SURA/JEFFERSON SCIENCE ASSOCIATES, LLC

COMPREHENSIVE HEALTH AND WELFARE BENEFIT PLAN

Amended and Restated

Effective June 1, 2006

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PREAMBLE

THIS EMPLOYEE BENEFIT PLAN, to be known as the SURA/Jefferson Science Associates, LLC Comprehensive Health and Welfare Benefit Plan (the "Plan") is restated by Southeastern Universities Research Association, Inc., effective as of June 1, 2006.

WHEREAS, Southeastern Universities Research Association, Inc. previously maintained a comprehensive health and welfare benefit plan entitled Southeastern Universities Research Association, Inc./Jefferson Lab Comprehensive Health and Welfare Benefit Plan (the "Prior Plan"); and

WHEREAS, Southeastern Universities Research Association, Inc. desires to amend and restate the Prior Plan in the form of this Plan; and

WHEREAS, this Plan shall be maintained for the exclusive purpose of providing benefits to covered Employees and, where applicable, their Dependents, and is intended to comply with the Internal Revenue Code of 1986, as amended, and the Employee Retirement Income Security Act of 1974, as amended, and other applicable law; and

WHEREAS, Southeastern Universities Research Association, Inc. desires to have Jefferson Science Associates, LLC adopt this Plan, even though Jefferson Science Associates, LLC is not a member of the same controlled group of employers, as defined under Sections 414(b) or (c) or the Internal Revenue Code of 1986, as amended, as Southeastern Universities Research Association, Inc.

NOW THEREFORE, Southeastern Universities Research Association, Inc. does hereby amend and restate this comprehensive health and welfare benefit plan, to be known as this Plan, as set forth in the following pages, attached Appendices, and documents that are incorporated herein by reference, effective June 1, 2006.

FURTHERMORE, Southeastern Universities Research Association, Inc. approves the adoption of the Plan by Jefferson Science Associates, LLC and acknowledges that the Plan will be considered a "multiple employer welfare arrangement."

The purpose of this Plan is, in essence, to consolidate separate health and welfare programs under a single "plan," to facilitate compliance with applicable reporting and disclosure rules. This Plan, then, "wraps" together one or more other health and welfare programs. While this document is designed to accomplish such consolidation, it is not the only Plan "document." Rather, the Plan "document" is actually a series of documents, consisting of this document plus the various contracts and/or booklets that describe the specific benefits, rights and features under the various welfare benefit programs that are consolidated in this Plan. Together, this and such other documents comprise the "Plan document." They may also comprise the summary plan description.

ARTICLE I

DEFINITIONS

The following terms, when used herein, shall have the following meaning, unless a different meaning is clearly required by the context. Capitalized terms are used throughout the Plan for terms defined by this and other sections.

1.1 Affiliated Employer

"Affiliated Employer" means any entity that is affiliated with the Employer or any entity that is part of a group of entities that includes the Employer and constitutes: (a) a controlled group of corporations (as defined in Section 414(b) of the Code); (b) a group of trades or businesses, whether or not incorporated, under common control (as defined in Section 414(c) of the Code); (c) an affiliated service group within the meaning of Section 414(m); or (d) any other entity required to be aggregated with the Employer pursuant to regulations under 414(o) of the Code.

1.2 Appendix

"Appendix" or "Appendices" means each of the appendices to the Plan. Each Appendix and any document included or incorporated therein shall be considered a part of the Plan and may be amended by the Employer at any time for any reason without consent of any person except as otherwise provided by law.

1.3 Code

"Code" means the Internal Revenue Code of 1986, as amended, and including all regulations promulgated pursuant thereto.

1.4 Component Document

"Component Document" means a written document identified in the Appendices and incorporated herein by reference, including, without limitation, any insurance, administrative services only, claims service only, third party administration, preferred provider organization ("PPO"), and health maintenance organization ("HMO") contracts, similar or related managed care organization contracts, and benefit descriptions.

1.5 Covered Person

"Covered Person" means an Eligible Employee or eligible Dependent who elects coverage under the Plan and has not for any reason become ineligible to participate in the Plan.

1.7 Dependent

A person is a "Dependent" of an Employee with respect to a benefit provided hereunder if such person is classified as a "Dependent" under the Component Document that describes such benefit and the classes of persons eligible therefore.

1.8 Eligible Employee

“Eligible Employee” means any Employee who meets the eligibility requirements under a Component Document. An Eligible Employee is an Eligible Employee only to the extent of, and only with respect to participation in, those portions of this Plan with respect to which he meets the eligibility requirements of the applicable Component Document. See Appendix III for a summary of eligibility rules.

1.9 Employee

“Employee” means any individual who is employed by an Employer, but (unless specifically included as an “Employee” under a Component Document) does not include any of the following:

(a) Temporary or seasonal Employees classified as such on the Employer's payroll records.

(b) Persons classified and treated by an Employer as independent contractors; if someone so classified and treated is subsequently determined by the Employer or any governmental agency or court not to be an independent contractor, such person shall not be considered an Employee until the day after the final determination that such person is not an independent contractor;

(c) Individuals characterized as leased Employees (as defined by Code Section 414(n)) or any individuals who would be leased Employees but for the fact they are common law Employees of an Employer;

(d) Individuals included in a unit covered by a collective bargaining agreement if retirement benefits were the subject of good faith bargaining; and

(e) Nonresident aliens who receive no United States source income from an Employer.

In the event a person listed in one or more subsections (a) through (e) above is specifically included as an “Employee” under a Component Document, he shall be considered an Employee under this Plan only with respect to the benefit described within such Component Document, and not with respect to other benefits hereunder, described in other Component Documents.

1.10 Employer

"Employer" means Southeastern Universities Research Association, Inc., with respect to its Eligible Employees, and any Affiliated Employers or other Participating Employers that are approved by Southeastern Universities Research Association, Inc. to participate in this Plan, with respect to their Eligible Employees; provided, however, that for purposes of Sections 5.1 and 5.2, the right to amend or terminate the Plan, to determine whether another employer may be a Participating Employer, or to perform other settlor-type functions, "Employer" means solely Southeastern Universities Research Association, Inc.

1.11 ERISA

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and including all regulations promulgated pursuant thereto.

1.12 FMLA

"FMLA" means the Family and Medical Leave Act of 1993, as amended, and including all regulations promulgated pursuant thereto.

1.13 Participating Employer

"Participating Employer" means an Employer that participates in this Plan for the benefit of its Eligible Employees, pursuant to approval of such participation by Southeastern Universities Research Association, Inc. Any Participating Employers are listed in Appendix II.

1.14 Plan

"Plan" means this SURA/Jefferson Science Associates, LLC Comprehensive Health and Welfare Benefit Plan, as amended from time to time.

1.15 Plan Administrator

"Plan Administrator" means the person or entity authorized to administer the Plan pursuant to Article V.

1.16 Plan Year

"Plan Year" means the 12-month period beginning each April 1 and ending the ensuing March 31.

1.17 USERRA

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and including all regulations promulgated pursuant thereto.

ARTICLE II

PARTICIPATION

2.1 Eligibility and Enrollment

(a) Eligibility

Any person who is an Eligible Employee or Dependent under a Component Document shall be considered a Covered Person in the Plan on the date such person, under the terms of such Component Document, acquires coverage for the benefit(s) described in such Component Document; in no event may an Eligible Employee or Dependent participate in this Plan with respect to a particular benefit provided under a Component Document until the date specified in such Component Document. Appendix III reflects a *summary* of the eligibility rules that apply under the various Component Documents and benefit programs reflected in those documents. Other eligibility rules may be reflected in the Component Documents themselves, or other documents.

(b) Enrollment

An Eligible Employee may elect participation in the Plan, for himself and for any eligible Dependent(s), with respect to any or all benefits described in Article III with respect to which the Eligible Employee and/or Dependent(s), as the case may be, are eligible for coverage under the terms of the applicable Component Document(s), by completing the appropriate enrollment forms when the Eligible Employee and/or Dependent, as the case may be, first becomes eligible to participate. If an Eligible Employee (on behalf of himself and/or an eligible Dependent) does not elect to participate (or elects to participate only with respect to some, but not all, benefits) when first eligible, he may not elect to participate (or elect to participate in those health benefits not selected) until the beginning of the next Plan Year, subject to Section 2.2 and any change in enrollment rules provided under a Component Document, such as a cafeteria plan under Section 125 of the Code.

