

2002

This Form is Open to Public Inspection.

Form 5500

Department of the Treasury Internal Revenue Service Department of Labor Pension and Welfare Benefits Administration Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning 10 01 2002 and ending 09 30 2002

- A This return/report is for: (1) a multiemployer plan; (2) a single-employer plan; (3) a multiple-employer plan; (4) a DFE (specify)
B This return/report is: (1) the first return/report filed for the plan; (2) an amended return/report; (3) the final return/report filed for the plan; (4) a short plan year return/report
C If the plan is a collectively-bargained plan, check here
D If filing under an extension of time or the DFVC program, check box and attach required information.

Part II Basic Plan Information - enter all requested information.

1a Name of plan

INEEL HEALTH CARE PLAN

1b Three-digit plan number (PN) 504

1c Effective date of plan 07 01 1966

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE Candace F. Wilkinson

Date 04 20 2004

Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE Candace F. Wilkinson

Date 04 20 2004

Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 13500F Form 5500 (2002)

0 1 0 2 A A 0 1 0 0



2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) CIO CANDACE F WILKINSON

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

2b Employer Identification Number (EIN)

94 3323797

2c Sponsor's telephone number

208 526 0066

2d Business code (see instructions)

541990

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

1) SAME

2) CIO

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

0 1 0 2 A A 0 2 0 P



5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3)

b EIN

4)

5)

c Telephone number

6)

6 Total number of participants at the beginning of the plan year

5964

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

4750

b Retired or separated participants receiving benefits

1084

c Other retired or separated participants entitled to future benefits

d Subtotal. Add lines 7a, 7b, and 7c

5834

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

f Total. Add lines 7d and 7e

5834

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)



8 Benefits provided under the plan (complete 8a and 8b, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4A

9a Plan funding arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(f) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(f) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- 1) R (Retirement Plan Information)
- 2) T (Qualified Pension Plan Coverage Information)
- If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ▶
- 3) B (Actuarial Information)
- 4) E (ESOP Annual Information)
- 5) SSA (Separated Vested Participant Information)

b Financial Schedules

- 1) H (Financial Information)
- 2) I (Financial Information--Small Plan)
- 3) 001 A (Insurance Information)
- 4) C (Service Provider Information)
- 5) D (DFE/Participating Plan Information)
- 6) G (Financial Transaction Schedules)
- 7) P (Trust Fiduciary Information)

0 1 0 2 A A 0 4 0 R



**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits
Administration

Pension Benefit Guaranty Corporation

For calendar plan year 2002
or fiscal plan year beginning

A Name of plan

INEEL HEALTH CARE PLAN

B Three-digit
plan number ▶

504

C Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BWXT IDAHO, LLC

D Employer Identification Number

94 3323797

Insurance Information

This schedule is required to be filed under section 104 of the
Employee Retirement Income Security Act of 1974.

- ▶ File as an attachment to Form 5500.
- ▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to
Public Inspection.

10 01 2002

and ending

09 30 2003

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

VISION SERVICE PLAN

(b) EIN

82 0339119

(c) NAIC code

47783

(d) Contract or identification number

12165723

(e) Approximate number of persons covered at end of policy or contract year

5967

Policy or contract year

(f) From

01 01 2002

(g) To

12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

0

0

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 13505I Schedule A (Form 5500) 2002

0 5 0 2 A A 0 1 0 S



v5.0

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

0 5 0 2 A A 0 2 0 T



Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates



b Premiums paid to carrier

c Premiums due but unpaid at the end of the year

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount
Specify nature of costs



e Type of contract (1) individual policies (2) group deferred annuity
(3) other (specify below)



f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶



6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

- (1) deposit administration
- (2) immediate participation guarantee
- (3) guaranteed investment
- (4) other (specify below)

b Balance at the end of the previous year

c Additions:

- (1) Contributions deposited during the year
- (2) Dividends and credits
- (3) Interest credited during the year
- (4) Transferred from separate account
- (5) Other (specify below)

(6) Total additions

d Total of balance and additions (add b and c(6))

e Deductions:

- (1) Disbursed from fund to pay benefits or purchase annuities during year
- (2) Administration charge made by carrier
- (3) Transferred to separate account
- (4) Other (specify below)

(5) Total deductions

f Balance at the end of the current year (subtract e(5) from d)

0 5 0 2 A A 0 4 0 V



Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

- (a) Health (other than dental or vision)
- (b) Dental
- (c) Vision
- (d) Life Insurance
- (e) Temporary disability (accident and sickness)
- (f) Long-term disability
- (g) Supplemental unemployment
- (h) Prescription drug
- (i) Stop loss (large deductible)
- (j) HMO contract
- (k) PPO contract
- (l) Indemnity contract
- (m) Other (specify below)

8 Experience-rated contracts

a Premiums:

- (1) Amount received
- (2) Increase (decrease) in amount due but unpaid
- (3) Increase (decrease) in unearned premium reserve
- (4) Earned ((1) + (2) - (3))

b Benefit charges:

- (1) Claims paid
- (2) Increase (decrease) in claim reserves
- (3) Incurred claims (add (1) and (2))
- (4) Claims charged

0 5 0 2 A A 0 5 0 W



c Remainder of premium:

(1) Retention charges (on an accrual basis) --

(A) Commissions

(B) Administrative service or other fees

(C) Other specific acquisition costs

(D) Other expenses

(E) Taxes

(F) Charges for risks or other contingencies

(G) Other retention charges

(H) Total retention

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.)...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement

(2) Claim reserves

(3) Other reserves

e Dividends or retroactive rate refunds due.

(Do not include amount entered in c(2).)

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier

457298

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount

Specify nature of costs below

0 5 0 2 A A 0 6 0 X



**SCHEDULE C
(Form 5500)**

Service Provider Information

Official Use Only

OMB No. 1210-0110

2002

**This Form is Open to
Public Inspection.**

Department of the Treasury
Internal Revenue Service

This schedule is required to be filed under section 104 of the
Employee Retirement Income Security Act of 1974.

Department of Labor Pension and
Welfare Benefits Administration

► File as an attachment to Form 5500.

Pension Benefit Guaranty Corporation

For calendar plan year 2002
or fiscal plan year beginning

10 01 2002

and ending

09 30 2003

A Name of plan

INEEL HEALTH CARE PLAN

B Three-digit
plan number ►

504

C Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BWXT IDAHO, LLC

D Employer Identification Number

94 3323797

Part I Service Provider Information (see instructions)

- Enter the total dollar amount of compensation paid by the plan to all persons, other than those listed below, who received compensation during the plan year:
- On the first item below list the contract administrator, if any, as defined in the instructions. On the other items, list service providers in descending order of the compensation they received for the services rendered during the plan year. List only the top 40. 103-12 IEs should enter N/A in (c) and (d).

