

PLAN ADMINISTRATOR

In carrying out its responsibilities under the plans, the Plan Administrator has the exclusive responsibility and full discretionary authority to control the operation and administration of the plans, including but not limited to, the power to interpret the terms of the plans, to determine eligibility for entitlement to plan benefits and to resolve all interpretive, equitable and other questions that arise in the operation and administration of the plans. All actions or determinations of the Plan Administrator are final, conclusive and binding on all persons. However, with respect to all benefits other than the Pension Plan and the Savings Program, the Plan Administrator has delegated its powers and duties with respect to claims determinations to a third party, who shall be the Claims Administrator for such plan.

PLAN DOCUMENTS

This handbook summarizes the key features of each of the plans in the Company's benefits program and applies to eligible employees of USEC, including those represented by collective bargaining units to the extent that they have been negotiated and accepted by the duly certified representatives of participating units. This handbook, together with the booklets and other descriptive materials you have received from the Company and the insurance companies, constitutes the Summary Plan Description (SPD) for each plan contained herein as required by ERISA.

ERISA also requires that employee benefit plans be maintained pursuant to a written plan document. With the exception of the Pension Plan, the Savings Program, and the Flexible Spending Accounts, this handbook, together with the contracts and agreements that the Company has entered into with the benefit providers for each plan, constitutes the written plan document for each plan. Complete details of each of the Pension Plan, the Savings Program, and the Flexible Spending Accounts can be found in the official plan documents that legally govern the operation of those plans. All statements made in this handbook are subject to the provisions and terms of those documents. In the event of a conflict between the official plan documents and the summaries in this handbook or any other descriptive materials provided by the Company or if there is any provision not discussed in the summaries or descriptive materials, the official plan documents are controlling.

The plan document, any changes to it, or any benefit payments to you under its terms do not constitute a contract of employment with the Company and do not give you the right to be retained in the employment of the Company.

PLAN TERMINATION AND AMENDMENT

The Company expects and intends to continue the plans in your benefits program but reserves its right to terminate each of the plans, in whole or in part, without notice. The Company also reserves the right to amend each of the plans at any time.

The Company may also increase or decrease its contributions or the participants' contributions to the plans.

The Company's decision to terminate or amend a plan may be due to changes in federal or state laws governing pension or welfare benefits, the requirements of the Internal Revenue Code or ERISA, or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does terminate or amend a plan, it may decide to set up a different plan providing similar or identical benefits.

If the Pension Plan or Savings Program is terminated while you are an employee of the Company, you will have a vested right to the value of your accrued retirement benefit under the Pension Plan or the entire value of your Savings Program account, as applicable. Once your Pension Plan benefit or Savings Program account value has been determined, it may be paid in the form of one or more cash payments. The exact form of payment may be set by law; if there is a choice, the Plan Administrator will decide the type and timing of payment.

If a welfare plan is terminated, you will not have any further rights, other than the payment of benefits for covered losses or expenses incurred before the plan was terminated. The amount and form of any final benefit you or your beneficiary receives will depend on any contract provisions affecting the plan and the Company's decisions.

CLAIMS PROCEDURES

For Dependent Care Flexible Spending Accounts, Short Term Disability, and Employee Stock Purchase Plan Benefits:

Refer to the specific provisions in this booklet regarding these benefits for details on how to file claims.

For Medical, Dental, Prescription Drug, Vision, Employee Assistance Program, Health Care Flexible Spending Accounts, Long Term Disability, Long Term Care, Life and Accident Insurance, Pension Plan, Savings Program Benefits:

Please refer to the specific provisions in this booklet regarding these benefits for the applicable claims procedures. However, effective for claims filed on or after January 1, 2003, the claims procedures for these benefits shall not be less favorable than the following:

The Claims Administrator is the sole judge of determinations regarding claims for benefits. Benefits under the plans shall be paid only if the Claims Administrator determines in its discretion that the applicant is entitled to them.

If you file a claim for benefit under a plan, the Claims Administrator will advise you of any benefits to which you are entitled under the plan.