2.2 Compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

The Plan shall comply with the special enrollment and nondiscrimination provisions of HIPAA, with respect to those benefits subject to HIPAA. See also Article IX.

2.3

Termination of Participation

Participation in a benefit provided under a Component Document shall terminate as provided in such Component Document. Participation by a person in this Plan shall terminate when the person is no longer covered for a benefit provided by any Component Document.

2.4 Continuation Coverage Rights

(a) Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")

Notwithstanding any other Plan provision regarding termination of coverage, in the event participation in a health benefit offered through this Plan would otherwise terminate, a former Covered Person may have the right to continue health insurance coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), or similar state or federal law. The Employer provides information about coverage continuation rights in the applicable Component Documents, and elsewhere in this Plan (see Article X). A former Covered Person who is eligible to, and elects to, continue coverage under the applicable coverage continuation law, may continue to participate in this Plan to the extent provided under the coverage continuation law. The applicable Component Documents may also describe terms and conditions of COBRA continuation coverage.

(b) FMLA

Notwithstanding any other Plan provision regarding termination of coverage, in the event participation in a health benefit offered through this Plan would terminate due to the Eligible Employee taking an FMLA leave of absence, such benefits shall be continued for the lesser of: the period of the leave or 12 weeks. Provided, however, coverage will continue only as long as any required Employee contributions are timely made. Employees on leave must make the same contribution as is required for active Employees. Coverage under other welfare benefits (other than health benefits) shall continue or terminate during a period of FMLA leave to the same extent as such benefits continue or terminate during periods of leave under similar circumstances (that is, paid or unpaid leave, as the case may be) that is not FMLA leave.

(c) USERRA

Notwithstanding any other Plan provision regarding termination of coverage, in the event participation in health benefits offered through this Plan would terminate due to the Eligible Employee taking a USERRA leave of absence, such benefits shall be continued for the lesser of: the period of leave or 18 months. Provided, however, coverage will continue

only as long as any required Employee contributions are timely made. Employees on a USERRA leave of less than 31 days must make the same contribution as is required for active Employees; Employees on a USERRA leave of 31 days or longer must pay up to 102% of the full cost (Employee and Employer contributions) of coverage, as determined by the Plan Administrator.

ARTICLE III

BENEFITS

3.1 Benefits Incorporated by Reference

Each Covered Person may elect to receive coverage under the benefits listed below, subject to any additional eligibility conditions provided under the applicable Component Document. The terms, conditions and limitations of benefits offered under this Plan are contained in the applicable Component Documents referenced in the Appendices and which are incorporated herein in full, as amended from time to time. The benefits and the method of providing them may change from time to time and shall be reflected in the applicable Component Documents.

The benefits are:

Comprehensive medical benefit program
Dental benefit program
Group term life insurance program
Long term disability benefit program
Short term disability program
Accidental death and dismemberment program

ARTICLE IV

FUNDING

4.1 Contributions

The benefits described in Article III shall be funded by Employer contributions or Employee contributions, or a combination thereof, as determined from time to time by the Employer. Contributions shall be paid to an insurance carrier or other third-party administrator or, with respect to a self-funded, self-administered benefit, amounts will be paid directly to or on behalf of a Covered Person.

4.2 Employee Contributions

Any Employee contributions may be deducted from an Eligible Employee's wages on an after-tax basis or on a pre-tax basis subject to and in accordance with a flexible benefits program maintained by the Employer pursuant to Section 125 of the Code, and shall be forwarded by the Employer to an insurance carrier or other third-party administrator or, with respect to benefits that are paid directly by the Employer, amounts will be collected by the Employer and paid directly to or on behalf of a Covered Person.

ARTICLE V

ADMINISTRATION

5.1 Plan Administrator

The Employer shall be the Plan Administrator of this Plan. The Employer may delegate its duties and authority as Plan Administrator to one or more Employees or to a committee appointed by the Board of Directors of the Employer.

5.2 Duties and Authority of Plan Administrator

Except to the extent an insurance company, under the terms of a Component Document, retains for itself or any other third-party (other than the Employer) the duties and responsibilities described herein, the following duties and responsibilities shall be the Employer's, as the Plan Administrator:

(a) Administrative Duties

The Plan Administrator shall administer the Plan consistent with the Nondiscrimination Rules described later in this Article, for the exclusive purpose of providing benefits to Covered Persons and their beneficiaries. The Plan Administrator shall perform all such duties as are necessary to supervise the administration of the Plan and to control its operation in accordance with the terms thereof, including, but not limited to, the following:

(i) make and enforce such rules and regulations as it shall deem necessary or proper for the efficient administration of the Plan;

(ii) interpret the provisions of the Plan and determine any question arising under the Plan, or in connection with the administration or operation thereof, including questions of fact;

(iii) determine all considerations affecting the eligibility of any individual to be or become a Covered Person;

(iv) determine eligibility for and amount of benefits for any Covered Person;

(v) authorize and direct all disbursements of benefits under the Plan;

(vi) authorize the recovery of benefit payments made in error; and

(vii) delegate and allocate, specific responsibilities, obligations and duties imposed by the Plan, to one or more employees, officers or such other persons as the Plan Administrator deems appropriate.

(b) General Authority

The Plan Administrator shall have all the powers necessary or appropriate to carry out its duties, including the discretionary authority to interpret the provisions of the Plan and the facts and circumstances of claims for benefits, and to decide questions of fact related thereto. Any interpretation or construction of or action by the Plan Administrator with respect to the Plan and its administration shall be conclusive and binding upon any all parties and persons affected hereby, subject to the exclusive appeal procedure set forth in Section 5.7.

5.3 Forms

All forms and other communications from any Covered Person or other person to the Plan Administrator required or permitted under the Plan shall be in the form prescribed from time to time by the Plan Administrator, shall be mailed first-class mail or delivered to the location specified by the Plan Administrator, shall be deemed to have been given and delivered to the location specified by the Plan Administrator, and shall be deemed to have been given and delivered only upon actual receipt thereof. Each Covered Person shall file on a form such pertinent information as the Plan Administrator may specify. However, to the extent the terms of a Component Document provide for different or contrary rules in this regard, and such terms are permitted by law, the terms of the Component Document shall control.

5.4 Examination of Documents

The Plan Administrator shall make available to each Covered Person or beneficiary this Plan document, including the Appendices and Component Documents, for examination at reasonable times during normal business hours. In the event a Covered Person or beneficiary requests copies of documents, the Plan Administrator may charge a reasonable amount to cover the cost of furnishing such documents in accordance with ERISA.

5.5 No Assets

Notwithstanding any Plan provision to the contrary, no assets shall be segregated for the purposes of providing benefits under the Plan. The Employer shall pay benefits under this Plan out of its general assets, to the extent such benefits are not paid under the terms of insurance contracts.

5.6 Reports

The Plan Administrator shall file or cause to be filed all annual reports, returns, and financial and other statements required by a federal or state statute, agency or authority within the time prescribed by law or regulation for filing said documents; and to furnish such reports, statements or other documents to such Covered Persons and beneficiaries as required by federal or state statute or regulation, within the time prescribed for furnishing such documents.

5.7 Claims Procedure

A Covered Person shall apply for Plan benefits in writing on a form provided by the Plan Administrator or its delegate, unless a claim is filed directly by a provider of benefits. A claim for reimbursement of expenses must be submitted in a manner and within the time period specified in the applicable Component Documents. Claims shall be evaluated by the Plan Administrator or such other person or entity specified in the applicable Component Documents and shall be approved or denied in accordance with the terms of the Plan including the Component Documents.

The following claims procedures shall apply (effective with respect to claims received on or after the first day of Plan Year beginning after June 30, 2002; for claims received prior to such date the rules of Department of Labor regulation § 2560.503-1 as in effect prior to that date shall control), but only to the extent not otherwise provided under the applicable Component Document. If the claim and appeal rules in this document apply, they shall be construed and applied in a manner consistent with Department of Labor regulation § 2560.503-1 as in effect on the date the claim was received:

(a) Notice of Action

Any time a claim for benefits receives an adverse determination (that is, the claim is denied in whole or in part), the Employee or beneficiary ("Claimant") shall be given written notice of such action within the "applicable period" after the claim is filed, unless special circumstances require an extension of time for processing. If there is an extension, the Claimant shall be notified of the extension and the reason for the extension within the initial applicable period. If any urgent care or pre-service claim is approved, the Claimant shall be notified of such approval and provided sufficient information to understand the import of the approval.