(a) Name

AETNA US HEALTHCARE

(b) Employer identification number (see instructions)

06 6033492

(c) Official plan position

Contract administrator

(d) Relationship to employer,
employee organization, or person
known to be a party-in-interest

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s)
(see instructions) 12

1801985

(a) Name

ECKERD HEALTH SERVICES

(b) Employer identification number (see instructions)

51 0353040

(c) Official plan position

CONTRACT ADMINISTRATOR

(d) Relationship to employer,
employee organization, or person
known to be a party-in-interest

CLAIMS PROCESSING

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s)
(see instructions) 12

40631

For Paperwork Reduction Act Notice and OMB Control Numbers, see the Instructions for Form 5500. Cat. No. 13515E Schedule C (Form 5500) 2002

0 9 0 2 A A 0 1 0 W



v5.0

(a) Name

CIGNA BEHAVIORAL HEALTH

(b) Employer identification number (see instructions)

41 1648670

(c) Official plan position

CONTRACT ADMINISTRATOR

(d) Relationship to employer, employee organization, or person known to be a party-in-interest

CLAIMS PROCESSING

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s) (see instructions) 12

179771

(a) Name

(b) Employer identification number (see instructions)

(c) Official plan position

(d) Relationship to employer, employee organization, or person known to be a party-in-interest

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s) (see instructions)

(a) Name

(b) Employer identification number (see instructions)

(c) Official plan position

(d) Relationship to employer, employee organization, or person known to be a party-in-interest

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s) (see instructions)

(a) Name

(b) Employer identification number (see instructions)

(c) Official plan position

(d) Relationship to employer, employee organization, or person known to be a party-in-interest

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s) (see instructions)

0 9 0 2 A A 0 2 0 X



Form **5500**

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits
Administration
Pension Benefit
Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

► **Complete all entries in accordance with the instructions to the Form 5500.**

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning

10 01 2002

and ending

09 30 2003

- A This return/report is for:
- (1) a multiemployer plan;
 - (2) a single-employer plan (other than a multiple-employer plan);
 - (3) a multiple-employer plan; or
 - (4) a DFE (specify)
- B This return/report is:
- (1) the first return/report filed for the plan;
 - (2) an amended return/report;
 - (3) the final return/report filed for the plan;
 - (4) a short plan year return/report (less than 12 months).

- C If the plan is a collectively-bargained plan, check here
- D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions)

Part II Basic Plan Information – enter all requested information.

1a Name of plan

INEEL DENTAL CARE PLAN

1b Three-digit plan number (PN) ► 510

1c Effective date of plan 01 01 1995

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE ► Candace F. Wilkinson

Date 04 20 2004

Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE ► Candace F. Wilkinson

Date 04 20 2004

Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Cat. No. 13500F Form 5500 (2002)

0 1 0 2 A A 0 1 0 0



v5.0

2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) CIO CANDACE F WILKINSON

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

2b Employer Identification Number (EIN)

94 3323797

2c Sponsor's telephone number

208 526 0066

2d Business code (see instructions)

541990

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

1) SAME

2) CIO

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

0 1 0 2 A A 0 2 0 P



5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3)

b EIN

4)

5)

c Telephone number

6)

6 Total number of participants at the beginning of the plan year

4893

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

4767

b Retired or separated participants receiving benefits

205

c Other retired or separated participants entitled to future benefits

d Subtotal. Add lines 7a, 7b, and 7c

4972

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

f Total. Add lines 7d and 7e

4972

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

0 1 0 2 A A 0 3 0 Q



8 Benefits provided under the plan (complete 8a and 8b, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

AD

9a Plan funding arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(f) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(f) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- 1) R (Retirement Plan Information)
- 2) T (Qualified Pension Plan Coverage Information)
- 3) B (Actuarial Information)
- 4) E (ESOP Annual Information)
- 5) SSA (Separated Vested Participant Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

b Financial Schedules

- 1) H (Financial Information)
- 2) I (Financial Information—Small Plan)
- 3) 002 A (Insurance Information)
- 4) C (Service Provider Information)
- 5) D (DFE/Participating Plan Information)
- 6) G (Financial Transaction Schedules)
- 7) P (Trust Fiduciary Information)



**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits
Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the
Employee Retirement Income Security Act of 1974.

- ▶ File as an attachment to Form 5500.
- ▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to
Public Inspection.

For calendar plan year 2002
or fiscal plan year beginning

10 01 2002 and ending 09 30 2003

A Name of plan

INEEL DENTAL CARE PLAN

B Three-digit
plan number ▶

510

C Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BWXT IDAHO, LLC

D Employer Identification Number

94 3323797

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

DELTA DENTAL PLAN OF CALIFORNIA

(b) EIN

94 1461312

(c) NAIC code

(d) Contract or identification number

5440

(e) Approximate number of persons covered at end of policy or contract year

4980

Policy or contract year

(f) From

01 01 2002

(g) To

12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

0

0

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 135051 Schedule A (Form 5500) 2002

0 5 0 2 A A 0 1 0 S



v5.0

230898-5

*U.S. GOVERNMENT PRINTING OFFICE: 2003-497-704

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose



Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates



b Premiums paid to carrier

c Premiums due but unpaid at the end of the year

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount
Specify nature of costs



e Type of contract (1) individual policies (2) group deferred annuity

(3) other (specify below)



f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

0 5 0 2 A A 0 3 0 U



6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

- (1) deposit administration
- (2) immediate participation guarantee
- (3) guaranteed investment
- (4) other (specify below)

b Balance at the end of the previous year

c Additions:

- (1) Contributions deposited during the year
- (2) Dividends and credits
- (3) Interest credited during the year
- (4) Transferred from separate account
- (5) Other (specify below)

(6) Total additions

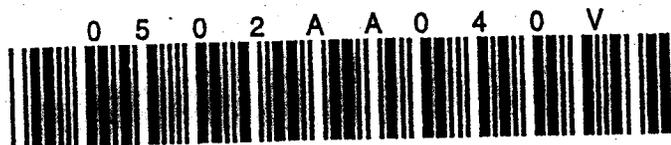
d Total of balance and additions (add b and c(6))

e Deductions:

- (1) Disbursed from fund to pay benefits or purchase annuities during year
- (2) Administration charge made by carrier
- (3) Transferred to separate account
- (4) Other (specify below)

(5) Total deductions

f Balance at the end of the current year (subtract e(5) from d)



Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

- (a) Health (other than dental or vision) (b) Dental (c) Vision (d) Life Insurance
- (e) Temporary disability (accident and sickness) (f) Long-term disability (g) Supplemental unemployment (h) Prescription drug
- (i) Stop loss (large deductible) (j) HMO contract (k) PPO contract (l) Indemnity contract
- (m) Other (specify below)

8 Experience-rated contracts

a Premiums:

- (1) Amount received **4336242**
- (2) Increase (decrease) in amount due but unpaid
- (3) Increase (decrease) in unearned premium reserve
- (4) Earned ((1) + (2) - (3)) **4336242**

b Benefit charges:

- (1) Claims paid **3782551**
- (2) Increase (decrease) in claim reserves
- (3) Incurred claims (add (1) and (2)) **3782551**
- (4) Claims charged

0 5 0 2 A A 0 5 0 W



c Remainder of premium:

(1) Retention charges (on an accrual basis) -

- (A) Commissions
- (B) Administrative service or other fees
- (C) Other specific acquisition costs
- (D) Other expenses
- (E) Taxes
- (F) Charges for risks or other contingencies
- (G) Other retention charges

356439

(H) Total retention

356439

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.)...

d Status of policyholder reserves at end of year:

- (1) Amount held to provide benefits after retirement
- (2) Claim reserves
- (3) Other reserves

400000

e Dividends or retroactive rate refunds due.

(Do not include amount entered in c(2).)

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, Item 2 above, report amount.....

