CARNEGIE INSTITUTION OF WASHINGTON
GROUP TRAVEL ACCIDENT PLAN

SUMMARY PLAN DESCRIPTION

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ELIGIBILITY

All active employees hired in the United States, recipients of fellowships, and guest investigators of Carnegie Institution are covered by the Group Travel Accident Plan.

COST FOR COVERAGE

The Plan is fully insured and provided by the Institution at no cost to you. The Institution pays an annual premium to the insurance company.

TRAVEL COVERAGE

The Plan is designed to provide financial security in the event of your death, dismemberment, total disability, or loss of sight, speech, or hearing incurred during business travel. The Plan provides you with 24-hour protection while traveling on behalf of the Institution, provided such travel is to points located away from the city of your permanent assignment. (Traveling to and residing in another city or location for more than 60 days is considered changing your city of permanent assignment to that location.) The Plan covers losses due to injury sustained during the course of any bonafide trip on Institution business. Business travel means any travel while on assignment by or at the direction of the Institution for furthering its purpose. It does not include everyday travel to and from work (commuter travel), or periods of Annual Leave. Business-related trips and activities during a leave of absence, paid or unpaid, are covered only to the extent that the leave of absence is for the purpose of continued research or career advancement, and has the prior approval of the Institution's President.

Coverage begins the later of the time you leave your residence or place of employment for the purpose of traveling while on the business of the Institution, and continues until the earlier of the time you return to your residence or place of employment.

COVERED LOSSES

Subject to the exclusions explained later in this booklet, if a covered accident takes place while you are traveling on behalf of the Institution, and if the covered accident results in any of the following specified losses to you within 365 days after the date of the accident which caused the injury, the insurance company will pay lump-sum benefits in accordance with the following schedule:

For Loss of:	Benefit
Life	$200,000
Two or more members	$200,000
One member	$100,000
Thumb and Index Finger of same hand	$ 50,000

The term "member" means a hand, foot, sight in one eye, speech, or hearing. The term "loss" means (1) with respect to the hand or foot, complete severance of the limb from the body through or above the knuckle joints of at least four fingers of the same hand or three fingers and thumb of the same hand, or ankle joint (including if the severed appendages are later reattached), (2) with respect to "sight", the permanent loss of sight in one eye, (3) with respect to speech and hearing, the permanent and irrecoverable loss of the capability of speech, or hearing in both ears and (4) with respect to the thumb and index finger, the complete severance through or above the knuckle joints. Benefits provided under the above schedule will not be paid for more than one of the above losses sustained by you as the result of one accident. If more than one loss is sustained, the largest amount will be payable.

EXPOSURE AND DISAPPEARANCE

If you suffer a covered loss from unavoidable exposure to the elements while on business of the Institution (as described in this book), benefits are payable in accordance with the aforementioned schedule.

In the event of your disappearance because of forced landing, stranding, sinking, or wrecking of any covered vehicle in which you are an occupant and you have not been found within one year of the disappearance, it will be presumed for purposes of this insurance that you have suffered loss of life. In this case, the $200,000 lump-sum benefit will be payable.

RECEIPT OF INSURANCE PAYMENT IN THE EVENT OF A COVERED LOSS

If you are in a covered accident, payment is made to you. In the event of your death, payment will be made to the beneficiary or beneficiaries that you have specifically designated in writing as filed with the Institution for purpose of this insurance. If there is no such designation in force at the time of death, payment will be made in one sum to the first surviving class of beneficiaries, in the following order:

(1) Your widow or widower, if surviving, otherwise;

(2) Your surviving child or children, in equal shares, otherwise;

(3) Your parents in equal shares or the surviving parent, otherwise;

(4) Your surviving brothers and sisters in equal shares or the survivors of them, otherwise;

(5) Your Executor or Administrator of your estate.

