SURA/JEFFERSON SCIENCE ASSOCIATES, LLC

COMPREHENSIVE HEALTH AND WELFARE BENEFIT PLAN

Summary Plan Description

Amended and Restated
Effective June 1, 2006

YOUR SUMMARY PLAN DESCRIPTION

This document is the principal document, but only one of several documents, that comprise the "summary plan description" of your SURA/Jefferson Science Associates, LLC Comprehensive Health and Welfare Benefit Plan. That Plan consolidates a number of health and welfare benefit programs (called "**Component Programs**") sponsored or maintained by Southeastern Universities Research Association, Inc. Think of the Plan as an umbrella, or shell, under which are incorporated the various health and welfare benefit Component Programs sponsored by Southeastern Universities Research Association, Inc.:

SURA/Jefferson Science Associates, LLC Comprehensive Health and Welfare Benefit Plan

Group Comprehensive Medical Benefits
Group Dental Benefits
Long-Term Disability Benefits
Short-Term Disability Benefits
Group Term Life Insurance Benefits
Accidental Death and Dismemberment Benefits

The *complete* summary plan description ("SPD") of the Plan is comprised of:

- This document, and
- The one or more booklets or coverage certificates describing the benefits of the Component Program(s) under which you're enrolled. These booklets or certificates are issued to you by your Employer, or by the insurer or claims administrator of the Component Program(s).

Like the SPD, the actual, formal Plan "document" is actually comprised of several documents, specifically:

- The SURA/Jefferson Science Associates, LLC Comprehensive Health and Welfare Benefit Plan document, and
- The insurance contracts, insurance certificates and other Component Program documents that describe the benefits (and eligibility and related rules) available under the various Component Programs that comprise the Plan.

As you can see from the diagram above, the Component Programs that comprise (and provide benefits through) the Plan include:

- SURA/Jefferson Science Associates, LLC Comprehensive Medical Benefit Program

- SURA/Jefferson Science Associates, LLC Dental Benefit Program
- SURA/Jefferson Science Associates, LLC Long-Term Disability Benefit Program
- SURA/Jefferson Science Associates, LLC Short-Term Disability Benefit Program
- SURA/Jefferson Science Associates, LLC Group Term Life Insurance Benefit Program
- SURA/Jefferson Science Associates, LLC Accidental Death and Dismemberment Insurance Benefit Program

If you are enrolled in one or more of these Programs, but did not receive a booklet or certificate describing the benefits for which you're eligible, please contact the Benefits Administrator and it will obtain copies for you.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

As you can see from the list above, the Component Programs include a variety of different benefit programs. In order to qualify for a benefit under a particular Component Program you must meet the eligibility requirements under *that particular Program*. For example, in order to qualify for comprehensive medical coverage under this Plan you must be eligible under the SURA/Jefferson Science Associates, LLC Group Comprehensive Medical Benefits Program that exists under the "umbrella" of this Plan.

The basic eligibility requirements for a particular benefit under a Component Program, how eligibility is maintained, and the options available if eligibility for that benefit is lost, are *summarized* in this document but are described in detail in the insurance contracts, insurance certificates and other Component Program documents issued by insurance carriers or your Employer. In all cases, the Plan may require certain documentation as proof of your eligibility. In no event may you or a Dependent participate in this Plan with respect to a particular benefit provided under a Component Program until the date specified by the Component Program.

For the purposes of this Plan, an "Eligible Employee" is any Employee who meets the eligibility requirements under a Component Program. Again, you are an Eligible Employee only to the extent of, and only with respect to your participation in, those portions of this Plan with respect to which you meet the eligibility requirements of the applicable Component Program. See the eligibility summary below.

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 Program that provides such benefit.

Enrollment

If you are eligible for coverage under a Component Program of this Plan, you may enroll for coverage during your initial eligibility period. You may also enroll during the Plan's (or Component Program's) annual enrollment period, or during certain special enrollment periods after you acquire new Dependents or lose other coverage. Contact the Benefits Administrator for more information. Because this Plan operates as merely an "umbrella" for a variety of Component Programs, you and your Dependents' eligibility for coverage, and effective date of

coverage, under this Plan begins when you become eligible (or, as the case may be, *covered*) under a Component Program.

Generally, your and your Dependents' eligibility and coverage under a Component Program occur as specified below:

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.

See also the booklets or certificates you received when you enrolled in the Component Program(s). Contact the Benefits Administrator for more information about eligibility issues and coverage effective dates.