Denial of Claim

If your application for benefits is denied in whole or in part, you will receive written notification from the Claims Administrator within a reasonable period of time, but not later than the following:

Type of Claim	Time Limit for Claim Denial	Extension Permitted
Health Benefits* - Urgent Claims (as medically determined) - Pre-Service Claims - Post-Service Claims - Concurrent Claims (claims for ongoing course of treatment)	72 hours 15 days 30 days Prior to termination of care (if sufficient notice)	None 15 days 15 days None
Life and Accident Insurance, Long Term Care, Pension Plan, and Savings Program	90 days	90 days
Long Term Disability Benefits	45 days	up to two 30 day extensions

* Health benefits include Medical, Dental, Prescription Drug, Vision, Employee Assistance Program, and Health Care Flexible Spending Account benefits.

If the Claims Administrator needs more information to make a determination on your claim, you will be notified within a reasonable period of time. Extensions are permitted if the Claims Administrator determines that special circumstances beyond its control require an extension of time for processing the claim. In such case, you will be provided with written notice of the extension prior to the termination of the time for responding.

The Claims Administrator’s notice of denial will include the following:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial was based
- A description of any additional material or information needed for you to complete the claim and an explanation of why such material is necessary
- A description of the plan’s review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA after you have exhausted the appeals process
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request

and

- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appealing a Claim

If your claim is denied, you or your duly authorized representative may submit a request for reconsideration of the claim to the Claims Administrator within the following timeframe:

Type of Claim	Time Limit for Appealing Denial
Health Benefits	180 days
Life and Accident Insurance, Long Term Care, Pension Plan, and Savings Program	60 days
Long Term Disability Benefits	180 days

Any such request should be accompanied by documents or records in support of the appeal. You or your representative may have reasonable access to, and copies of, all documents, records and other information relevant to your claims for benefits and a listing of medical or vocational experts whose advice was obtained on behalf of the plans in connection with the benefit determination. A failure to request a review of a denied claim will be treated as full and complete agreement with the denial.

Determination on Appeal

The Claims Administrator will respond within a reasonable period of time, but not later than the following:

Type of Claim	Time Limit for Claim Denial	Extension Permitted
Health Benefits		
- Urgent Claims	72 hours	None
- Pre-Service Claims	30 days	None
- Post-Service Claims	60 days	None
- Concurrent Claims (claims for ongoing course of treatment)	Prior to termination of care (if sufficient notice)	None
Life and Accident Insurance, Long Term Care, Pension Plan, and Savings Program	60 days	60 days
Long Term Disability Benefits	45 days	45 days

If the denial of a claim for benefits was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who was not consulted in connection with the denial that is the subject of the appeal, is not the subordinate of anyone who was consulted, and who has appropriate training and experience in the field of medicine involved in the medical judgment. In making the determination on appeal, the Claims Administrator will not afford deference to the initial claim denial.

In its response to the appeal, the Claims Administrator will explain, in writing, the following:

- The specific reason or reasons for the denial
- Specific reference to plan provisions on which the denial is based
- Statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits
- An internal rule, guideline, protocol, or other similar criterion if one was relied upon in making the adverse determination, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request
- A statement of your right to sue under section 502(a) of ERISA

and

- That you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

If a decision is not furnished within the specified time period, your claim will be deemed denied on review.

MILITARY SERVICE

Employees and dependents who lost health coverage due to the employee's qualified military leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") may elect to continue coverage for up to 18 months. Any individual who elects to continue such coverage will be required to make the same premium payments as a COBRA participant.

Participants in the Savings Program who return to work after a period of qualified military service will be eligible to make retroactive before-tax contributions and to receive retroactive employer contributions (if any were made) and service credit under the Savings Program for the period of qualified military service in accordance with USERRA.

Participants in the Pension Plan who return to work after a period of qualified military service will be eligible for service credit during the period of qualified military service in accordance with USERRA.

Contact the Plan Administrator for more information regarding military service and its effect on your benefits.

CHANGE OF ADDRESS

It is important that you notify the Company of any change in your address while you are a participant in the Company-sponsored benefit plan so that you will be assured of receiving Company communications regarding your benefit.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A qualified medical child support order (QMCSO) is an order or judgment from a state court directing the Plan Administrator to cover a child for benefits under the health care plans. Coverage will be provided according to a valid order that is served on the Company or the Company's agent for service of legal process. If you are affected by such an order, you and each child will be notified about further procedures to validate and implement the order.

SPECIAL PROVISIONS APPLICABLE TO THE PENSION PLAN AND SAVINGS PROGRAM

There are a few special provisions that apply only to the Pension Plan and Savings Program.

Maximum Benefits

Federal tax laws impose certain limitations on the benefits and contributions under qualified retirement plans. These limitations generally apply only to highly compensated employees. You will be notified if these limitations apply to you. More information is available from Human Resources.