EXCLUSIONS UNDER THE PLAN

You are not covered under the Plan for any loss caused by or resulting from any one or more of the following:

(1) Suicide or attempted suicide, whether sane or insane; or an intentional self-inflicted injury;

(2) Any act of war, declared or undeclared (declared or undeclared war does not include acts of terrorism);

(4) Emotional trauma, mental illness, disease, pregnancy, childbirth, miscarriage, or any bacterial infection that was not caused by an accidental cut, wound, or food poisoning;

(5) Travel or flight while in or on, or while boarding or alighting from any aircraft that is owned, leased, or operated by the Institution or by an employee of the Institution, or where the insured is acting or training as a pilot or crew member (except for passengers who temporarily perform pilot or crew functions in a life threatening emergency).

OVERALL LIMIT OF LIABILITY

For losses arising out of any covered common accident, the insurance company's total limit of liability under the Plan is $1,000,000. If the $1,000,000 limit of liability prevents full payment of the benefits otherwise due to covered persons in a common accident, proportionately reduced benefits will be paid to each appropriate recipient.

REQUESTING INFORMATION AND CLAIMS PROCEDURES

This section contains administrative information required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Requesting Information

The Plan Administrator will answer any written question or request about enrollment, participation, or other administrative matters. You will receive a written explanation within a reasonable period of time (not more than 90 days after the Plan Administrator receives your written request). If special circumstances require a delay to your request or question, the plan Administrator will notify you not more than 90 days after the day the request was submitted. The notice will explain the reasons for the delay. A response to your request or question will be sent not more than 90 days after the notice of the delay.

If your request for information is denied, the explanation will include the reason for the denial, a description of any materials necessary to complete the request, and an explanation of why this material is necessary. If your request is denied or you are not satisfied with the response, you may ask for a review. Write directly to the plan Administrator within 60 days of receiving the response. You or your duly authorized representative may examine any documents pertaining to our request. You will receive a written decision on the review within a reasonable time (not more than 60 days). If special circumstances require a delay to your request for review, the Plan Administrator will notify you not more than 60 days after the day the request for review was submitted. The notice will explain the reasons for the delay. A response to your request or question will be sent not more than 60 days after the notice of the delay.

Claim Procedures

The insurance company must receive a written notice of claim within 20 days after the occurrence or commencement of any loss covered by the Plan, or as soon thereafter as is reasonably possible. Therefore, you or your personal representative or beneficiary should report the covered accident or death promptly through your Department Business manager or to the Manager of Human Resources and Insurance, 1530 P Street, N.W., Washington, D.C. 20005, telephone (202)939-1113. The insurance company name and address is: Federal Insurance Corporation, 1133 Connecticut Avenue, Washington, D.C. 20036.

Upon receipt of the notice of claim, the insurance company will provide the claimant the necessary proof of loss forms. If such forms are not furnished by the insurance company within 15 days after the receipt of the notice of claim, the claimant should provide other proof of loss by the date claim forms would be due. The claim form must be returned to the insurance company within 90 days after the date of loss, written proof covering the occurrence, the character, and the extent of the loss.

The insurance company, at its own expense, reserves the right and opportunity to examine the insured when, and as often as, it is reasonably required during the pendency of a claim, and to make an autopsy in case of death where it is not forbidden by law.

You will be notified of the determination of your claim within 45 days after receipt of the claim. If special circumstances require a delay in determining your claim, the claims administrator will notify you within 45 days after receipt of the claim and the determination period may be extended for up to 30 days. If special circumstances require still another delay, the period for determination will be extended for up to an additional 30 days, in which case you will be notified again prior to the expiration of the first 30-day extension.

When circumstances require additional time to make a determination, the notification will include the circumstances requiring an extension, the standards on which the

entitlement to benefits is based, the unresolved issues or additional information that is needed and the date by which a decision can be expected. If additional information is requested, you will have 45 days within which to provide the specified information. In such case, the 30-day extension period(s) for determination will begin on the date the claims administrator receives the additional information.

Payment of Claims

Upon receipt of proof of a valid claim, any benefits due will be paid to you. Any benefits due because of your death will be paid to your designated beneficiary. See "Receipt of Insurance Payment In Event of Covered Loss".