Changing Your Election During The Year

Generally, you cannot change your enrollment election during the year. However, if you or your Dependents experience certain "change in status" events, or if other special circumstances arise, you may be permitted to change your coverage election. Please refer to the Benefits Administrator for more information on "change in status" and similar events. The terms of a particular Component Program will dictate whether, when and how you may change an election to participate in, or cease participation in that Program.

When Coverage Ends

The eligibility summary listed above also summarizes when coverage ends after you (or, in the case of a Dependent, the eligible Dependent) lose eligibility (for example, because you terminate employment or, in the case of a Dependent, the person ceases to be considered a Dependent under the Component Program).

Coverage for your covered Dependents ends when your coverage ends or, if earlier, when they cease to be considered an eligible Dependent under the applicable Component Program. In certain circumstances health benefits can be continued for you and/or your Dependents for a limited time. Please refer to the "Continuation Coverage" rules below.

Compliance with HIPAA

The Plan will comply with the special enrollment and nondiscrimination provisions of the Health Insurance Portability and Accountability Act of 1996, with respect to those benefits subject to HIPAA. These rules may have the effect of limiting or even eliminating a health program's application of a pre-existing condition restriction to you or a Dependent. These rules may require the Plan to provide benefits for reconstructive breast surgery following a mastectomy, and provide certain minimum benefits for nervous and mental benefits if a health benefit Component Program provides nervous and mental benefits. See the actual Plan document (available from the Benefits Administrator) and the various booklets and coverage certificates that describe the benefits available under the Component Programs providing health benefits.

CONTINUATION COVERAGE

This section contains important information about the right to COBRA continuation coverage, which is a temporary extension of health insurance coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under a health care component of the Plan when they would otherwise lose group health coverage. The "health care components" of this Plan are the following:

- SURA/Jefferson Science Associates, LLC Comprehensive Medical Benefit Program
- SURA/Jefferson Science Associates, LLC Dental Benefit Program

This section generally explains COBRA continuation coverage, when it may become available, and what one needs to do to protect the right to receive it. This section gives only a summary of COBRA continuation coverage rights. For more information about rights and obligations under the Plan and under federal law, review the Plan document, a copy of which is available from the Plan Administrator.

Administering COBRA Coverage

The Plan Administrator is described in the section of this booklet titled, "Plan Information." The Plan Administrator may or may not be responsible for administering COBRA coverage under the various health benefit programs offered under this Plan. Here is a list that shows who is responsible for *administering* the COBRA coverage:

Comprehensive medical benefits:

The Plan Administrator, but as delegated to the specific individuals set forth in the "Plan Information" section of this booklet with respect to employees (and dependents) of Southeastern Universities Research Association, Inc. and Jefferson Science Associates, LLC, respectively

Dental benefits:

The Plan Administrator, but as delegated to the specific individuals set forth in the "Plan Information" section of this booklet with respect to employees (and dependents) of Southeastern Universities Research Association, Inc. and Jefferson Science Associates, LLC, respectively

Qualifying Events and Qualified Beneficiaries

COBRA continuation coverage is a continuation of coverage under a health care component of this Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below.

COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is an individual who is entitled to COBRA continuation

coverage because they would otherwise lose coverage on account of a “qualifying event.” Depending on the type of qualifying event, you, your spouse and your Dependent children may be qualified beneficiaries. In addition to those individuals covered under a health care component of this Plan immediately preceding a qualifying event, a child born to a qualified beneficiary who is a former covered Eligible Employee or who is adopted by or placed for adoption with such a former covered Eligible Employee, during the Employee's period of continuation coverage, is also a qualified beneficiary.

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

You become a qualified beneficiary if you lose coverage under a health care component of this Plan because either one of the following qualifying events happens:

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

Your spouse becomes a qualified beneficiary if he or she loses coverage under a health care component of the Plan because any of the following qualifying events happens:

- You die,
- Your hours of employment are reduced,
- Your employment ends for any reason other than your gross misconduct,
- You become enrolled in Medicare (Part A, Part B, or both), or
- You and your spouse are divorced or legally separated.

Dependent children will become qualified beneficiaries if they will lose coverage under a health care component of the Plan because any of the following qualifying events happens:

- You die,
- Your hours of employment are reduced,
- Your employment ends for any reason other than your gross misconduct,
- You become enrolled in Medicare (Part A, Part B, or both),
- You and the child’s other parent become divorced or legally separated, or
- The child stops being eligible for coverage under the plan as a "Dependent child."

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

Notice Requirements
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, your death, commencement of a proceeding in bankruptcy with respect to the employer, or your enrollment in Medicare (Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events (of course, where the Plan Administrator is the Employer, there's no need for the Employer to notify itself of these events).