Specify nature of costs below



Form **5500**

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits
Administration
Pension Benefit
Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Official Use Only
OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning 10 01 2002 and ending 09 30 2003

- A This return/report is for:
- (1) a multiemployer plan;
 - (2) a single-employer plan (other than a multiple-employer plan);
 - (3) a multiple-employer plan; or
 - (4) a DFE (specify)
- B This return/report is:
- (1) the first return/report filed for the plan;
 - (2) an amended return/report;
 - (3) the final return/report filed for the plan;
 - (4) a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ▶

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ▶

Part II Basic Plan Information – enter all requested information.

1a Name of plan

INEEL LIFE INSURANCE PLAN

1b Three-digit plan number (PN) ▶

503

1c Effective date of plan

07 01 1966

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE ▶ Candace F. Wilkinson

Date 04 20 2004

Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE ▶ Candace F. Wilkinson

Date 04 20 2004

Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 13500F Form 5500 (2002)

0 1 0 2 A A 0 1 0 0



v5.0

2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) CIO CANDACE F WILKINSON

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

2b Employer Identification Number (EIN)

94 3323797

2c Sponsor's telephone number

208 526 0066

2d Business code (see instructions)

541990

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) CIO

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

0 1 0 2 A A 0 2 0 P



5 Preparer Information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3)

b EIN

4)

5)

c Telephone number

6)

6 Total number of participants at the beginning of the plan year

6539

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

4994

b Retired or separated participants receiving benefits

c Other retired or separated participants entitled to future benefits

1465

d Subtotal. Add lines 7a, 7b, and 7c

6459

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

f Total. Add lines 7d and 7e

6459

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

0 1 0 2 A A 0 3 0 Q



8 Benefits provided under the plan (complete 8a and 8b, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

HB

9a Plan funding arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(l) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(l) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- 1) R (Retirement Plan Information)
- 2) T (Qualified Pension Plan Coverage Information)
- 3) B (Actuarial Information)
- 4) E (ESOP Annual Information)
- 5) SSA (Separated Vested Participant Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

b Financial Schedules

- 1) H (Financial Information)
- 2) I (Financial Information--Small Plan)
- 3) 003 A (Insurance Information)
- 4) C (Service Provider Information)
- 5) D (DFE/Participating Plan Information)
- 6) G (Financial Transaction Schedules)
- 7) P (Trust Fiduciary Information)

0 1 0 2 A A 0 4 0 R



**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits
Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the
Employee Retirement Income Security Act of 1974.

- ▶ File as an attachment to Form 5500.
- ▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to
Public Inspection.

For calendar plan year 2002
or fiscal plan year beginning

10 01 2002

and ending

09 30 2003

A Name of plan

INEEL LIFE INSURANCE PLAN

B Three-digit
plan number ▶

503

C Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BWXT IDAHO, LLC

D Employer Identification Number

94 3323797

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

PRUDENTIAL FINANCIAL

(b) EIN

22 1211670

(c) NAIC code

68241

(d) Contract or identification number

24927-1

(e) Approximate number of persons covered at end of policy or contract year

3223

Policy or contract year

(f) From

01 01 2002

(g) To

12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

0

0

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 135051 Schedule A (Form 5500) 2002



v5.0

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose



Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates



b Premiums paid to carrier

c Premiums due but unpaid at the end of the year

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount
Specify nature of costs



e Type of contract (1) individual policies (2) group deferred annuity
(3) other (specify below)



f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶

0 5 0 2 A A 0 3 0 U



6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

- (1) deposit administration
- (2) immediate participation guarantee
- (3) guaranteed investment
- (4) other (specify below)



b Balance at the end of the previous year

c Additions:

- (1) Contributions deposited during the year
- (2) Dividends and credits
- (3) Interest credited during the year
- (4) Transferred from separate account
- (5) Other (specify below)



(6) Total additions

d Total of balance and additions (add b and c(6))

e Deductions:

- (1) Disbursed from fund to pay benefits or purchase annuities during year
- (2) Administration charge made by carrier
- (3) Transferred to separate account
- (4) Other (specify below)



(5) Total deductions

f Balance at the end of the current year (subtract e(5) from d)

0 5 0 2 A A 0 4 0 V



Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

- (a) Health (other than dental or vision)
- (b) Dental
- (c) Vision
- (d) Life Insurance
- (e) Temporary disability (accident and sickness)
- (f) Long-term disability
- (g) Supplemental unemployment
- (h) Prescription drug
- (i) Stop loss (large deductible)
- (j) HMO contract
- (k) PPO contract
- (l) Indemnity contract
- (m) Other (specify below)

8 Experience-rated contracts

a Premiums:

- (1) Amount received
- (2) Increase (decrease) in amount due but unpaid
- (3) Increase (decrease) in unearned premium reserve
- (4) Earned ((1) + (2) - (3))

b Benefit charges:

- (1) Claims paid
- (2) Increase (decrease) in claim reserves
- (3) Incurred claims (add (1) and (2))
- (4) Claims charged



c Remainder of premium:

(1) Retention charges (on an accrual basis) --

(A) Commissions

(B) Administrative service or other fees

(C) Other specific acquisition costs

(D) Other expenses

(E) Taxes

(F) Charges for risks or other contingencies

(G) Other retention charges

(H) Total retention

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.)...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement

(2) Claim reserves

(3) Other reserves

e Dividends or retroactive rate refunds due.

(Do not include amount entered in c(2).)

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier

1019403

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount

Specify nature of costs below

0 5 0 2 A A 0 6 0 X



**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits
Administration

Pension Benefit Guaranty Corporation

For calendar plan year 2002
or fiscal plan year beginning

Insurance Information

This schedule is required to be filed under section 104 of the
Employee Retirement Income Security Act of 1974.

- ▶ File as an attachment to Form 5500.
- ▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to
Public Inspection.

10 01 2002 and ending 09 30 2003

A Name of plan

INEEL LIFE INSURANCE PLAN

B Three-digit plan number ▶

503

C Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BWXT IDAHO, LLC

D Employer Identification Number

94 3323797

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

PRUDENTIAL FINANCIAL

(b) EIN

22 1211670

(c) NAIC code

68241

(d) Contract or identification number

23750-1

(e) Approximate number of persons covered at end of policy or contract year

5670

Policy or contract year

(f) From

01 01 2002

(g) To

12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

0

0

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 135051 Schedule A (Form 5500) 2002

0 5 0 2 A A 0 1 0 S



v5.0

230898-5

U.S. GOVERNMENT PRINTING OFFICE: 2002-107-704

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

0 5 0 2 A A 0 2 0 T



Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates



b Premiums paid to carrier

c Premiums due but unpaid at the end of the year

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount
Specify nature of costs

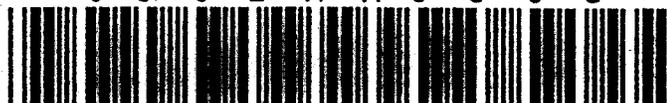


e Type of contract (1) individual policies (2) group deferred annuity
(3) other (specify below)



f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶

0 5 0 2 A A 0 3 0 U



6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

- (1) deposit administration
- (2) immediate participation guarantee
- (3) guaranteed investment
- (4) other (specify below)

b Balance at the end of the previous year

c Additions:

- (1) Contributions deposited during the year
- (2) Dividends and credits
- (3) Interest credited during the year
- (4) Transferred from separate account
- (5) Other (specify below)

(6) Total additions

d Total of balance and additions (add b and c(6))

e Deductions:

- (1) Disbursed from fund to pay benefits or purchase annuities during year
- (2) Administration charge made by carrier
- (3) Transferred to separate account
- (4) Other (specify below)