(b) Categories of Claims, "Applicable Periods," and Extensions

(1) "Urgent" Health Care Claims

Urgent health care claims are requests for verification or approval of coverage for health care or treatment where, if the request were not handled expeditiously the delay could jeopardize the life or health of the Claimant or the ability of the Claimant to regain

maximum function, or in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to *severe pain* that cannot be adequately managed without the care or treatment that is the subject of the claim. The "applicable period" for an urgent care claim is no longer than the period necessary to decide the matter (that is, "as soon as possible"), but in no event longer than 72 hours. If the Plan cannot render a decision within 72 hours because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan Administrator or its delegate must notify the Claimant within 24 hours of the specific information needed to complete the claim. The Claimant must be given at least 48 hours to provide the required information. Within 48 hours after the earlier of (1) the Plan's receiving the required information or (2) the expiration of the period afforded to the Claimant to provide the information, the Plan Administrator or its delegate must notify the Claimant of the Plan's benefit determination. The Claimant may agree to extend these deadlines.

An appeal of an adverse determination regarding an urgent care claim (where the claim is still an urgent care claim) must be decided as soon as possible, but no later than 72 hours after the Plan receives the request for review or appeal.

(2) "Pre-Service" Health Care Claims

A pre-service health care claim is any request for approval of health care coverage for a service or item that under the terms of the Plan requires advance approval. The "applicable period" for a pre-service claim is 15 days after receipt of the claim by the Plan. The Plan Administrator may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Plan Administrator or its delegate must notify the Claimant within the timeframe of the reason for the extension and the date the Plan expects to render its decision.

If the Claimant has not followed the Plan's procedures for filing a pre-service claim, the Plan must notify the Claimant within 5 days of the proper procedures to be followed in order to complete the claim. Further, if the Plan cannot render a decision within 15 days because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension must describe the specific information needed to complete the claim; the Claimant must be given at least 45 days from receipt of the notice to provide

the required information; and the Plan has 15 days from the date of receiving the Claimant's information to render its decision. The Claimant may agree to extend these deadlines.

(3) "Concurrent" Health Care Claims

A concurrent health care claim may be either an urgent care claim or a pre-service claim. Generally, it is a claim for an ongoing course of health care treatment to be provided over a period of time or number of treatments. An adverse determination involving concurrent care must be made sufficiently in advance of any reduction or termination in treatment to allow the Covered Person to appeal the adverse benefit determination. If a course of treatment involves urgent care, a request by the Claimant to extend the course of treatment must be decided as soon as possible, but not later than 24 hours after receipt of the request by the Plan, provided that the request is made at least 24 hours prior to the expiration of treatment.

Expiration of an approved course of treatment is not an adverse determination under these rules. However, any reduction or termination by the Plan of the course of treatment (other than by Plan amendment or termination) before the end of the period of time or number of treatments originally prescribed is an adverse determination and may be appealed. Notice must be provided a reasonable time before the treatments will stop; however, the Plan is not required to allow the Claimant the 180 days to appeal the Plan's decision, before the Plan may terminate the treatment.

(4) "Post-Service" Health Care Claim

A post-service health care claim is a claim that is not an urgent care, pre-service or concurrent care claim. The "applicable period" for a post-service claim is 30 days after receipt of the claim by the Plan. The Plan Administrator may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Plan Administrator or its delegate must notify the Claimant within the timeframe of the reason for the extension and the date by which the Plan expects to render its decision.

If the Plan cannot render a decision within 30 days because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension must describe the specific information needed to complete the claim. The Claimant must be

given at least 45 days from receipt of the notice to provide the required information. The Plan has 30 days from the date of receiving the Claimant's information to render its decision. The Claimant may agree to extend these deadlines.

(5) Disability Benefit Claim

The "applicable period" for a disability benefit claim is 45 days after receipt of the claim by the Plan. If the Plan requires additional time to process the claim, it may extend the applicable period by up to two (2) thirty-day extensions, but the Plan Administrator or its delegate will notify the Claimant of the need for the extension prior to the beginning of any such extension period.

(6) Other Claims

The "applicable period" for a benefit claims not described in subsections (1) to (5) above is 90 days after receipt of the claim by the Plan. If the Plan requires additional time to process the claim, it may extend the applicable period by up to 90 days, but the Plan Administrator or its delegate must notify the Claimant of the need for the extension prior to the beginning of any such extension period.

(c) Form and Content of Notice of Adverse Determination on Claims

If a claim is denied in whole or in part, notice of such adverse determination must be provided to the Claimant. Notice must be written or electronic; oral notice is permitted with respect to urgent care claims, but only if written or electronic confirmation is furnished to the Claimant within three (3) days after the oral notice is provided.

The notice must include the following: the specific reason or reasons for the adverse determination; reference to the specific Plan provisions on which the determination is based; if applicable, a description of any additional information needed for the Claimant to perfect the claim and an explanation of why such information is needed; a description of the Plan's review procedures, including the Claimant's right to bring a civil action under Section 502(a) of ERISA; (for health care and disability claims) a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request; (for health care and disability claims) if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the

Plan to the Claimant's medical circumstances, or a statement that this will be provided without charge upon request; and in the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims.

(d) Right to Request Review

Any person who has had a claim for benefits denied in whole or in part by the Plan Administrator or its delegate, or is otherwise adversely affected by action of the Plan Administrator or its delegate, shall have the right to request review by the Plan Administrator. Such request must be in writing, and must be made within 180 days (for health care and disability benefit claims) or 60 days (for other claims) after such person is advised of the Plan Administrator's (or its delegate's) action. If written request for review is not made within such 180-day (or 60-day, as the case may be) period, the Claimant shall forfeit his or her right to review. The Claimant or a duly authorized representative of the Claimant may review all pertinent documents and submit issues and comments in writing. The Plan Administrator may prescribe a reasonable procedure under which a Claimant may designate an authorized representative.

(e) Review of Claim

The Plan Administrator or its delegate shall then review the claim. The person or entity that reviews the claim must be a named fiduciary under the Plan, and (in the case of reviews of health care or disability claims) must not be the same person, or a person subordinate to the person, who initially decided the claim. If in the case of a health care or disability claim the adverse benefit determination was based on medical judgment, the person handling the appeal must consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved, and such professional may not be the same professional who was consulted with respect to the initial action on the claim.

The person or entity deciding the appeal may hold a hearing if it deems it necessary and shall issue a written or electronically disseminated decision reaffirming, modifying or setting aside its former action. The decision on appeal must be made within 72 hours for a claim involving urgent health care, 30 days for a pre-service health care claim, 45 days for a disability claim, or 60 days for a post-service health care claim or claim for a benefit other than a health care or disability benefit; the time period begins to run on the date the appeal is received by the Plan. The Claimant may agree to extend these deadlines.

The decision on review may be delayed for up to 45 days (in the case of a disability benefit claim) or 60 days (in the case of a claim other than for a health care or disability benefit) where special circumstances require the

delay. The Plan Administrator or its delegate shall provide notice of the extension, and the reason therefore, to the Claimant prior to the end of the initial review period.

A copy of the decision shall be furnished to the Claimant. The decision shall set forth: the specific reason or reasons for the adverse determination; reference to the specific Plan provisions on which the determination is based; a statement that the Claimant is entitled to receive without charge reasonable access to any document (1) relied on in making the determination; (2) submitted, considered or generated in the course of making the benefit determination; (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination; or (4) in the case of a group health Plan or disability Plan, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on; a statement of any voluntary appeals procedures and the Claimant's right to receive information about the procedures as well as the Claimant's *right to bring a civil action* under Section 502(a) of ERISA; a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request; if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that this will be provided without charge upon request; and the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency." (However, this latter statement is not required if there is no alternative dispute resolution process (e.g., arbitration).)

The decision shall be final and binding upon the Claimant and all other persons involved.

5.8 Expenses

Unless specified otherwise in a Component Document, the Employer shall pay all reasonable expenses that are necessary to operate and administer the Plan.