Contact Persons for Giving Required Notices
For the other qualifying events (your divorce or legal separation or a Dependent child's losing eligibility for coverage as a Dependent child), you (or someone on your behalf) must notify the Plan Administrator. The Plan requires this notice to occur within **60 days** after the qualifying event occurs. The notice must be sent, ***in writing***, to the person indicated below:

For COBRA qualifying events involving:

***Comprehensive medical coverage*:**

The Plan Administrator, but in care of the specific individuals to whom the Plan Administrator has delegated certain administrative duties as set forth in the "Plan Information" section of this booklet with respect to employees (and dependents) of Southeastern Universities Research Association, Inc. and Jefferson Science Associates, LLC, respectively

***Dental coverage*:**

The Plan Administrator, but in care of the specific individuals to whom the Plan Administrator has delegated certain administrative duties as set forth in the "Plan Information" section of this booklet with respect to employees (and dependents) of Southeastern Universities Research Association, Inc. and Jefferson Science Associates, LLC, respectively

Duration of COBRA Coverage
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is your death, enrollment in Medicare (Part A, Part B, or both), your divorce or legal separation, or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage may last for up to **36 months**.

When the qualifying event is the end of your employment or reduction in your hours of employment, COBRA continuation coverage may last for up to **l8 months**. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

First, if you or anyone in our family covered under a health care component of the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you (or someone on your behalf) notifies the Plan Administrator in a timely fashion, you and all other members of the family (who were covered by the health care component of the Plan at the time of the qualifying event) can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. ***The Plan Administrator must be notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage***. This notice should be sent, in writing, to the appropriate person described above, under the heading "*Contact Persons for Giving Required Notices."*

Second, if your family experiences another qualifying event while receiving COBRA continuation coverage (due to a qualifying event that allows you and the family to purchase up to 18 months of COBRA coverage), the spouse and Dependent children can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and Dependent children if during the initial 18-month period of COBRA coverage you die, enroll in Medicare (Part A, Part B, or both), or get divorced or legally separated from your spouse. The extension is also available to a Dependent child when that child stops, during the initial 18-month COBRA period, being eligible under the Plan as a Dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent, in writing, to the appropriate person described above, under the heading "*Contact Persons for Giving Required Notices*."

Special Trade Act Extension

Special COBRA rights apply to Eligible 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. If you qualify or may qualify for assistance under the Trade Act of 1974, you may contact the SURA/Jefferson Science Associates, LLC Benefits Administrator for additional information. You must contact the Benefits Administrator promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights.

Early Termination Of COBRA Coverage
Once you elect to continue your coverage, your coverage may continue for the period described above, unless:

- If you were entitled to 29 months of COBRA continuation coverage (due to your or another person's disability), the Social Security Administration determines that you (or such other person) are no longer disabled, in which case your extended COBRA 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;
- You become entitled to Medicare, after the date you elect COBRA continuation coverage;
- You fail to make a required monthly payment within the 30 day grace period pursuant to this provision;
- You become covered—after the date you elect COBRA 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;
- You become covered—*after the date you elect COBRA 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
- The Plan is terminated and the Employer maintains no group health plan for any of its active Employees.

Benefits that May Continue
If you elect COBRA continuation coverage, it will be identical to the health coverage then being provided under the Plan to active Employees or, if you are a Dependent, to covered Dependents of active Employees. You do not have to prove insurability to choose continuation coverage, but you do have to pay for it.

Application and Payment Procedures
After you experience a COBRA qualifying event (and provide any notice required by the preceding "Notification of a Qualifying Event" section of this booklet), you will be sent a more detailed notice and an Application for Continued Coverage. To continue coverage under COBRA, you must complete and return the Application to the Plan Administrator within 60 days from the later of the date the Application is sent to you or the date your coverage would otherwise terminate.

Your payment for the period from the date your coverage would otherwise terminate through the 45th day after COBRA continuation coverage is elected must be made by that 45th day (for example, if you elect COBRA continuation coverage on the 30th day of the 60-day election period, you must make your first payment by the 75th day after you elected COBRA continuation coverage, and the payment must be for the period of COBRA continuation coverage from the date you 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 by the Plan Administrator, and will not exceed 102% of the cost of coverage under the Plan for similarly situated Covered Persons. However, if you qualify for periods of extended coverage due to a disability (whether yours 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.

Questions and More Information

If you have questions about your COBRA continuation coverage, you should contact the SURA/Jefferson Science Associates, LLC Benefits Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

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

FMLA

If your participation in a health benefit offered under a Component Program of this Plan would terminate due to your taking an FMLA leave of absence, the benefits will continue for the period of the leave or 12 weeks, whichever is less. However, coverage will continue only as long as you make 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) will continue or terminate during a period of FMLA leave to the same extent as the 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.