(5) Total deductions

f Balance at the end of the current year (subtract e(5) from d)

0 5 0 2 A A 0 4 0 V



Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

- (a) Health (other than dental or vision)
- (b) Dental
- (c) Vision
- (d) Life insurance
- (e) Temporary disability (accident and sickness)
- (f) Long-term disability
- (g) Supplemental unemployment
- (h) Prescription drug
- (i) Stop loss (large deductible)
- (j) HMO contract
- (k) PPO contract
- (l) Indemnity contract
- (m) Other (specify below)

8 Experience-rated contracts

a Premiums:

- (1) Amount received 1680999
- (2) Increase (decrease) in amount due but unpaid -171476
- (3) Increase (decrease) in unearned premium reserve
- (4) Earned ((1) + (2) - (3)) 1509523

b Benefit charges:

- (1) Claims paid 1579085
- (2) Increase (decrease) in claim reserves 57837
- (3) Incurred claims (add (1) and (2)) 1636922
- (4) Claims charged 1636922



c Remainder of premium:

(1) Retention charges (on an accrual basis) -

(A) Commissions

(B) Administrative service or other fees

(C) Other specific acquisition costs

(D) Other expenses

(E) Taxes

(F) Charges for risks or other contingencies

(G) Other retention charges

(H) Total retention

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.) ...

-37015
50481
25959

39425

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement

(2) Claim reserves

(3) Other reserves

e Dividends or retroactive rate refunds due.

(Do not include amount entered in c(2).)

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.....

Specify nature of costs below



**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits
Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the
Employee Retirement Income Security Act of 1974.

- ▶ File as an attachment to Form 5500.
- ▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to
Public Inspection.

For calendar plan year 2002
or fiscal plan year beginning

10 01 2002

and ending

09 30 2003

A Name of plan

INEEL LIFE INSURANCE PLAN

B Three-digit
plan number ▶

503

C Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BWXT IDAHO, LLC

D Employer Identification Number

94 3323797

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

PRUDENTIAL FINANCIAL

(b) EIN

22 1211670

(c) NAIC code

68241

(d) Contract or identification number

23750-3

(e) Approximate number of persons covered at end of policy or contract year

8898

Policy or contract year

(f) From

01 01 2002

(g) To

12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

0

0

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 135051 Schedule A (Form 5500) 2002

0 5 0 2 A A 0 1 0 S



v5.0

230898-5

*U.S. GOVERNMENT PRINTING OFFICE:2003-497-704

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

0 5 0 2 A A 0 2 0 T



Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 **Contracts With Allocated Funds**

a State the basis of premium rates



b Premiums paid to carrier

c Premiums due but unpaid at the end of the year

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount

Specify nature of costs



e Type of contract (1) individual policies (2) group deferred annuity

(3) other (specify below)



f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶

0 5 0 2 A A 0 3 0 U



6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

- (1) deposit administration (2) immediate participation guarantee (3) guaranteed investment
- (4) other (specify below)

b Balance at the end of the previous year

c Additions:

- (1) Contributions deposited during the year
- (2) Dividends and credits
- (3) Interest credited during the year
- (4) Transferred from separate account
- (5) Other (specify below)

(6) Total additions

d Total of balance and additions (add b and c(6))

e Deductions:

- (1) Disbursed from fund to pay benefits or purchase annuities during year
- (2) Administration charge made by carrier
- (3) Transferred to separate account
- (4) Other (specify below)

(5) Total deductions

f Balance at the end of the current year (subtract e(5) from d)

0 5 0 2 A A 0 4 0 V



Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

- (a) Health (other than dental or vision)
- (b) Dental
- (c) Vision
- (d) Life Insurance
- (e) Temporary disability (accident and sickness)
- (f) Long-term disability
- (g) Supplemental unemployment
- (h) Prescription drug
- (i) Stop loss (large deductible)
- (j) HMO contract
- (k) PPO contract
- (l) Indemnity contract
- (m) Other (specify below)

8 Experience-rated contracts

a Premiums:

- (1) Amount received
- (2) Increase (decrease) in amount due but unpaid
- (3) Increase (decrease) in unearned premium reserve
- (4) Earned ((1) + (2) - (3))

b Benefit charges:

- (1) Claims paid
- (2) Increase (decrease) in claim reserves
- (3) Incurred claims (add (1) and (2))
- (4) Claims charged



c Remainder of premium:

(1) Retention charges (on an accrual basis) --

(A) Commissions

(B) Administrative service or other fees

(C) Other specific acquisition costs

(D) Other expenses

(E) Taxes

(F) Charges for risks or other contingencies

(G) Other retention charges

(H) Total retention

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.)...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement

(2) Claim reserves

(3) Other reserves

e Dividends or retroactive rate refunds due.

(Do not include amount entered in c(2).)

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier

1596029

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount..... Specify nature of costs below

0 5 0 2 A A 0 6 0 X



2002

This Form Is Open to Public Inspection.

Form 5500

Annual Return/Report of Employee Benefit Plan

Department of the Treasury Internal Revenue Service Department of Labor Pension and Welfare Benefits Administration Pension Benefit Guaranty Corporation

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning 10 01 2002 and ending 09 30 2003

- A This return/report is for: (1) a multiemployer plan; (2) X a single-employer plan (other than a multiple-employer plan); (3) a multiple-employer plan; or (4) a DFE (specify)
B This return/report is: (1) the first return/report filed for the plan; (2) an amended return/report; (3) the final return/report filed for the plan; (4) a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here
D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions)

Part II Basic Plan Information - enter all requested information.

1a Name of plan

INEEL ACCIDENTAL DEATH AND DISMEMBERMENT PLAN

1b Three-digit plan number (PN) 502

1c Effective date of plan 09 01 1966

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE Candace F. Wilkinson

Date 04 20 2004

Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE Candace F. Wilkinson

Date 04 20 2004

Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Cat. No. 13500F Form 5500 (2002)

0 1 0 2 A A 0 1 0 0



2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) C/O CANDACE F WILKINSON

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

2b Employer Identification Number (EIN)

94 3323797

2c Sponsor's telephone number

208 526 0066

2d Business code (see instructions)

541990

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) C/O

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN



5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3)

b EIN

4)

5)

c Telephone number

6)

6 Total number of participants at the beginning of the plan year

3872

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

3821

b Retired or separated participants receiving benefits

c Other retired or separated participants entitled to future benefits

d Subtotal. Add lines 7a, 7b, and 7c

3821

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

f Total. Add lines 7d and 7e

3821

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

0 1 0 2 A A 0 3 0 Q



8 Benefits provided under the plan (complete 8a and 8b, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

HQ

9a Plan funding arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(l) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(l) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- 1) R (Retirement Plan Information)
- 2) T (Qualified Pension Plan Coverage Information)
- 3) B (Actuarial Information)
- 4) E (ESOP Annual Information)
- 5) SSA (Separated Vested Participant Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

b Financial Schedules

- 1) H (Financial Information)
- 2) I (Financial Information—Small Plan)
- 3) 001 A (Insurance Information)
- 4) C (Service Provider Information)
- 5) D (DFE/Participating Plan Information)
- 6) G (Financial Transaction Schedules)
- 7) P (Trust Fiduciary Information)

0 1 0 2 A A 0 4 0 R



**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits
Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the
Employee Retirement Income Security Act of 1974.

- ▶ File as an attachment to Form 5500.
- ▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form Is Open to
Public Inspection.