5.9 Bonding and Insurance

To the extent required by law, with respect to benefits subject to ERISA, every fiduciary of the Plan and every person handling Plan funds shall be bonded. The Plan Administrator shall take such steps as are necessary to assure compliance with applicable bonding requirements. The Plan Administrator may apply for and obtain fiduciary liability insurance insuring the Plan against damages by reason of breach of fiduciary

responsibility and insuring each fiduciary against liability to the extent permissible by law at the Employer's expense.

5.10 Nondiscrimination Rules

(a) The Plan Administrator shall not take any action or direct any action with respect to any of the benefits provided hereunder that would be impermissibly discriminatory in favor of Employees who are officers or highly compensated Employees of the Employer or an Affiliated Employer, or that would result in benefiting one Covered Person or group of Covered Persons at the expense of another, or in the application of different rules to substantially similar sets of facts.

(b) The Plan shall comply with all applicable nondiscrimination rules under the Code. Should the Plan be subject to nondiscrimination testing under the Code or any other applicable law, the Plan Administrator may make any decisions or elections, whether voluntary or required by law, necessary to facilitate such testing. Any elections required to be in writing shall be stated from time to time in Appendices to the Plan.

5.11 Qualified Medical Child Support Orders

The Plan will honor the terms of a Qualified Medical Child Support Order. Qualified Medical Child Support Orders are typically issued in or after divorce proceedings, and may create or recognize the right of a child to be covered under this Plan (specifically, to be covered under a Component Plan providing health benefits).

Medical child support orders shall be evaluated by the Plan Administrator or such other person or entity specified in the applicable Component Documents and shall be approved or denied. The Plan Administrator (or such other person or entity specified in the applicable Component Documents) shall, promptly after receiving a medical child support order, notify the Participant and each child designated in the order. The notification will contain information that permits the child to designate a representative for receipt of copies of notices that are sent to the child with respect to a medical child support order.

Within forty (40) business days after receipt of the order (or, in the case a national medical support notice, the date of the notice) the Plan Administrator (or such other person or entity specified in the applicable Component Documents) will determine whether the order is a "qualified" medical child support order. Upon determination of whether a medical child support order is or is not qualified, the Plan Administrator (or such other person or entity specified in the applicable Component Documents) will send a written copy of the determination to the Participant and each child (or, where an official of the state agency issuing the order is substituted for the name of the child, notify such official).

If the Plan Administrator (or such other person or entity specified in the applicable Component Documents) determines that the medical child support order is qualified, the Participant, the child or his representative must furnish to the Plan Administrator or its designee any required enrollment information. In the case of a national medical support notice, the Plan Administrator or its designee will: (i) notify the state agency issuing the notice whether coverage is available to the child under the Plan and, if so, whether such child is covered under the Plan and either the effective date of such coverage or any steps to be taken by the child's custodial parent or an official of the state agency that issued the notice to effectuate such coverage, and (ii) provide the custodial parent (or, where an official of the state agency issuing the order is substituted for the name of the child, notify such official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

Typically the Participant must provide such information to the Plan within forty-five (45) days immediately following the date the determination was made that the order is a Qualified Medical Child Support Order. In the case of a national medical support notice, if there are multiple coverage options available to the child under the Plan the state agency issuing the notice will select an option, but if it fails to do so within twenty (20) days after the Plan Administrator's (or designee's) notice described in the preceding paragraph, the child will be enrolled under the Plan's default option (if any).

Unless the Qualified Medical Child Support Order provides otherwise, the Participant will be responsible to make any required contribution to pay for such coverage. In no event will coverage provided under a Qualified Medical Child Support Order become effective for a child prior to the date the Order is received by the Plan.

If the Plan Administrator or its designee determines that the medical child support order is not "qualified," a written determination to that effect will be furnished to the Participant and the child or the child's representative. The Participant or the child (or the child's representative) may appeal the determination to the Plan Administrator or its designee. Any request for review of a determination must be filed with the Plan Administrator or its designee within sixty (60) days after the Plan Administrator or its designee issues its original determination.

For purposes of this Section, a "Qualified Medical Child Support Order" is an order issued by a court having proper jurisdiction, or issued under an administrative process established under state law that has the force and effect of law under applicable state law) and which creates or recognizes the existence of a child's rights to, or assigns to such child the right to, receive health benefits for which a Dependent is eligible under this Plan, provided such order clearly specifies: (i) the name and last known mailing address of the Employee, and the name and mailing address of each child covered by the order (to the extent provided in the order, the name and mailing address of an official of the state agency issuing the order may be substituted for the name and mailing address of the child); (ii) a reasonable description of the type of coverage to be provided by the Plan to each child, or the manner in which coverage is to be determined; (iii) the time period to which such order applies; and (iv) the Plan's name, and meets other legal requirements. A

national medical support notice that meets (or, pursuant to federal regulations, is deemed to meet) the foregoing requirements will be considered a Qualified Medical Child Support Order.

ARTICLE VI

RIGHT TO RECOVERY, REIMBURSEMENT, SUBROGATION AND SET-OFF

6.1 Applicability

The provisions of this Article VI apply to the extent the reimbursement and subrogation terms of an applicable Component Document do not supply greater rights to the Plan. If the reimbursement and subrogation terms of an applicable Component Document supply greater rights, the terms of such Component Document shall apply. For purposes of this Article, a Component Document is "applicable" if benefits under the Component Document are the subject of a reimbursement or subrogation claim by this Plan. For purposes of this Article, a law shall not be considered an "applicable law" if it is preempted by ERISA.

6.2 Corrective Payments

To the extent permitted by applicable law, whenever payments that should have been made under this Plan in accordance with the coordination of benefits provisions have been made under any Other Plans, this Plan shall have the right to pay to any persons making such other payments any amounts they determine to be warranted in order to satisfy the intent of the coordination of benefits provisions. Amounts so paid shall be deemed to be benefits paid under this Plan, and to the extent of such payments, this Plan shall be fully discharged from liability.

6.3 Reimbursement

To the extent permitted by applicable law, whenever this Plan makes payments that together with the payments the Covered Person has received or is entitled to receive from any Other Plan or Person, exceed the maximum amount necessary to satisfy the intent of this provision; or exceed, under the terms of this Plan, the benefits properly payable to or on behalf of the Covered Person, Plan, provider, or person to or for or with respect to whom the payments were made, this Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan Administrator in its sole discretion shall determine:

(a) The Covered Person;
(b) If the Covered Person is an eligible Dependent or former eligible Dependent, the Covered Person or former Covered Person with respect to whom the Covered Person is or was an eligible Dependent;
(c) Any Other Plan, provider, or person to or for or with respect to whom such payments were made;
(d) Any insurance company or Other Plan or Person that should have made the payment; and
(e) Any other organizations.

Alternatively, the Plan Administrator or its designee may set-off the amount of such payments, to the extent of such excess, against any amount owing, at that time or in the future, under this Plan to one or more of the Covered Person, Plans, persons, providers, insurance companies, or other organizations as listed above.

For example, but not by way of limitation, if this Plan pays a claim submitted by a Covered Person or by a health care provider who treated the Covered Person, and the Plan Administrator or its designee later determines that the claim was for an expense not covered under this Plan, the Plan is entitled to recover the payment from the Covered Person or the provider, or to recover part of the payment from the Covered Person and part from the provider, or set-off the amount of the payment from amounts the Plan may owe in the future to the Covered Person or the provider, or both. This same rule applies if the Plan makes payment to a Covered Person or a provider of an expense that is a Covered Expense, but the amount so paid exceeds the amount the Plan requires be paid.

These reimbursement provisions also apply where this Plan makes payments of covered expenses incurred for treatment of an injury or sickness for which any Other Plan or Person is or may be liable, and where this Plan's subrogation provisions do not provide this Plan with a right to recover amounts this Plan pays or may pay for treatment of the injury or sickness. If the Other Plan or Person makes payment to or on behalf of a Covered Person as compensation for the injury or sickness, and this Plan is not subrogated with respect to the payment, this Plan is entitled to reimbursement from the Covered Person (or anyone who received such payment on behalf of the Covered Person) in an amount equal to the lesser of the benefits paid by this Plan for treatment of the injury or sickness, or the amount paid to or on behalf of the Covered Person by the Other Plan or Person or its insurer. This provision shall not apply where the Other Plan is a medical Plan with respect to which this Plan, pursuant to its coordination of benefits provisions, is the primary payer of the Covered Person's covered expenses.

