SUMMARY PLAN DESCRIPTION
FOR EMPLOYEES OF WACO, INC.

GENERAL INFORMATION

NAME OF PLAN - **Life Insurance Plan for Employees of Waco, Inc.**

PLAN SPONSOR - The Plan is sponsored by:

Waco, Inc.
5450 Lewis Road
Sandston, VA 23150
Ph: 804/222-8440

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:

TYPE OF WELFARE PLAN - The Plan provides a death benefit and an accidental death and dismemberment benefit.

PLAN ADMINISTRATOR - The Plan Administrator is:

Waco, Inc.
5450 Lewis Road
Sandston, VA 23150
Ph: 804/222-8440

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.

Costs of the Plan are funded by contributions made by the Plan Sponsor.

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

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

BENEFIT INFORMATION - The Life Insurance Plan for Employees of Waco, Inc. provides a $25,000 death benefit and a $25,000 accidental death and dismemberment benefit. The Company will maintain a group life insurance policy, and insure eligible employees at the Company's expense. Premiums are paid quarterly or monthly, depending upon the arrangement with the insurance carrier in use at any particular time. Death benefits will be paid to the

beneficiary designated on the employee's enrollment card. Dismemberment benefits are payable according to the schedule of benefits in the current policy. Death benefits are reduced at ages 65, 70 and 75.

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.

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 contract currently in effect constitute the Plan documents. If inconsistencies exist between the two the master group insurance contract will control.

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 l80 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 his 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 requires more time. Under no circumstances, however, will it take more than l20 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 l974 (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 costs 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 is 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.