which booklets describing the terms and conditions of coverage are separately provided). Costs of the Plan are funded by contributions made by the Plan Sponsor and employees.

PLAN YEAR - The Plan records are kept on a fiscal year beginning May 1.

BENEFIT INFORMATION - The Plan provides for premium payment for a group insurance

contract for medical services for the employee on a company paid basis. Dependent coverage may also be provided on an employee paid basis through payroll deduction. Various group insurance contracts will be used depending upon the location of residence of the employee. Each will provide for payment for inpatient, outpatient, and major medical services. Various deductibles and co-payment schedules will apply depending upon the group insurance contract. Various expense limitations and maximum lifetime benefits will also apply. Waiting periods may apply for pre-existing and certain other conditions, and all plans exclude certain other services (such as eye care and cosmetic surgery).

In certain geographic areas, dental insurance is provided on an employee paid basis. The master group contract provides a thorough description of the services provided.

In no event will the Plan provide benefits greater than premiums paid or to have been paid under the group insurance contract.

ELIGIBILITY - An employee becomes eligible to participate in the Plan on the first day of the month following 60 days of continuous full time employment. If a break in service of 30 days or greater occurs for any reason (a break in service is a calendar period in which the employee does not work), then 60 days of continuous full time employment will again be required. Enrollment forms will be mailed to the employee two to four weeks prior to the eligibility date. The employee must complete and return the enrollment form in order to obtain coverage. Coverage will not be in effect until the first of the month following receipt of the enrollment form. If the employee has not received an enrollment form two weeks prior to eligibility date, he or she should contact the Plan Administrator.

Under our group insurance contracts, an employee must enroll in the Plan at the time of eligibility. If enrollment does not occur at that time, then enrollment at a later date may be subject to medical qualification. In this case, the employee must undergo a medical evaluation to determine eligibility. If restrictions occur as a result of medical qualification, the Plan will have no further obligation to the participant.

Dependents of an enrolled employee may be provided coverage at the employee's expense. Payroll deduction will be the primary means of collection. The entire premium for the dependent cost must be received by the Plan prior to the date coverage is to become effective. If insufficient funds are available by payroll deduction, the employee must make payment to the Plan prior to the coverage date for initial or subsequent premium periods.

A dependent of an employee must be enrolled upon becoming eligible, or wait until the Open Enrollment Period during each year (which occurs during the month of January). Dependents become eligible upon eligibility of the employee, and also when they become a "new" dependent (such as a newborn child). "New" dependents and eligible dependents are defined in each Master Insurance Contract.

An employee may discontinue coverage for dependents at any time. Coverage for dependents will be discontinued for non-payment of premiums. Once coverage is discontinued, it may not be reinstated until the Open Enrollment Period.

Coverage will terminate at the end of the month in which the beginning of a 30 day break in service occurs.

PLAN DOCUMENTS - This summary plan description and the master group insurance contracts currently in effect constitute the Plan documents. If inconsistencies exist between the two, the master group insurance contracts will control.

COBRA RIGHTS - Under the Consolidated Omnibus Budget Reconciliation Act of 1985, employees and their dependents may elect to continue coverage under the Plan in the event of a discontinuance of benefits, under the following qualifying events:

1. Termination of employment for reasons other than gross misconduct on the part of an employee).
2. Deduction in hours of employment that results in a loss of Plan coverage.

A spouse (or child) of a covered employee has the right to a continuation of coverage under the above qualifying events or:

1. Death of spouse (or parent).Divorce or legal separation of spouse (or parent).
2. Entitlement to medical benefits under Title XVIII of the Social Security Act by spouse (or parent).
3. Loss of dependent status under terms of the Plan.

In the event of divorce, legal separation, or loss of dependent status, the covered employee, spouse, or dependent child must inform the Plan Administrator of the event within 60 days. The Plan Administrator will notify you of your COBRA Rights in the event of termination of employment, or reduction of hours, or Medicare Entitlement.

Under COBRA, you have an election period of at least 60 days to decide whether you want Continuation Coverage. Your 60 day election period begins on the later of (1) the date you would lose regular Plan coverage because of one of the qualifying events described above or (2) the date you are sent a notice about your eligibility to elect Continuation Coverage. If you inform the Plan within your 60 day election period that you want Continuation Coverage, Continuation Coverage begins on the date your regular Plan coverage ends. There is one exception, however, if you waive Continuation Coverage you may revoke your waiver at any time before your 60 day election period ends, but in that case, your Continuation Coverage begins on the date your waiver is revoked (it will not include coverage for the period between the date your regular Plan coverage ends and the date your waiver is revoked).

If you do not choose Continuation Coverage within your 60 day election period, your eligibility for Continuation Coverage under the Plan will end.

To receive Continuation Coverage, you must pay the full cost of the monthly premium plus a two percent administrative charge. If you are determined to have been disabled under Title II or XVI of the Social Security Act at the time of the qualifying event, then your Continuation Coverage will cost 150 percent of the monthly premium for all months after the 18th month of Continuation Coverage. If you experience a qualifying event, you will be notified about the premium rates and the due dates for payments.

If you choose Continuation Coverage, your coverage is identical to the coverage then being provided under the Plan to similarly situated employees, their spouses, and their dependent children who have not experienced a qualifying event. If their coverage changes, Continuation Coverage will change in the same way. You do not have to show that you are insurable to choose Continuation Coverage.