For calendar plan year 2002
or fiscal plan year beginning

10 01 2002

and ending

09 30 2003

A Name of plan

INEEL ACCIDENTAL DEATH AND
DISMEMBERMENT PLAN

B Three-digit
plan number ▶

502

C Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BWXT IDAHO, LLC

D Employer identification number

94 3323797

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

TRANSAMERICA OCCIDENTAL LIFE
INSURANCE

(b) EIN

95 1060502

(c) NAIC code

67121

(d) Contract or identification number

05228082

(e) Approximate number of persons covered at end of policy or contract year

3993

Policy or contract year

(f) From

01 01 2002

(g) To

12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

0

0

For Paperwork Reduction Act Notice and OMB Control Numbers, see the Instructions for Form 5500. Cat. No. 135051 Schedule A (Form 5500) 2002

0 5 0 2 A A 0 1 0 S



v5.0

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose



Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates



b Premiums paid to carrier

c Premiums due but unpaid at the end of the year

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount

Specify nature of costs



e Type of contract (1) Individual policies (2) group deferred annuity

(3) other (specify below)



f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here



6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

- (1) deposit administration (2) immediate participation guarantee (3) guaranteed investment
- (4) other (specify below)

b Balance at the end of the previous year

c Additions:

- (1) Contributions deposited during the year
- (2) Dividends and credits
- (3) Interest credited during the year
- (4) Transferred from separate account
- (5) Other (specify below)

(6) Total additions

d Total of balance and additions (add b and c(6))

e Deductions:

- (1) Disbursed from fund to pay benefits or purchase annuities during year
- (2) Administration charge made by carrier
- (3) Transferred to separate account
- (4) Other (specify below)

(5) Total deductions

f Balance at the end of the current year (subtract e(5) from d)

0 5 0 2 A A 0 4 0 V



Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

- (a) Health (other than dental or vision)
- (b) Dental
- (c) Vision
- (d) Life Insurance
- (e) Temporary disability (accident and sickness)
- (f) Long-term disability
- (g) Supplemental unemployment
- (h) Prescription drug
- (i) Stop loss (large deductible)
- (j) HMO contract
- (k) PPO contract
- (l) Indemnity contract
- (m) Other (specify below)

▶ ACCIDENTAL DEATH AND DISMEMBERMENT

8 Experience-rated contracts

a Premiums:

- (1) Amount received
- (2) Increase (decrease) in amount due but unpaid
- (3) Increase (decrease) in unearned premium reserve
- (4) Earned ((1) + (2) - (3))

b Benefit charges:

- (1) Claims paid
- (2) Increase (decrease) in claim reserves
- (3) Incurred claims (add (1) and (2))
- (4) Claims charged

0 5 0 2 A A 0 5 0 W



c Remainder of premium:

(1) Retention charges (on an accrual basis) --

(A) Commissions

(B) Administrative service or other fees

(C) Other specific acquisition costs

(D) Other expenses

(E) Taxes

(F) Charges for risks or other contingencies

(G) Other retention charges

(H) Total retention

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.)...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement

(2) Claim reserves

(3) Other reserves

e Dividends or retroactive rate refunds due.

(Do not include amount entered in c(2).)

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.....
Specify nature of costs below

461474

0 5 0 2 A A 0 6 0 X



Form **5500**

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits
Administration
Pension Benefit
Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning

10 01 2002

and ending

09 30 2003

- A** This return/report is for:
- | | | | |
|-----|---|-----|------------------------------|
| (1) | a multiemployer plan; | (3) | a multiple-employer plan; or |
| (2) | <input checked="" type="checkbox"/> a single-employer plan (other than a multiple-employer plan); | (4) | a DFE (specify) |
- B** This return/report is:
- | | | | |
|-----|---|-----|--|
| (1) | the first return/report filed for the plan; | (3) | the final return/report filed for the plan; |
| (2) | an amended return/report; | (4) | a short plan year return/report (less than 12 months). |
- C** If the plan is a collectively-bargained plan, check here
- D** If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions)

Part II Basic Plan Information -- enter all requested information.

1a Name of plan

INEEL SHORT TERM DISABILITY PLAN

1b Three-digit plan number (PN) ▶

508

1c Effective date of plan

08 01 1992

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE ▶ Candace F. Wilkinson

Date 04 20 2004

Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE ▶ Candace F. Wilkinson

Date 04 20 2004

Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Cat. No. 13500F Form 5500 (2002)

0 1 0 2 A A 0 1 0 0



v5.0

2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) C/O CANDACE F WILKINSON

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID B3415-3200

2b Employer Identification Number (EIN)

94 3323797

2c Sponsor's telephone number

208 526 0066

2d Business code (see instructions)

541990

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) C/O

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

0 1 0 2 A A 0 2 0 P



5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3)

b EIN

4)

5)

c Telephone number

6)

6 Total number of participants at the beginning of the plan year

5053

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

4969

b Retired or separated participants receiving benefits

c Other retired or separated participants entitled to future benefits

d Subtotal. Add lines 7a, 7b, and 7c

4969

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

f Total. Add lines 7d and 7e

4969

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

0 1 0 2 A A 0 3 0 Q



8 Benefits provided under the plan (complete 8a and 8b, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4F

9a Plan funding arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(f) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(f) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- 1) R (Retirement Plan Information)
- 2) T (Qualified Pension Plan Coverage Information)
- If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ▶
- 3) B (Actuarial Information)
- 4) E (ESOP Annual Information)
- 5) SSA (Separated Vested Participant Information)

b Financial Schedules

- 1) H (Financial Information)
- 2) I (Financial Information--Small Plan)
- 3) 001 A (Insurance Information)
- 4) C (Service Provider Information)
- 5) D (DFE/Participating Plan Information)
- 6) G (Financial Transaction Schedules)
- 7) P (Trust Fiduciary Information)

0 1 0 2 A A 0 4 0 R



**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits
Administration
Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

- ▶ File as an attachment to Form 5500.
- ▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning

10 01 2002 and ending 09 30 2003

A Name of plan

INEEL SHORT TERM DISABILITY PLAN

B Three-digit plan number ▶

508

C Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BWXT IDAHO, LLC

D Employer Identification Number

94 3323797

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

CIGNA LIFE INSURANCE COMPANY OF NORTH AMERICA

(b) EIN

23 1503749

(c) NAIC code

65498

(d) Contract or identification number

LK 008044

(e) Approximate number of persons covered at end of policy or contract year

5189

Policy or contract year

(f) From

01 01 2002

(g) To

12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

0

0

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 135051 Schedule A (Form 5500) 2002

0 5 0 2 A A 0 1 0 S



v5.0

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

0 5 0 2 A A 0 2 0 T



Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates



b Premiums paid to carrier

c Premiums due but unpaid at the end of the year

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount
Specify nature of costs



e Type of contract (1) individual policies (2) group deferred annuity
(3) other (specify below)



f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here



6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

- (1) deposit administration
- (2) immediate participation guarantee
- (3) guaranteed investment
- (4) other (specify below)



b Balance at the end of the previous year

c Additions:

- (1) Contributions deposited during the year
- (2) Dividends and credits
- (3) Interest credited during the year
- (4) Transferred from separate account
- (5) Other (specify below)



(6) Total additions

d Total of balance and additions (add b and c(6))

e Deductions:

- (1) Disbursed from fund to pay benefits or purchase annuities during year
- (2) Administration charge made by carrier
- (3) Transferred to separate account
- (4) Other (specify below)