These reimbursement provisions shall not be construed to prevent the Plan, in its sole discretion, from obtaining full reimbursement from the Covered Person (or, in the Plan's sole discretion) any other person who received payment on behalf of the Covered Person, such as a parent or guardian) by, for example, apportioning the obligation to reimburse the Plan among the Covered Person and any other person, such as the Covered Person's legal counsel. The preceding sentence is specifically intended to avoid requiring the Plan, in order to obtain full reimbursement, to seek reimbursement from any person (such as the Covered Person's legal counsel) other than the Covered Person (or the Person, such as a parent or legal guardian, who received payment on behalf of the Covered Person) where the Plan can be made whole entirely from amounts actually received by the Covered Person (or the Person, such as a parent or legal guardian, who received such amounts on behalf of the Covered Person). This same rule shall apply to the Plan's rights to set-off as described above.

In addition, where an Other Plan or Person pays compensation to or on behalf of a Covered Person for an injury or sickness for which an Other Plan or Person is or may be liable, and the Covered Person incurs (either before or after payment of such

compensation) otherwise covered expenses for treatment of the injury or sickness, a special rule applies. In such a case, such otherwise covered expenses that were incurred after the date on which the compensation was paid, or which were incurred before such date but not paid by the Plan as of such date, shall be excluded from coverage under the Plan to the extent of the excess (if any) of the compensation received by or on behalf of the Covered Person, over the covered expenses which the Plan has already paid for treatment of the injury or sickness.

This Plan shall not be responsible for any costs or expenses (including attorneys' fees) incurred by or on behalf of a Covered Person in connection with any recovery from any Other Plan or Person unless this Plan agrees in writing to pay a part of those expenses. The characterization of any amounts paid to or on behalf of a Covered Person, whether in a settlement agreement or otherwise, shall not affect this Plan's right to reimbursement and to characterize otherwise covered charges as excludable covered expenses pursuant to these provisions.

6.4 Subrogation

To the extent permitted by applicable law, the Plan shall be subrogated, to the extent of benefits paid or payable by this Plan, to any monies (*i.e.*, "first dollar" monies) paid or payable by any Other Plan or Person by reason of the injury or sickness which occasioned or would occasion the payment of benefits by this Plan, whether or not those monies are sufficient to make whole the Covered Person to whom or on whose behalf this Plan made its payments or to whom or on whose behalf this Plan's payments are payable. The Plan shall not be responsible for any costs or expenses, including attorneys' fees, incurred by or on behalf of a Covered Person in connection with any efforts to recover monies from any Other Plan, unless this Plan agrees in writing to pay a portion of those expenses. The characterization of any amounts paid to or on behalf of a Covered Person, whether under a settlement agreement or otherwise, shall not affect this Plan's right to subrogation and to claim, pursuant to such right, all or a portion of such payment.

These subrogation provisions shall not be construed to prevent the Plan, in its sole discretion, from obtaining full satisfaction of its subrogation lien from the Covered Person (or, in the Plan's sole discretion) any other Person who received payment on behalf of the Covered Person, such as a parent or guardian) by, for example, apportioning liability for satisfaction of the subrogation lien among the Covered Person and any other Person, such as the Covered Person's legal counsel.

This Plan shall also be subrogated to the extent of benefits paid under this Plan to any claim a Covered Person may have against any Other Plan or Person for the injury or sickness that occasioned the payment of benefits under this Plan. Upon written notification to the Covered Person, this Plan may (but shall not be required to) collect the claim directly from the Other Plan or Person in any manner this Plan chooses without the Covered Person's consent. This Plan shall apply any monies collected from the Other Plan or Person to payments made under this Plan and to any reasonable costs and expenses (including attorneys' fees) incurred by this Plan in connection with the collection of the claim up to the amount of the award or settlement. Any balance

remaining shall be paid to the Covered Person as soon as administratively practical. The Plan Administrator may, within its sole discretion, apportion the monies such that this Plan receives less than full reimbursement.

6.5 Implementation

The Plan Administrator shall determine which of the Plan's rights and remedies it is within the best interests of this Plan to pursue. The Plan Administrator may agree to recover less than the full amount of excess payments or to accept less than full reimbursement if (1) this Plan has made, or caused to be made, such reasonable, diligent and systematic collection efforts as are appropriate under the circumstances; and (2) the terms of such agreement are reasonable under the circumstances based on the likelihood of collecting such monies in full or the approximate expenses this Plan would incur in an attempt to collect such monies.

6.6 Subrogation/Reimbursement Agreement

To the extent permitted by applicable law, except as otherwise provided herein (*e.g.*, the coordination rules regarding automobile insurance), if a Covered Person incurs an injury or sickness under circumstances where compensation may be payable to the Covered Person by some Other Plan or Person (as defined in this Article), the Plan may agree to pay benefits for that injury or sickness to the extent otherwise payable under the Plan, provided the Covered Person or someone legally qualified and authorized to act for the Covered Person in writing:

(a) Consents to the Plan's subrogation of any recovery or right of recovery the Covered Person has with respect to the injury or sickness;

(b) Promises not to take any action that would prejudice the Plan's subrogation rights;

(c) Promises to reimburse the Plan for any such benefits payments to the extent that the Covered Person receives a recovery from an Other Plan or Person, irrespective of how the recovery is made or characterized, and irrespective of whether the recovery is sufficient to make the Covered Person whole. This reimbursement must be made within 30 days after the Covered Person (or anyone on his or her behalf) receives the payment; and

(d) Promises to cooperate fully with the Plan in asserting its subrogation rights and supply the Plan with any and all information and execute any and all forms the Plan may need for this purpose.

In the event the Covered Person fails to, or refuses to, execute whatever assignment, form or document requested by the Plan Administrator or its designee, the Plan shall be relieved of any and all legal, equitable or contractual obligation for any benefits or Covered Expense incurred by the Covered Person and each member of the Covered Person's family, including claims then incurred but unpaid.

Nothing in this Reimbursement Agreement provision shall be construed to prevent application of the provisions of the Reimbursement provisions above, regarding the Plan's exclusion of otherwise Covered Expenses which have not been paid at the time the Covered Person receives compensation for the injury or sickness that gave rise to the expenses.

6.7 Constructive Trust

In the event the Plan, pursuant to these reimbursement and subrogation provisions, is entitled under such provisions to be reimbursed for benefits it has paid for treatment of a Covered Person's sickness or injury, and where the Covered Person or someone (including an individual, estate or trust) on behalf of the Covered Person receives or is entitled to receive compensation for such sickness or injury from some other source, the Plan shall have a constructive trust on such compensation to the extent of the benefits paid by this Plan. Such constructive trust shall be imposed upon the person or entity then in possession of such compensation.

6.8 Right To Receive And Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this Plan or any Other Plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which the Plan Administrator deems to be necessary for such purposes, with respect to any person claiming benefits under this Plan. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

6.9 Special Definitions

For purposes of this Article VI, the following special definitions will apply:

(a) "Covered Person" means a Covered Person as defined in Section I, or a participating COBRA (or other coverage continuation) beneficiary who meets the eligibility requirements for coverage as specified in this Plan and is properly enrolled under the Plan.

(b) "Other Plan" includes, but is not limited to, any of the following providing payments on account of an injury or Sickness:

(i) Any group, blanket or franchise health insurance, or coverage similar to same;

(ii) A group contractual prepayment or indemnity Plan, or coverage similar to same;

(iii) A Health Maintenance Organization (HMO), whether group practice or individual practice association;

(iv) A labor-management trusted Plan or a union welfare Plan;

(v) An Employer or multiemployer Plan or Employee welfare benefit Plan;

(vi) A governmental medical benefit program;

(vii) Insurance required or provided by statute;

(viii) Automobile, no-fault, homeowners or general liability insurance (not merely the medical expense benefit provisions of such insurance);

(ix) Settlement or judgment proceeds (regardless of the manner in which such proceeds are characterized).

The term “Other Plan” does not include any individual health insurance policies or contracts, or public medical assistance programs such as Medicaid, except as otherwise provided herein. The term "Other Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of Other Plans into consideration in determining its benefits and that portion which does not.

(c) “Person” means any individual, association, partnership, corporation or any other organization.