Claims Appeal

If a claim is denied in whole or in part, you will receive a written notice from the claims administrator of the decision within 45 days after receipt of the claim. The notice will include: (1) the specific reason(s) for the denial, (2) reference to the specific plan provisions, statutes or regulations on which the denial was based, (3) a description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary, and (4) information about steps to be taken if you, your dependents, or an authorized representative wished to submit the claim for review. You may request a review within 180 days of receiving notice of the denied claim. A written decision will be made within 45 days from receipt of the request for review.

If special circumstances require a delay in responding to your request for review, you will be notified within 45 days of receipt of the request. The notice will indicate the circumstances requiring an extension and the date by which you may expect a determination. A written decision will be sent no more than 45 days from the date of the notice of delay.

When circumstances require additional time to make a determination, the notification will include the circumstances requiring an extension, the standards on which the entitlement to benefits is based, the unresolved issues or additional information that is needed and the date by which a decision can be expected. If additional information is requested, you will have 45 days within which to provide the specified information. In such case, the 45-day extension period for determination will begin on the date the claims administrator receives the additional information.

YOUR ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted to help assure that all employer-sponsored group benefit programs conform to standards set by Congress. An employee who is a participant in the plan is entitled to certain rights and

protections under ERISA, which provides that all participants will be entitled to: (1) examine, without charge, at the plan administrator's office and at other specified, such as worksites and union halls, all plan documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500), filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration; (2) obtain, upon written request to the plan administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500) and updated summary plan descriptions, subject to a reasonable charge for the copies; and (3) receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report. Plan records are kept on a plan year basis.

In addition to creating rights for participants, ERISA imposes duties upon people responsible for the operation of the plan who are called "fiduciaries" and who have a duty to operate the plan prudently and in the interests of participants and beneficiaries. No one, including your employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If a claim for a benefit under the plan 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 claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials and do not receive them within 30 days, you may file suit in a federal court. In such a case, the plan administrator will provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the plan administrator's control.

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. In addition, if you disagree with the plan administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay the court costs and fees. If you lose, the court may order you to pay the costs and fees, for example, if it finds the claim to be frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your ERISA rights, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

WHAT ELSE YOU SHOULD KNOW ABOUT THE PLAN

Plan Name and Number - The Group Travel Accident Plan of the Carnegie Institution of Washington - Number 506

Type of Plan - This is an Employee Welfare Benefit Plan

Name and Address of Employer - Carnegie Institution of Washington, 1530 P Street, N.W., Washington, DC 20005, (202)387-6400

Plan Sponsor and Plan Administrator - Carnegie Institution of Washington is both the Plan Sponsor and Plan Administrator. Questions about the Plan should be directed to the Manager of Human Resources and Insurance at the Institution's address given above.

Name and Address of Insurance Carrier – Federal Insurance Corporation, 1133 Connecticut Avenue, N.W., Washington, D.C. 20036

Employer Identification Number - 53-0196523

Plan Year - July 1 through June 30

Plan Document - This booklet summarizes the major features of the Plan. Complete details of the Plan document can be found in the group policy issued by the insurance company. Since the group policy is in complete detail, the final interpretation of any specific provision is to be governed by it.

Plan Continuation - It is intended that this Plan continue indefinitely, but the Institution reserves the right to terminate, suspend, withhold, amend, or modify the Plan in whole or in part at any time, subject to the provisions of the Plan document. Such action would be taken only after careful consideration.

Agent for Service of Legal Process - Service of legal process should be directed to the Plan Administrator at the address in this section. Legal action may also be made upon the insurance company, but only after the expiration of 60 days after the written proof of loss has been furnished in accordance with the policy. No action may be brought against the insurance company after the expiration of two years after the date when written proof of loss is required to be furnished.

For Your Information – Carnegie Institution of Washington intends to continue this plan indefinitely, however, reserves the right to modify, suspend, terminate, and interpret the benefits described herein. This right may be exercised without notice, although every effort will be made to give ample notice.