(5) Total deductions

f Balance at the end of the current year (subtract e(5) from d)

0 5 0 2 A A 0 4 0 V



Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

- (a) Health (other than dental or vision)
- (b) Dental
- (c) Vision
- (d) Life Insurance
- (e) Temporary disability (accident and sickness)
- (f) Long-term disability
- (g) Supplemental unemployment
- (h) Prescription drug
- (i) Stop loss (large deductible)
- (j) HMO contract
- (k) PPO contract
- (l) Indemnity contract
- (m) Other (specify below)

8 Experience-rated contracts

a Premiums:

- (1) Amount received
- (2) Increase (decrease) in amount due but unpaid
- (3) Increase (decrease) in unearned premium reserve
- (4) Earned ((1) + (2) - (3))

b Benefit charges:

- (1) Claims paid
- (2) Increase (decrease) in claim reserves
- (3) Incurred claims (add (1) and (2))
- (4) Claims charged



c Remainder of premium:

(1) Retention charges (on an accrual basis) --

- (A) Commissions
- (B) Administrative service or other fees
- (C) Other specific acquisition costs
- (D) Other expenses
- (E) Taxes
- (F) Charges for risks or other contingencies
- (G) Other retention charges

(H) Total retention

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.)...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement

(2) Claim reserves

(3) Other reserves

e Dividends or retroactive rate refunds due.

(Do not include amount entered in c(2).)

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier

2419467

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount

Specify nature of costs below



2002

This Form Is Open to Public Inspection.

Form 5500

Annual Return/Report of Employee Benefit Plan

Department of the Treasury Internal Revenue Service Department of Labor Pension and Welfare Benefits Administration Pension Benefit Guaranty Corporation

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning 10 01 2002 and ending 09 30 2003

- A This return/report is for: (1) a multiemployer plan; (2) X a single-employer plan (other than a multiple-employer plan); (3) a multiple-employer plan; or (4) a DFE (specify)

- B This return/report is: (1) the first return/report filed for the plan; (2) an amended return/report; (3) the final return/report filed for the plan; (4) a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions)

Part II Basic Plan Information - enter all requested information.

1a Name of plan INEEL LONG TERM DISABILITY INSURANCE PLAN

1b Three-digit plan number (PN) 505 1c Effective date of plan 12 01 1968

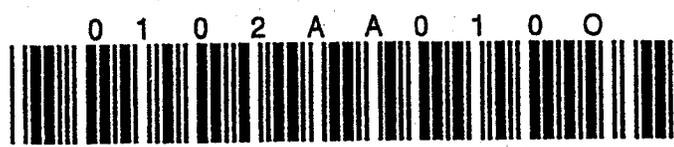
Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator SIGN HERE Candace F. Wilkinson Date 04 20 2004

a CANDACE F WILKINSON Signature of employer/plan sponsor/DFE SIGN HERE Candace F. Wilkinson Date 04 20 2004

b CANDACE F WILKINSON

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 13500F Form 5500 (2002)



2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) CIO CANDACE F WILKINSON

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID B3415-3200

2b Employer Identification Number (EIN)

94 3323797

2c Sponsor's telephone number

208 526 0066

2d Business code (see instructions)

541990

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) CIO

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

0 1 0 2 A A 0 2 0 P



5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3)

b EIN

4)

5)

c Telephone number

6)

6 Total number of participants at the beginning of the plan year

3980

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

3781

b Retired or separated participants receiving benefits

77

c Other retired or separated participants entitled to future benefits

d Subtotal. Add lines 7a, 7b, and 7c

3858

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

f Total. Add lines 7d and 7e

3858

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)



8 Benefits provided under the plan (complete 8a and 8b, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

44

9a Plan funding arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(f) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(f) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- 1) R (Retirement Plan Information)
- 2) T (Qualified Pension Plan Coverage Information)
- If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ▶
- 3) B (Actuarial Information)
- 4) E (ESOP Annual Information)
- 5) SSA (Separated Vested Participant Information)

b Financial Schedules

- 1) H (Financial Information)
- 2) I (Financial Information—Small Plan)
- 3) 001 A (Insurance Information)
- 4) C (Service Provider Information)
- 5) D (DFE/Participating Plan Information)
- 6) G (Financial Transaction Schedules)
- 7) P (Trust Fiduciary Information)

0 1 0 2 A A 0 4 0 R



**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits
Administration

Pension Benefit Guaranty Corporation

For calendar plan year 2002
or fiscal plan year beginning

Insurance Information

This schedule is required to be filed under section 104 of the
Employee Retirement Income Security Act of 1974.

- ▶ File as an attachment to Form 5500.
- ▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to
Public Inspection.

10 01 2002 and ending 09 30 2003

A Name of plan

**INEEL LONG TERM DISABILITY
INSURANCE PLAN**

B Three-digit
plan number ▶

505

C Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BWXT IDAHO, LLC

D Employer Identification Number

94 3323797

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

**CIGNA LIFE INSURANCE COMPANY OF
NORTH AMERICA**

(b) EIN

23 1503749

(c) NAIC code

65498

(d) Contract or identification number

LK 008044

(e) Approximate number of persons covered at end of policy or contract year

3960

Policy or contract year

(f) From

01 01 2002

(g) To

12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

0

0

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 135051 Schedule A (Form 5500) 2002

0 5 0 2 A A 0 1 0 S



v5.0

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose



Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 **Contracts With Allocated Funds**

a State the basis of premium rates



b Premiums paid to carrier

c Premiums due but unpaid at the end of the year

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount

Specify nature of costs

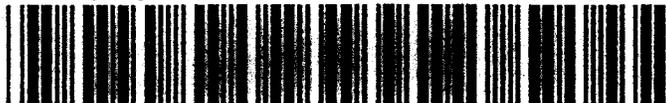


e Type of contract (1) individual policies (2) group deferred annuity (3) other (specify below)



f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

0 5 0 2 A A 0 3 0 U



6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

- (1) deposit administration (2) Immediate participation guarantee (3) guaranteed investment
- (4) other (specify below)

b Balance at the end of the previous year

c Additions:

- (1) Contributions deposited during the year
- (2) Dividends and credits
- (3) Interest credited during the year
- (4) Transferred from separate account
- (5) Other (specify below)

(6) Total additions

d Total of balance and additions (add b and c(6))

e Deductions:

- (1) Disbursed from fund to pay benefits or purchase annuities during year
- (2) Administration charge made by carrier
- (3) Transferred to separate account
- (4) Other (specify below)

(5) Total deductions

f Balance at the end of the current year (subtract e(5) from d)

0 5 0 2 A A 0 4 0 V



Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

- (a) Health (other than dental or vision)
- (b) Dental
- (c) Vision
- (d) Life Insurance
- (e) Temporary disability (accident and sickness)
- (f) Long-term disability
- (g) Supplemental unemployment
- (h) Prescription drug
- (i) Stop loss (large deductible)
- (j) HMO contract
- (k) PPO contract
- (l) Indemnity contract
- (m) Other (specify below)

8 Experience-rated contracts

a Premiums:

- (1) Amount received
- (2) Increase (decrease) in amount due but unpaid
- (3) Increase (decrease) in unearned premium reserve
- (4) Earned ((1) + (2) - (3)).....

b Benefit charges:

- (1) Claims paid
- (2) Increase (decrease) in claim reserves
- (3) Incurred claims (add (1) and (2))
- (4) Claims charged



c Remainder of premium:

(1) Retention charges (on an accrual basis) --

- (A) Commissions
- (B) Administrative service or other fees
- (C) Other specific acquisition costs
- (D) Other expenses
- (E) Taxes
- (F) Charges for risks or other contingencies
- (G) Other retention charges

(H) Total retention

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.)...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement

(2) Claim reserves

(3) Other reserves

e Dividends or retroactive rate refunds due.