ARTICLE VII

AMENDMENT AND TERMINATION

7.1 Amendment or Termination

The Employer establishes this Plan with the intention that it will be maintained indefinitely; however, the Employer reserves the right at any time and from time to time to amend any or all of the provisions of the Plan, or terminate the Plan and/or Employer contributions thereunder, in whole or in part, for any reason and without consent of any person and without liability to any person for such amendment or termination, provided that the payment of claims that are incurred at the time of any such amendment or termination shall not be adversely affected. Any amendment of the Plan shall be made in writing and shall be approved by the Employer and executed by a duly-authorized officer of the Employer, provided that an amendment of any of the Appendices may be made by the Plan Administrator. Nothing in this Plan shall be construed to require continuation of this Plan with respect to existing or future Covered Persons or beneficiaries.

Any insurer providing benefits under this Plan under the terms of a Component Document may amend such Component Document as and to the extent provided therein.

Where a Component Document is amended or replaced with a similar document (for example, a group insurance contact is replaced by a similar contract issued by the same or different insurer), or where the claims administrator for a particular component program is changed, the Employer may, without resorting to the formalities of a formal amendment, replace the Appendices attached hereto with Appendices reflecting the updated information regarding the Component Document or its issuer.

7.2 Exclusive Purpose of Providing Benefits to Covered Persons

The Employer establishes this Plan for the exclusive benefit of Covered Persons. No Plan amendment or termination shall be made which would cause or permit benefits to be provided other than for the exclusive benefit of such individuals, unless such amendment is made to comply with federal or local law.

7.3 Surplus Assets After Plan Termination

If a benefit is terminated and surplus assets attributable to that benefit remain after all liabilities regarding such benefit have been paid, such surplus shall revert to the Employer to the extent permitted by applicable law, unless otherwise specified in the Component Documents for such benefit.

ARTICLE VIII

GENERAL PROVISIONS

8.1 Plan Interpretation

This Plan document, including the attached Appendices and Component Documents incorporated herein by reference, sets forth the provisions of this Plan. This Plan shall be read in its entirety and not severed except as provided in Section 8.8. The provisions of this document shall control over the provisions of any Component Document, except to the extent this document expressly provides to the contrary.

8.2 Participation by Affiliated Employers

The Employer may permit any of its Affiliated Employers or other Employers ("Participating Employers") to participate in one or more benefits under the Plan. In that event the Participating Employers shall be identified in Appendix II.

8.3 Non-Alienation of Benefits

No benefit, right or interest of any person hereunder shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law. However, the Plan shall recognize and comply with any "qualified medical child support order" as defined in ERISA Section 609(a), with respect to health benefits. A description of the Plan's qualified medical child support order procedures is available from the Plan Administrator, at no charge.

8.4 No Additional Rights

No person shall have any rights under the Plan, except as, and only to the extent, expressly provided for in the Plan. Neither the establishment or amendment of the Plan or the creation of any fund or account, or the payment of benefits, nor any action of the Employer or the Plan Administrator shall be held or construed to confer upon any person any right to be considered or continued as an Employee, or, upon dismissal, any right or interest in any account or fund other than as herein provided. The Employer expressly reserves the right to discharge any Employee at any time.

8.5 Representations

The Employer does not represent or guarantee that any particular federal or state income, payroll, personal property, Social Security or other tax consequences will result from participation in this Plan. A Covered Person should consult with professional tax advisors to determine the tax consequences of participation.

8.6 Notice

To the extent allowed under applicable law, all notices, statements, reports and other communications from the Employer to any Employee or other person required or permitted under the Plan shall be deemed to have been duly given when delivered (with respect to electronic communications such as electronic mail, facsimile transmissions, telex, and telegrams) to, or when mailed by first-class mail, postage prepaid and addressed to, such Employee, or other person at the address last appearing on the Employer's records.

8.7 Masculine and Feminine, Singular and Plural

Whenever used herein, a pronoun shall include the opposite gender and the singular shall include the plural, and the plural shall include the singular, whenever the context shall plainly so require.

8.8 Severability

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

8.9 Governing Law

This Plan shall be construed in accordance with applicable federal law and to the extent otherwise applicable, the laws of the Commonwealth of Virginia.

8.10 Disclosure to Covered Persons

To the extent required by law, each Covered Person shall be advised of the general provisions of the Plan and, upon written request addressed to the Plan Administrator, shall be furnished any information requested regarding the Covered Person's status, rights and privileges under the Plan as may be required by law.

8.11 Accounting Period

The accounting period for the Plan shall be the Plan Year.

8.12 Facility of Payment

In the event any benefit under this Plan shall be payable to a person who is under legal disability or is in any way incapacitated so as to be unable to manage his or her financial affairs, the Plan Administrator may direct payment of such benefit to a duly appointed guardian, committee or other legal representative of such person, or in the absence of a guardian or legal representative, to a custodian for such person under a Uniform Gifts to Minors Act or to any relative of such person by blood or marriage, for such person's benefit. Any payment made in good faith pursuant to this provision shall fully discharge the Employer and the Plan of any liability to the extent of such payment.

8.13 Correction of Errors

In the event an incorrect amount is paid to or on behalf of a Covered Person or beneficiary, any remaining payments may be adjusted to correct the error. The Plan Administrator may take such other action it deems necessary and equitable to correct any such error.

8.14 Workers' Compensation

This Plan is not in place of and does not affect any requirement for coverage by workers' compensation insurance, unless this Plan specifically provides that it is in place of, and affects, a requirement for such insurance.

8.15 Managed Care Directories

To the extent any Component Document hereunder provided health benefits under one or more managed care networks, a directory of network providers may be furnished or made available to each Eligible Employee in writing or electronically. However, upon written request, each Eligible Employee shall receive, at no cost, a written directory of network providers, which may be provided in a separate document.

ARTICLE IX
HIPAA PRIVACY PROTECTIONS

9.1 Background

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes upon the portion of this Plan providing health benefits, and certain other entities, certain responsibilities to ensure that Protected Health Information ("PHI") pertaining to Covered Persons remains confidential, subject to limited exceptions in which PHI may be disclosed. "Protected Health Information" means health information (including oral information) that:

(a) is created or received by a health care providers, health plans, or health care clearinghouses;
(b) relates to an individual's past, present or future physical or mental health condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; and
(c) identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

9.2 Applicability and Effective Date

The rules contained in this Article do not apply to the Plan or the Employer until such date as the HIPAA Privacy Regulations (45 C.F.R. § 160.101 et seq.) apply to the Plan. The rules only apply to the portions of the Plan that provide benefits (e.g., medical, dental and vision) that are not "excepted benefits" under the HIPAA Privacy Regulations.

9.3 Disclosure of PHI

Provided that the Plan (or the Employer on behalf of the Plan) provides to Covered Persons a HIPAA Privacy Notice that, among other things, states the Plan may disclose PHI to the Employer, the Plan may disclose PHI (relating to a Covered Person) to the Employer, as further described below, without the consent or authorization of the Covered Person. In no event may the Plan disclose PHI to the Employer, without the consent or authorization of the Covered Person or his authorized representative, for purposes of employment-related actions or decisions or in connection with any other benefit or Employee benefit plan of the Employer.

The Plan may disclose PHI to the Employer, without the consent or authorization of the Covered Person, subject to the Employer's obligations described below in Section 9.4 for Plan administrative functions such as quality assurance, claims processing, auditing, and monitoring. However, only the minimum amount of PHI necessary to accomplish a particular Plan administration function may be disclosed to the person(s) performing such functions.

In addition to disclosing PHI to the Employer to allow the Employer to perform Plan administrative functions, the Plan may disclose certain limited summary health information to the Employer, without the consent or authorization of the Covered Person, for purposes such as obtaining premium bids for health insurance or reinsurance, or for modifying, amending or terminating the Plan. "Summary health information" is health information that summarizes claims history, expenses, or types of claims by individuals, but from which has been removed at least 18 specific identifiers, including names, dates (except year), telephone numbers, Social Security numbers, medical record numbers, and other identifiers. In addition, the Plan may disclose enrollment and disenrollment information to the Employer without the consent or authorization of the Covered Person.