Continuation Coverage may last for up to 36 months if you lose regular Plan coverage because of your spouse's death, divorce or legal separation from your spouse, or because your spouse becomes entitled to Medicare benefits under Title XVIII of the Social Security Act, or because you lose dependent status under the terms of the Plan.

If you lose regular plan coverage due to a termination of employment or a reduction in hours of employment, Continuation Coverage generally may last for only 18 months.

If, however, you lose regular Plan coverage due to a termination of employment or a reduction in hours of employment and you are determined to have been disabled under Title II or XVI of the Social Security Act at the time of the termination or reduction in hours, then Continuation Coverage may last for up to 29 months, provided, however, that you notify the Plan of the disability determination before the end of the regular 18 month period and within 60 days of the date the determination is made. (You must also notify the Plan within 30 days if a final determination is made that you are no longer disabled under Title II or XVI of the Social Security Act.)

This 18 (or 29) month period of Continuation Coverage may under certain circumstances be extended for up to 36 months if a second "qualifying event" occurs during the 18 (or 29) month period. For example, if a terminated employee chooses Continuation Coverage for himself or herself and his or her spouse and the employee dies before the 18 (or 29) month period ends, the spouse may elect to receive Continuation Coverage for a total of 36 months. The 36 months would be measured from the date of the employee's termination of employment.

COBRA provides that your Continuation Coverage may be cut short before the 18 month, 29 month or 36 month period ends, if any of the following events occur:

(1) The premium for your Continuation Coverage is not paid within 30 days of the

due date;
(2) You become covered under another group health plan (as an employee or otherwise), provided that plan does not contain any exclusion or limitation with respect to any pre-existing condition you have;
(3) You become entitled to Medicare benefits under Title XVIII of the Social Security Act;
(4) The Company no longer provides group health coverage to any of its employees;
(5) If you were disabled at the time of the qualifying event (as explained above) and you have been receiving Continuation Coverage for 18 months or more, your Continuation Coverage may be terminated if a final determination is made that you are no longer disabled under Title II or XVI of the Social Security Act. In that case, your Continuation Coverage will end as of the first day of the month that begins more than 30 days after the date the final determination is made.

INTERPRETATION - The Plan Administrator has the authority to interpret the Plan's provisions. His decisions are conclusive and binding.

CLAIMS PROCEDURE AND ERISA RIGHTS

FILING A CLAIM - To receive a death or dismemberment benefit, you or your beneficiary should contact the Plan Administrator and ask for the appropriate form for your claim. You or your beneficiary should then complete the form and send it and any other required documentation to the Plan Administrator. This constitutes your claim for a benefit. Within 90 days, the Plan Administrator will notify you, in writing, that:

- Your claim for a benefit has been accepted, or
- Your claim for a benefit has been rejected, or
- Additional information is needed to reach a decision on your claim, or
- Additional time is needed to reach a decision on your claim.

If you are not contacted by the Plan Administrator within 90 days of your submission of a claim for benefits, you should consider your claim denied, and you can request a review of the denial.

Should your claim for a benefit be rejected, the Plan Administrator will state the specific reasons for the rejection and will reference the Plan provisions upon which the rejection is based. He will also describe the steps you may take to request a review of his decision.

Should additional information be needed to reach a decision on your claim, the Plan Administrator will list the items which you must provide. He will also indicate why the additional information is necessary

Should additional time be needed to reach a decision on your claim, the Plan Administrator will let you know why more time is needed. He will also indicate when he anticipates arriving at his

decision. The Plan Administrator must, however, reach a decision within 180 days of the date you initially submitted your claim for a benefit.

REQUESTING A REVIEW - If your claim for a benefit is rejected by the Plan Administrator, you can ask him to reconsider his decision. To do so, you, or your authorized representative, must submit to the Plan Administrator a written request for a review of his decision. This written request must be made within 60 days of the Plan Administrator's rejection of your claim. You, or your authorized representative, can examine any of the documents that relate to your claim and can submit written comments. Within 60 days of your request for a review, the Plan Administrator will notify you, in writing, that:

- A review has been made and your claim for a benefit has been accepted, or
- A review has been made and your claim for a benefit has been rejected, or
- Additional time is needed to review the decision on your claim.

If you are not contacted by the Plan Administrator within 60 days of your request for a review, you should consider your request denied.

If, after reviewing your decision, the Plan Administrator decides to reject your claim, he will state the specific reasons for his rejection. He will also state the specific Plan provisions upon which his decision is based.

If the Plan Administrator needs more time to review his decision, he will state the reasons his review required more time. Under no circumstances, however, will it take more than 120 days to complete the review.

Any questions concerning the filing of a claim or requesting a review should be directed to the attention of YOUR PLAN ADMINISTRATOR.

Federal law and regulations require your Summary Plan Description to include a statement outlining your rights under ERISA.

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

-Examine, without charge, at the Plan Administrator's office and other specified locations, such as worksites, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, 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 the summary annual report;

-Obtain a statement telling you whether you have a right to receive a pension on your Normal Retirement Age and if so, what your benefits would be on your Normal Retirement Age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once a year. The Plan must provide the 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 Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, 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 claim 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 review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is 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's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court cost and legal fees. If you are successful, the court may order the person you have sued to pay the costs and fees. If you lose, the court may order you to pay these costs and fees. For example, if it finds your claim if frivolous. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

TERMINATION OR AMENDMENT - The Plan sponsor has the right to amend or terminate the Plan at any time and for any reason.