(Do not include amount entered in c(2).)

9 Nonexperience-rated contracts:

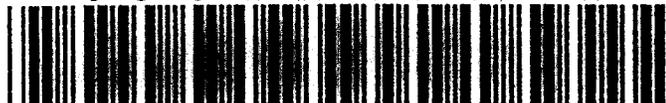
a Total premiums or subscription charges paid to carrier

1322858

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.....

Specify nature of costs below

0 5 0 2 A A 0 6 0 X



2002

This Form is Open to Public Inspection.

Form 5500

Annual Return/Report of Employee Benefit Plan

Department of the Treasury Internal Revenue Service Department of Labor Pension and Welfare Benefits Administration Pension Benefit Guaranty Corporation

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning

10 01 2002

and ending

09 30 2003

- A This return/report is for: (1) a multiemployer plan; (2) a single-employer plan; (3) a multiple-employer plan; (4) a DFE (specify)
B This return/report is: (1) the first return/report filed for the plan; (2) an amended return/report; (3) the final return/report filed for the plan; (4) a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here
D If filing under an extension of time or the DFVC program, check box and attach required information.

Part II Basic Plan Information - enter all requested information.

1a Name of plan

SEVERANCE PAY PLAN

1b Three-digit plan number (PN)

507

1c Effective date of plan

10 01 1987

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE

Candace Wilkinson

Date

04 20 2004

Type or print name of individual signing as plan administrator

a

CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE

Candace Wilkinson

Date

04 20 2004

Type or print name of individual signing as employer, plan sponsor or DFE

b

CANDACE F WILKINSON

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Cat. No. 13500F

Form 5500 (2002)



2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) CIO CANDACE F WILKINSON

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

2b Employer Identification Number (EIN)

94 3323797

2c Sponsor's telephone number

208 526 0066

2d Business code (see instructions)

541990

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) CIO

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

0 1 0 2 A A 0 2 0 P



5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3)

b EIN

4)

5)

c Telephone number

6)

6 Total number of participants at the beginning of the plan year

5080

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

5004

b Retired or separated participants receiving benefits

c Other retired or separated participants entitled to future benefits

d Subtotal. Add lines 7a, 7b, and 7c

5004

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

f Total. Add lines 7d and 7e

5004

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)



8 Benefits provided under the plan (complete 8a and 8b, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4 I

9a Plan funding arrangement (check all that apply)

9b Plan benefit arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(i) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

- (1) Insurance
- (2) Code section 412(i) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

b Financial Schedules

- 1) R (Retirement Plan Information)
- 2) T (Qualified Pension Plan Coverage Information)
- If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ▶
- 3) B (Actuarial Information)
- 4) E (ESOP Annual Information)
- 5) SSA (Separated Vested Participant Information)

- 1) H (Financial Information)
- 2) I (Financial Information--Small Plan)
- 3) A (Insurance Information)
- 4) C (Service Provider Information)
- 5) D (DFE/Participating Plan Information)
- 6) G (Financial Transaction Schedules)
- 7) P (Trust Fiduciary Information)



Form **5500**

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit
Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2003

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2003 or fiscal plan year beginning 01 01 2003 and ending 12 31 2003

- A This return/report is for:
- | | | | |
|-----|---|-----|------------------------------|
| (1) | a multiemployer plan; | (3) | a multiple-employer plan; or |
| (2) | <input checked="" type="checkbox"/> a single-employer plan (other than a multiple-employer plan); | (4) | a DFE (specify) |
- B This return/report is:
- | | | | |
|-----|---|-----|--|
| (1) | the first return/report filed for the plan; | (3) | the final return/report filed for the plan; |
| (2) | an amended return/report; | (4) | a short plan year return/report (less than 12 months). |
- C If the plan is a collectively-bargained plan, check here ▶
- D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ▶

Part II Basic Plan Information -- enter all requested information.

1a Name of plan

INEEL VISION CARE PLAN

1b Three-digit plan number (PN) ▶ 509

1c Effective date of plan 01 01 1993

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE ▶ Candace Wilkinson

Date 07 21 2004

Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE ▶ Candace Wilkinson

Date 07 21 2004

Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 13500F Form 5500 (2003)

0 1 0 3 A A 0 1 0 P



2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) C I O

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

2b Employer Identification Number (EIN)

94 3323797

2c Sponsor's telephone number

208 526 0066

2d Business code (see instructions)

541990

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) C I O

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN



5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3)

b EIN

4)

5)

c Telephone number

6)

6 Total number of participants at the beginning of the plan year

1417

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

1387

b Retired or separated participants receiving benefits

23

c Other retired or separated participants entitled to future benefits

d Subtotal. Add lines 7a, 7b, and 7c

1410

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

f Total. Add lines 7d and 7e

1410

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

0 1 0 3 A A 0 3 0 R



8 Benefits provided under the plan (complete 8a and 8b, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

AE

9a Plan funding arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(l) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(l) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- 1) R (Retirement Plan Information)
- 2) T (Qualified Pension Plan Coverage Information)
- If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ▶
- 3) B (Actuarial Information)
- 4) E (ESOP Annual Information)
- 5) SSA (Separated Vested Participant Information)

b Financial Schedules

- 1) H (Financial Information)
- 2) I (Financial Information--Small Plan)
- 3) 001 A (Insurance Information)
- 4) C (Service Provider Information)
- 5) D (DFE/Participating Plan Information)
- 6) G (Financial Transaction Schedules)
- 7) P (Trust Fiduciary Information)

0 1 0 3 A A 0 4 0 S



**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

For calendar plan year 2003
or fiscal plan year beginning

A Name of plan

INEEL VISION CARE PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BWXT IDAHO, LLC

B Three-digit
plan number

509

D Employer Identification Number

94 3323797

Insurance Information

This schedule is required to be filed under section 104 of the
Employee Retirement Income Security Act of 1974.

▶ File as an attachment to Form 5500.

▶ Insurance companies are required to provide this information
pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2003

This Form is Open to
Public Inspection.