Top-Heavy Provisions

Under current tax law, the Pension Plan and Savings Program are required to contain provisions that apply in the event that a significant portion of the plan's benefits are payable to highly compensated employees. These provisions - called "top-heavy" rules - provide for accelerated vesting of plan benefits and certain minimum benefit accruals in the event the plans become top-heavy. The plans are not top-heavy now. Therefore, the top-heavy rules are not likely to affect your benefits under the plans.

A more detailed explanation of these provisions will be provided if and when these plans become top-heavy.

Loss of Retirement Benefits

Other than failing to meet the age and service requirements for a benefit, there are no plan provisions which would cause you to forfeit your Pension Plan benefits. Under the Savings Program, you are always 100% vested in your own contributions and you become 100% vested in Company matching contributions after you complete three years of Credited Service. After three years of Credited Service, you are fully vested in your account balance, but the investment choices you make will affect that balance.

Assets Upon Termination

If the Savings Program terminates, participants' accounts will be distributed after plan expenses are paid. The Trustee will make account distributions as instructed by the Plan Administrator.

Any assets remaining in the Pension Plan after all liabilities to participants and beneficiaries are satisfied and after all expenses are paid will revert to the Company.

Pension Benefit Guaranty Corporation

If the Pension Plan terminates, benefits are insured by the Pension Benefit Guaranty Corporation (PBGC). The PBGC does not guarantee benefits of the Savings Program because federally sponsored insurance does not apply to this kind of plan. If the Pension Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people lose certain benefits.

Generally, the PBGC guarantees most vested normal retirement age benefits, early retirement benefits and certain disability and survivors' pensions. However, the PBGC does not guarantee all types of benefits under covered plans, and the amount of benefit protection is limited.

The PBGC guarantee generally does not cover: 1) benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; 2) some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the time the plan terminates; 3) benefits that are not vested because you have not worked long enough for the Company; 4) benefits for which you have not met all of the requirements at the time the plan terminates; 5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and 6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Pension Plan has and on how much money the PBGC collects from the Company.

For more information on the PBGC insurance protection and its limitations, contact the Company or the PBGC at the PBGC's Technical Assistance Division, 1200 K Street, N.W., Suite 930, Washington, D.C. 20005-4206 or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional assistance is available through the PBCG's website on the Internet at <http://www.pbgc.gov>.

Assignment or Alienation of Benefits

Except as required by applicable law, benefits provided under the Pension Plan and Savings Program are not subject to assignment, alienation, attachment, lien, garnishment, levy, pledge, bankruptcy, execution or any other form of transfer.

Qualified Domestic Relations Order

A qualified domestic relations order (QDRO) is a legal judgment, decree or order that recognizes the rights of another individual under the Savings Program or Pension Plan with respect to child or other dependent support, alimony or marital property rights.

In the event of a QDRO, benefits under the Pension Plan and Savings Program may be payable to someone other than your designated beneficiary to satisfy a legal obligation you may have to a spouse, former spouse, child or other dependent. Your Pension Plan or Savings Program benefits will be reduced by the benefits payable under the QDRO to someone else.

There are specific requirements which a domestic relations order must meet to be recognized by the Company as a QDRO and specific procedures regarding the amount and timing of payments. You will be notified if you are affected by such an order.

Collective Bargaining Agreements

The Pension Plan and the Hourly Savings Program are maintained, in part, pursuant to collective bargaining agreements between the Company and SPFPA Local 66, SPFPA Local 111, USW Local 550 and USW Local 689. A complete list of the employer and employee organizations sponsoring the plans, as well as the collective bargaining agreements, may be obtained by writing to the Plan Administrator. Participants and their beneficiaries also may examine the listing of the employers and the collective bargaining agreements at the Plan Administrator's office and at other specified locations, such as worksites and union halls.