9.4 Obligations of Employer Regarding Receipt and Use of PHI

As a condition of receiving PHI from the Plan for Plan administrative functions the Employer specifically agrees to:

(a) not use or further disclose the PHI other than as permitted by this Plan or as required by law, or as permitted by the Covered Person to whom the PHI relates;
(b) ensure that any agents or subcontractors to whom it shares or provides the PHI received from the Plan agree to these same restrictions and conditions;
(c) not use the PHI for employment-related actions or in connection with any of its other benefit plans without the consent or authorization from the Covered Person to whom the PHI relates;
(d) report to the Plan any improper uses or disclosures of the PHI;
(e) provide Covered Persons access to PHI that relates to them, allow them to request amendments to the PHI, and upon request provide Covered Persons an accounting of all disclosures of their PHI by the Employer (except for those disclosures with respect to which no accounting is required);
(f) make available to appropriate federal authorities the Employer's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan; and
(g) return or destroy (to the extent feasible) all copies of the PHI received from the Plan once the Employer's need for which the PHI was requested no longer exists or, if this is not feasible, limit further uses and disclosures of the PHI.

9.5 Use And Disclosure Of PHI By The Employer; Dispute Resolution

When the Employer obtains PHI from the Plan for Plan administrative functions, the PHI will be provided to the Benefits Adminstrator of the Employer, the Employer's payroll department, and may also be provided to the Employer's chief financial officer and his designees. The persons in these departments, except as otherwise provided in a specific authorization granted by the Covered Person or his authorized representative to the

Employer, will have access to and may use the PHI solely to perform Plan administrative functions that the Employer performs for or with respect to the Plan.

The Employer may use PHI that it receives from the Plan to carry out Plan administrative functions and may use summary health information for the purposes described in section above titled, "Disclosures of PHI." The Employer may also disclose PHI relating to a Covered Person, without the consent or authorization of the Covered Person, as required or as otherwise permitted by law. For example, the law allows PHI to be disclosed, without the consent or authorization of the Covered Person, to law enforcement, public health, and judicial agencies in certain circumstances. PHI pertaining to a minor Covered Person may, to the extent permitted by local law, be disclosed to the Covered Person's parent or guardian without the consent or authorization of the minor. There are other situations in which PHI may be disclosed without the Covered Person's consent. For more information please review the Plan's Privacy Notice or see the Plan's Privacy Official.

In the event a Covered Person or any other person believes that the Employer or any of its agents have misused PHI disclosed to it or to them by the Plan, such persons may notify the Employer's Privacy Official (contact the Benefits Adminstrator for more information regarding how to contact the Privacy Official), or may file a complaint as described in the Plan's Privacy Notice, a copy of which you should have already received (an additional copy is available from the Benefits Adminstrator). If the complaint is filed with the Privacy Official the Privacy Official will investigate the complaint and the events and circumstances related to it, as provided in the Employer's Privacy Policy and Procedure.

ARTICLE X
COBRA COVERAGE CONTINUATION RIGHTS

10.1 Background

Eligible Employees and Dependents have the opportunity to continue their health coverage (e.g., medical, dental and vision, as the case may be) in certain instances where coverage would otherwise terminate. Such continuation coverage is as described in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and is therefore sometimes referred to as "COBRA Continuation Coverage."

10.2 Entitlement And Qualifying Events

Under COBRA, a covered Employee or covered Dependent may elect to continue health coverage if that coverage would otherwise terminate due to a "qualifying event." Qualifying events are:

(a) A covered Employee's termination of employment, for reasons other than gross misconduct, or reduction in work hours;
(b) Death of the covered Employee;
(c) Divorce or legal separation of the covered Employee and his spouse;
(d) A covered Dependent Child's ceasing to satisfy the Plan's definition of Dependent Child; or
(e) A covered Employee's entitlement to Medicare.

10.3 COBRA Qualified Beneficiaries

A Qualified Beneficiary is an individual who is entitled to COBRA Continuation Coverage. In addition to those individuals covered under the Plan immediately preceding a qualifying event, a child born to a Qualified Beneficiary who is a former covered Employee or who is adopted by or placed for adoption with such a former covered Employee, during the Employee's period of Continuation Coverage, is also a Qualified Beneficiary.

10.4 Maximum Coverage Continuation Periods

Generally, coverage under COBRA may continue for up to:

(a) Eighteen (18) months for an Employee or Dependent whose coverage would cease because of a termination of employment or reduction in work hours; or
(b) Twenty-nine (29) months (i.e. 18 plus 11) for a disabled individual who:

    (1) becomes entitled to the 18 months of continued coverage available after an Employee's termination of employment or reduction in work hours;

(2) is determined by the Social Security Administration to have been disabled on the date of that termination of employment or reduction in work hours or at any time during the first 60 days of COBRA Continuation Coverage; and

(3) notifies the Plan of that disability determination within 60 days after the person receives it and while still purchasing the first 18 months of COBRA Continuation Coverage.

Please note that a COBRA Qualified Beneficiary is eligible for this additional 11 months of coverage, even if not disabled, if he is entitled to COBRA Continuation Coverage due to the same qualifying event that entitles a disabled person to the additional 11 months of coverage.

(c) Thirty-six (36) months, for a divorced or widowed spouse, or a child who has ceased to be a "Dependent" under the terms of the Plan.

10.5 Special Second Election Period for Certain Trade-Displaced Individuals Who Did Not Elect COBRA Coverage

Special COBRA rights apply to Employees who lose health coverage as a result of termination or reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which the Employee begins receiving a trade readjustment allowance (or would be eligible to begin receiving the allowance but for the requirement to exhaust unemployment benefits) or begins receiving alternative trade adjustment assistance, but only if the election is made within the six months immediately after the Employee's group health plan coverage ended.

10.6 Multiple Qualifying Events

If a Dependent is eligible to choose and chooses to continue coverage under these provisions after an Employee's termination or employment or reduction in work hours, and then another COBRA qualifying event (other than termination of employment or reduction in work hours) occurs during the original COBRA Continuation Coverage period, that Dependent may continue coverage for up to 36 months, measured from the date of the initial qualifying event. In no case will any period of COBRA Continuation Coverage exceed 36 months.

10.7 Special Continuation of Coverage Period for Medicare Entitlement

When an individual becomes entitled to Medicare and then, within 18 months thereafter, experiences a qualifying event that is loss of coverage due to termination of employment

or reduction in work hours, the COBRA Continuation Coverage period for the Dependent spouse or Dependent children may continue for up to 36 months from the date of the Medicare entitlement.

10.8 Early Termination Of COBRA Coverage

Once a COBRA Qualified Beneficiary elects to continue coverage, coverage may continue for the period described above, unless:

(a) In the case of a person entitled to 29 months of COBRA Continuation Coverage (due to his or another person's disability), the Social Security Administration determines that he (or such other person) is no longer disabled, in which case the extended Continuation Coverage will cease on the first day of the month that begins more than 30 days after the Social Security Administration makes such a determination;
(b) If the person becomes entitled to Medicare, after the date he elects Continuation Coverage;
(c) The person fails to make a required monthly payment within the 30 day grace period pursuant to this provision;
(d) The person becomes covered - after the date he elects Continuation Coverage - under another employer group health plan (because of employment or otherwise) and that coverage contains no exclusion or limitation with respect to any pre-existing condition;
(e) The person becomes covered - after the date he elects Continuation Coverage - under another group health plan (because of employment or otherwise) that contains an exclusion or limitation with respect to a pre-existing condition which is nullified, waived or does not apply because of the Health Insurance Portability and Accountability Act (HIPAA) rules; or
(f) The Plan is terminated and the Employer maintains no group health plan for any of its active Employees.

10.9 Notification Of A Qualifying Event

To preserve rights to COBRA Continuation Coverage, a COBRA Qualified Beneficiary must notify the Plan Administrator within 60 days of a divorce or legal separation, of a child ceasing to meet the Plan's definition of "Dependent", or of the Social Security Administration's determination of disability. In addition, if the person is a disabled individual who obtained 29 months of COBRA Continuation Coverage, he must notify the Plan Administrator of any determination by the Social Security Administration that he is no longer disabled. Notification to the Plan Administrator must be made within 30 days of the date such determination is made.

10.10 Benefits That May Continue

If a COBRA Qualified Beneficiary elects COBRA Continuation Coverage, it will be identical to the health coverage then being provided under the Plan to Eligible Employees

or, if in the case of a Dependent, to covered Dependents of Eligible Employees. COBRA Qualified Beneficiaries do not have to prove insurability to choose continuation coverage, but are required to pay for it.