01 01 2003 and ending *12 31 2003*

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

VISION SERVICE PLAN

(b) EIN

82 0339119

(c) NAIC code

47783

(d) Contract or identification number

12154777

(e) Approximate number of persons covered at end of policy or contract year

1410

Policy or contract year

(f) From

01 01 2003

(g) To

12 31 2003

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 135051 Schedule A (Form 5500) 2003

0 5 0 3 A A 0 1 0 T



(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose



Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates



b Premiums paid to carrier

c Premiums due but unpaid at the end of the year

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount
Specify nature of costs



e Type of contract (1) individual policies (2) group deferred annuity
(3) other (specify below)



f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶



6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

- (1) deposit administration (2) immediate participation guarantee (3) guaranteed investment
- (4) other (specify below)

b Balance at the end of the previous year

c Additions:

- (1) Contributions deposited during the year
- (2) Dividends and credits
- (3) Interest credited during the year
- (4) Transferred from separate account
- (5) Other (specify below)

(6) Total additions

d Total of balance and additions (add b and c(6))

e Deductions:

- (1) Disbursed from fund to pay benefits or purchase annuities during year
- (2) Administration charge made by carrier
- (3) Transferred to separate account
- (4) Other (specify below)

(5) Total deductions

f Balance at the end of the current year (subtract e(5) from d)



Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

- (a) Health (other than dental or vision)
- (b) Dental
- (c) Vision
- (d) Life Insurance
- (e) Temporary disability (accident and sickness)
- (f) Long-term disability
- (g) Supplemental unemployment
- (h) Prescription drug
- (i) Stop loss (large deductible)
- (j) HMO contract
- (k) PPO contract
- (l) Indemnity contract
- (m) Other (specify below)

8 Experience-rated contracts

a Premiums:

- (1) Amount received
- (2) Increase (decrease) in amount due but unpaid
- (3) Increase (decrease) in unearned premium reserve
- (4) Earned ((1) + (2) - (3))

b Benefit charges:

- (1) Claims paid
- (2) Increase (decrease) in claim reserves
- (3) Incurred claims (add (1) and (2))
- (4) Claims charged



8c Remainder of premium:

(1) Retention charges (on an accrual basis) --

(A) Commissions

(B) Administrative service or other fees

(C) Other specific acquisition costs

(D) Other expenses

(E) Taxes

(F) Charges for risks or other contingencies

(G) Other retention charges

(H) Total retention

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.) ...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement

(2) Claim reserves

(3) Other reserves

e Dividends or retroactive rate refunds due.

(Do not include amount entered in c(2).)

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier

316225

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount

Specify nature of costs below



Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Part I Annual Report Identification Information

For the calendar plan year 2003 or fiscal plan year beginning 01 01 2003 and ending 12 31 2003

- A This return/report is for: (1) a multiemployer plan; (3) a multiple-employer plan; or
 (2) a single-employer plan (other than a multiple-employer plan); (4) a DFE (specify)

- B This return/report is: (1) the first return/report filed for the plan; (3) the final return/report filed for the plan;
 (2) an amended return/report; (4) a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions)

Part II Basic Plan Information -- enter all requested information.

1a Name of plan
INEEL BUSINESS TRAVEL INSURANCE PLAN

1b Three-digit plan number (PN) ▶ 501 1c Effective date of plan 04 01 1966

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
 Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator
SIGN HERE ▶ Candace F. Wilkinson Date 07 12 2004
 Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE
SIGN HERE ▶ Candace F. Wilkinson Date 07 12 2004
 Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON



2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) C I O

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

2b Employer Identification Number (EIN)

94 3323797

2c Sponsor's telephone number

208 526 0066

2d Business code (see instructions)

541990

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) C I O

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN



5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3)

b EIN

4)

5)

c Telephone number

6)

6 Total number of participants at the beginning of the plan year

5221

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

4974

b Retired or separated participants receiving benefits

c Other retired or separated participants entitled to future benefits

d Subtotal. Add lines 7a, 7b, and 7c

4974

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

f Total. Add lines 7d and 7e

4974

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

0 1 0 3 A A 0 3 0 R



8 Benefits provided under the plan (complete 8a and 8b, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4Q

9a Plan funding arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(l) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) Insurance
- (2) Code section 412(l) insurance contracts
- (3) Trust
- (4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- 1) R (Retirement Plan Information)
- 2) T (Qualified Pension Plan Coverage Information)
- 3) B (Actuarial Information)
- 4) E (ESOP Annual Information)
- 5) SSA (Separated Vested Participant Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ▶

b Financial Schedules

- 1) H (Financial Information)
- 2) I (Financial Information--Small Plan)
- 3) 001 A (Insurance Information)
- 4) C (Service Provider Information)
- 5) D (DFE/Participating Plan Information)
- 6) G (Financial Transaction Schedules)
- 7) P (Trust Fiduciary Information)

0 1 0 3 A A 0 4 0 S



**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

For calendar plan year 2003
or fiscal plan year beginning

A Name of plan

INEEL Business Travel Insurance Plan

B Three-digit
plan number

501

C Plan sponsor's name as shown on line 2a of Form 5500

Bechtel BUXT Idaho, LLC

D Employer Identification Number

94 3323797

Insurance Information

This schedule is required to be filed under section 104 of the
Employee Retirement Income Security Act of 1974.

► File as an attachment to Form 5500.

► Insurance companies are required to provide this information
pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2003

This Form is Open to
Public Inspection.

01 01 2003 and ending *12 31 2003*

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III
can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

*TRANSAMERICA OCCIDENTAL LIFE
INSURANCE*

(b) EIN

95 1060502

(c) NAIC code

67121

(d) Contract or identification number

05228081

(e) Approximate number of persons covered at end of policy or contract year

4974

Policy or contract year

(f) From

01 01 2003

(g) To

12 31 2003

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions
below and list agents, brokers and other persons individually in descending order of the amount paid in the items on
the following page(s) in Part I.

Totals

Total amount of commissions paid

Total fees paid / amount

0

0

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Cat. No. 135051 Schedule A (Form 5500) 2003

0 5 0 3 A A 0 1 0 T



(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose



Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates



b Premiums paid to carrier

c Premiums due but unpaid at the end of the year

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount

Specify nature of costs



e Type of contract (1) individual policies (2) group deferred annuity

(3) other (specify below)



f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

0 5 0 3 A A 0 3 0 V



6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

- (1) deposit administration (2) immediate participation guarantee (3) guaranteed investment
- (4) other (specify below)

b Balance at the end of the previous year

c Additions:

- (1) Contributions deposited during the year
- (2) Dividends and credits
- (3) Interest credited during the year
- (4) Transferred from separate account
- (5) Other (specify below)

(6) Total additions

d Total of balance and additions (add b and c(6))

e Deductions:

- (1) Disbursed from fund to pay benefits or purchase annuities during year
- (2) Administration charge made by carrier
- (3) Transferred to separate account
- (4) Other (specify below)

(5) Total deductions

f Balance at the end of the current year (subtract e(5) from d)



Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

- (a) Health (other than dental or vision)
- (b) Dental
- (c) Vision
- (d) Life Insurance
- (e) Temporary disability (accident and sickness)
- (f) Long-term disability
- (g) Supplemental unemployment
- (h) Prescription drug
- (i) Stop loss (large deductible)
- (j) HMO contract
- (k) PPO contract
- (l) Indemnity contract
- (m) Other (specify below)

▶ TRAVEL ACCIDENTAL DEATH & DISMEMBER

8 Experience-rated contracts

a Premiums:

- (1) Amount received
- (2) Increase (decrease) in amount due but unpaid
- (3) Increase (decrease) in unearned premium reserve
- (4) Earned ((1) + (2) - (3))

b Benefit charges:

- (1) Claims paid
- (2) Increase (decrease) in claim reserves
- (3) Incurred claims (add (1) and (2))
- (4) Claims charged



8c Remainder of premium:

(1) Retention charges (on an accrual basis) --

(A) Commissions

(B) Administrative service or other fees

(C) Other specific acquisition costs

(D) Other expenses

(E) Taxes

(F) Charges for risks or other contingencies

(G) Other retention charges

(H) Total retention

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.)...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement

(2) Claim reserves

(3) Other reserves

e Dividends or retroactive rate refunds due.

(Do not include amount entered in c(2).)

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier

5409

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount..... Specify nature of costs below

0 5 0 3 A A 0 6 0 Y