YOUR RIGHTS UNDER COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- your hours of employment are reduced, or
- your employment ends for any reason other than your gross misconduct

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct;
- your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- you become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- the parents become divorced or legally separated; or
- the child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to USEC, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts 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. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the

qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. This notice must be sent to the Plan Administrator within 60 days of the disability determination by the Social Security Administration.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

COBRA and the Trade Act

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

As a participant in the medical, vision, prescription drug, dental, life and accident, long term disability, employee assistance, long term care, healthcare flexible spending account, pension and/or savings program benefit plans (Employee Stock Purchase Plan, Short Term Disability and Dependent Care Flexible Savings Account are not subject to ERISA) described in this handbook, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that as a plan participant, you shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for copies
- Receive a summary annual report 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
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at 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 every twelve (12) months. The plan must provide the statement free of charge
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation of coverage rights
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation of coverage, and when your COBRA continuation of coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit 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, your union, or any other person, may fire you, or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in state or federal court. In addition, if you disagree with the plan’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 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 you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance With Your Questions

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 rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Privacy of Health Information

Effective April 14, 2003, the receipt, use and disclosure of protected health information by the medical (including prescription drug and vision care), dental, employee assistance program, and healthcare flexible spending account plans is governed by regulations issued under the Health Insurance Portability and Accountability Act (commonly referred to as "HIPAA"). In accordance with these regulations, the Plan Administrator, certain employees of the plans and the plans' business associates may receive, use and disclose protected health information in order to carry out payment, treatment and health care operations under the plans. These entities and individuals may use protected health information for such purposes without your consent or written authorization. In addition, your protected health information may be shared with the Plan Sponsor without your consent or written authorization for administrative purposes.

In the normal course, if your protected health information is used or disclosed for any other purpose, your written authorization for such use or disclosure will be required. All participants of the plans will receive a Notice of Privacy Practices on or before April 14, 2003 that explains the plans' obligations to protect your protected health information and that describes certain rights you will have with regard to your protected health information.

Security of Health Information

Effective April 20, 2005, the Company will take steps to safeguard your electronic protected health information. The Company will implement safeguards to protect the confidentiality, integrity and availability of electronic protected health information, implement security measures to ensure adequate separation between the Company and the Plan, and ensure that any agent to which it provides electronic protected health information also agrees to implement security measures. The Company will report to the Plan any security incident of which it becomes aware involving electronic protected health information.

PLAN INFORMATION

Benefit	Health and Welfare	Savings Program	Pension Plan
Plan Name	United States Enrichment Corporation Health Benefit Program for Employees	USEC Savings Program	USEC Health & Welfare Plan for Retirees
Type of Plan	Welfare plan providing medical, dental, prescription drug, vision, disability, long term care, and life insurance benefits, flexible spending accounts, and an employee assistance program	401(k) plan	Pension Plan
Plan Identification Number	Plan 506	Plan 001	Plan 002
Employer Identification Number	52-2109255	52-2107911	52-2109255
Plan Year-End	December 31	December 31	December 31
Plan Administrator	USEC c/o MS-1032 PO Box 1410 Paducah, Kentucky 42002-1410	USEC, Inc. c/o Director of Human Resources 6903 Rockledge Drive Bethesda, Maryland 20817	USEC C/O MS-1032 PO Box 1410 Paducah, Kentucky 42002-1410
Claims Administrator	See Contact Information	USEC, Inc. 6903 Rockledge Drive Bethesda, Maryland 20817	USEC 6903 Rockledge Drive Bethesda, Maryland 20817
Plan Sponsor	USEC 6903 Rockledge Drive Bethesda, Maryland 20817	USEC, Inc. 6903 Rockledge Drive Bethesda, Maryland 20817	USEC 6903 Rockledge Drive Bethesda, Maryland 20817
Agents for Service of Legal Process**	Kentucky: USEC Attn: CT Corporation System 1511 Kentucky Home Life Building Louisville, Kentucky 40202-3333 Ohio: USEC Attn: CT Corporation System 441 Vine Street Cincinnati, Ohio 45202	Kentucky: USEC Attn: CT Corporation System 1511 Kentucky Home Life Building Louisville, Kentucky 40202-3333 Ohio: USEC Attn: CT Corporation System 441 Vine Street Cincinnati, Ohio 45202	Kentucky: USEC Attn: CT Corporation System 1511 Kentucky Home Life Building Louisville, Kentucky 40202-3333 Ohio: USEC Attn: CT Corporation System 441 Vine Street Cincinnati, Ohio 45202
Plan Trustee	Not applicable	Fidelity Investments	Northern Trust Company 150 W. LaSalle Street Chicago, Illinois 60675
Funding	Self Insured* and Fully Insured (contact the plan administrator for additional information)	Employer and Employee Contributions	Employer Contributions

* Self insured means claims are paid from the general assets of USEC and not insured through a third party.

** Service of legal process may also be made on the Plan Administrator or Plan Trustee, if applicable.