10.11 Application And Payment Procedures

After a COBRA qualifying event (and the provision of any notice required by COBRA Qualified Beneficiary, as described in Section 10.8), the Plan Administrator will send or cause to be sent a more detailed notice and an application for continued coverage. To continue coverage under COBRA, a COBRA Qualified Beneficiary must complete and return the application to the Plan Administrator or its designee within 60 days from the later of the date the application is sent or the date coverage would otherwise terminate.

Payment for the period from the date coverage would otherwise terminate through the 45th day after COBRA Continuation Coverage is elected must be made by that 45th day (for example, if a person elects COBRA Continuation Coverage on the 30th day of the 60-day election period, he must make his first payment by the 75th day after he elected COBRA Continuation Coverage, and the payment must be for the period of COBRA Continuation Coverage from the date he would otherwise lose coverage to that 75th day. Thereafter, payments must be made within thirty (30) days after the monthly premium due date to be considered timely. The Plan will terminate coverage as of the qualifying event, but will reinstate it retroactively to the date of the qualifying event if a timely election for COBRA Continuation Coverage, and timely initial payment, are made.

The monthly cost of COBRA Continuation Coverage will be set for 12-month periods, and will not exceed 102% of the cost of coverage under the Plan for similarly situated Covered Persons. However, if a person qualifies for periods of extended coverage due to a disability (whether his or another Qualified Beneficiary's), the monthly COBRA premium during the period of extended coverage may be 150% of the cost of coverage under the Plan for similarly situated Covered Persons, depending on whether the disabled person continued coverage during the extended coverage period.

Please note that the terms of the Component Documents might set forth slightly different procedures for applying and paying for COBRA Continuation Coverage, or providing notice of certain qualifying events, or for other rights and obligations regarding COBRA Continuation Coverage. In that case the terms of the Component Document will control over this Article X, to the extent the terms of the Component Document are consistent with applicable law.

ARTICLE XI
STATEMENT OF ERISA RIGHTS

11.01 Covered Persons' Rights

As an Eligible Employee covered under the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all covered Eligible Employees shall be entitled to:

(a) Receive Information About Your Plan and Benefits:

(1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

(2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Plan Administrator is normally required by law to furnish each participant with a copy of this summary annual report.

(b) Continue Group Health Plan Coverage:

(1) Continue health care coverage for yourself, covered spouse or other Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your covered Dependents may have to pay for such coverage. Review this document and the Component Documents for the rules governing your COBRA continuation coverage rights.

(2) Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it

before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

(c) Prudent Actions by Plan Fiduciaries:

In addition to creating rights for covered Eligible Employees, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Covered Persons. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

(d) Enforce Your Rights:

(1) If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suite in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

(2) If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

(e) Assistance with Your Questions:

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

IN WITNESS WHEREOF, the Employer has caused this Plan to be executed on this _____ day of _____, 200__.

SOUTHEASTERN UNIVERSITIES RESEARCH ASSOCIATION, INC.

By: _____

Name: _____

Title: _____

APPENDIX I

COMPONENT DOCUMENTS

Effective June 1, 2006, the terms, conditions and limitations of the benefits described in Article II of the Plan are contained in the Component Documents listed from time to time in this Appendix I, which are incorporated herein by reference.

A. Group Comprehensive Medical Benefits

Benefits provided under an insured arrangement with:

Anthem Blue Cross & Blue Shield
PO Box 27401
Richmond, VA 23279
(804) 354-7000

HealthKeepers
2220 Edward Holland Drive
Richmond, VA 23230
(804) 354-7000

Sentara Optima Health Plan
4417 Corporation Lane
Virginia Beach, VA 23462
(800) 736-8272

B. Group Dental Benefits

Benefits provided under an insured arrangement with:

Delta Dental Plan of Virginia
4818 Starkey Road
SW Roanoke, VA 24014
(540) 989-8000

C. Group Long-Term Disability Benefits

Benefits provided under an insured arrangement with:

Metropolitan Life Insurance Company (MetLife)
200 Park Avenue
New York, New York 10166
(800) 300-4296

D. Group Short-Term Disability Benefits

Benefits provided under an insured arrangement with:

Metropolitan Life Insurance Company (MetLife)
200 Park Avenue
New York, New York 10166
(800) 300-4296

E. Group Term Life Insurance Benefits

Benefits provided under an insured arrangement with:

Metropolitan Life Insurance Company (MetLife)
200 Park Avenue
New York, New York 10166
(800) 275-4638

F. Group Accidental Death and Dismemberment Benefits

Benefits provided under an insured arrangement with:

Metropolitan Life Insurance Company (MetLife)
200 Park Avenue
New York, New York 10166
(800) 275-4638

APPENDIX II

ADMINISTRATIVE FACTS

Plan Name:	SURA/Jefferson Science Associates, LLC Comprehensive Health and Welfare Benefit Plan
Plan Number:	501
Type of Plan:	Welfare benefit plan including benefits under the following programs: Comprehensive medical benefit program Dental benefit program Group term life insurance program Long term disability benefit program Short term disability program Accidental death and dismemberment program
Plan Year:	12-month period beginning April 1 and ending March 31.
Plan Sponsor:	Southeastern Universities Research Association, Inc. 1201 New York Avenue, N.W. Suite 430 Washington, DC 20005 (202) 408-7872 Employer ID No.: 54-1156453
Participating Employers:	Jefferson Science Associates, LLC Employer ID No.: 20-3974952
Plan Administrator:	Southeastern Universities Research Association, Inc. 1201 New York Avenue, N.W., Suite 430 Washington, DC 20005 (202) 408-7872 Southeastern Universities Research Association, Inc., delegates the Plan Administrator duties to: Human Resources Consultant Jefferson Science Associates, LLC 628 Hofstadter Road, Suite 2 Newport News, VA 23606 (757) 269-7576
Sources of Contributions:	Employee contributions and Employer contributions.

Funding Medium:	Benefits are provided through one or more insurance contracts and the component programs referenced in Appendix I, purchased with contributions by the Participating Employers and with specified Employee contributions, as applicable.
Type of Administration:	Administered according to the Component Documents. Some benefits under the Plan are insured by one or more insurance companies. Appendix I describes the various benefits, whether they are insured or self-insured, and the identity of the insurance companies and/or third-party administrators.
Agent for Legal Process:	Service of legal process may be made upon the Plan Administrator.

APPENDIX III

ELIGIBILITY MATRIX

Important Note: This Matrix is merely a summary of the eligibility rules under the various component programs. More complete information is available from the Component Documents themselves, and from the Benefits Adminstrator.

Group Comprehensive Medical Benefits
Employee Eligibility Classification: All full-time and part-time Employees working at least 50% of full-time hours.
Employee Effective Date: Date of hire.
Dependent Effective Date: Date of Employee's hire.
Coverage Termination Date: First day of month following loss of eligibility.

Group Dental Benefits
Employee Eligibility Classification: All full-time and part-time Employees working at least 50% of full-time hours.
Employee Effective Date: Date of hire.
Dependent Effective Date: Date of Employee's hire.
Coverage Termination Date: First day of month following loss of eligibility.

Long-Term Disability Benefits
Employee Eligibility Classification: All full-time Employees who work at least 50% of full-time hours.
Employee Effective Date: Date of hire.
Coverage Termination Date: Date lose eligibility.

Short-Term Disability Benefits
Employee Eligibility Classification: All full-time and part-time Employees working at least 50% of full-time hours.
Employee Effective Date: Date of hire.
Coverage Termination Date: Date lose eligibility.

Group Term Life Insurance Benefits
Employee Eligibility Classification: All full-time and part-time Employees working at least 50% of full-time hours.
Employee Effective Date: Date of hire.
Coverage Termination Date: Date lose eligibility.

Accidental Death and Dismemberment Benefits
Employee Eligibility Classification: All full-time and part-time Employees working at least 50% of full-time hours.
Employee Effective Date: Date of hire.
Coverage Termination Date: Date lose eligibility.

Please note that coverage may also terminate due to nonpayment of premiums, elimination of coverage by the Employer, disenrollment by the Employee, or any other reason permitted under the terms of the applicable Component Documents.