USERRA

If your participation in health benefits offered under a Component Program through this Plan would terminate due to your taking a leave of absence under the Uniformed Service Employment and Reemployment Rights Act of 1994, the benefits will continue for the period of leave or 18 months, whichever is less. However, coverage will continue only as long as you continue to timely make any required Employee contributions. If your USERRA leave is less than 31 days you must make the same contribution as is required for active Employees; if your leave is 31 days or longer you must pay up to 102% of the full cost (Employee and Employer contributions) of coverage, as determined by the Plan Administrator.

SCHEDULE OF BENEFITS

The Plan provides a variety of benefits under various benefit programs, including:

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

A Schedule of Benefits for a particular Component Program is provided to you in the booklet or certificate issued to you when you enrolled in the Program. Please refer to your applicable booklets or certificates for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage (those documents are incorporated into this SPD by reference). As noted in several places, if this summary conflicts in any way with a Component Program document, the Component Program document controls.

Provider Network

The Plan may use a network of providers for certain health care benefits. If you receive covered services from a network provider, usually the Plan pays a larger percentage of your expenses than if you received care from a non-network provider, but this does not mean that all services and supplies are automatically covered. If you have questions regarding coverage of a particular treatment, diagnostic test or supply, we strongly recommend that you contact the Benefits Administrator for coverage information rather than rely on a physician or his or her staff, who deal with many different plans on a daily basis.

You can always find out if a particular provider is in the network or obtain a list of providers in your area at no charge by contacting the Benefits Administrator.

Procedures for Obtaining Health Care Services

As a general rules, you are eligible for coverage of health care services under a particular Component Program if such services are medically necessary and not excluded by the terms of this Plan (including the terms of any Component Program documents; see your Schedule of Benefits for a particular Component Program). All coverage is subject to the terms, conditions, exclusions and limitations of the Component Program documents. Before the Plan will pay for health services provided by a non-network provider, you may be required to first satisfy payment of any annual deductible, and generally these non-network expenses are covered at a lower level than health services from a network provider. In addition, you may be required to pay for these services up front and file the claim with the insurance company or claims administrator for reimbursement. Please refer to your Component Program booklet or certificate for information regarding services from a non-network provider that are not covered. Generally you must obtain prior approval to obtain care from a non-network provider for certain health services. You are responsible for assuring that the required prior approval is received before services are received

from non-network providers. Failure to obtain prior approval may result in a lower level of coverage for such health services.

Newborns' and Mothers' Health Protection Act (NMHPA)
The Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or to less than 96 hours in the case of a Cesarean section. In addition, the Plan will not require a hospital, physician or other medical provider to obtain authorization or pre-certification from SURA/Jefferson Science Associates, LLC or an insurer (if applicable) or their respective medical review specialist for prescribing any length of stay described above. However, these rules do not apply where the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay periods described above is made by the mother's or child's attending physician in consultation with the mother.

Coordination of Benefits
Benefits provided by health plans vary substantially. Coordination of Benefits (COB) applies when an individual has health care coverage through more than one group program. The purpose of COB is to ensure that the individual receives all of the coverage for which the individual is entitled, but no more than the actual cost for the care received. In other words, total payments from all of the coverages combined cannot be more than the total charges incurred.

The Plan will also coordinate benefits with all other group and private health plans when benefits are not payable for any illness, injury, disease or other condition for which a third party may be liable or legally responsible. "Third party" means an insurance carrier, organization or individual other than the participant or Dependent who suffers loss. It includes insurance carriers liable under no-fault and/or uninsured motorist policies.

Reimbursement
The rules in this "Reimbursement" section, and the following section titled, "Subrogation," apply to the extent the reimbursement and subrogation terms of an applicable Component Program document do not supply greater rights to the Plan (if the reimbursement and subrogation terms of an applicable Component Document supply greater rights, those terms apply).

To the extent permitted by law, when this Plan makes payments that, together with payments you receive or are entitled to receive from any Other Plan or Person, exceed the amount necessary to satisfy the intent of this provision or exceed the benefits properly payable, the Plan has the right to recover the payments to the extent of the excess. Recovery may be had from among one or more of the following: you; if you are an eligible Dependent or former eligible Dependent, your sponsor (the Employee or former Employee); any Other Plan, provider, or person to or for or with respect to whom such payments were made; any insurance company or Other Plan or Person that should have made the payment; and any other organizations.

Alternatively, the Plan may set-off the amount of the payments, to the extent of the excess, against any amount owing at that time or in the future under this Plan to one or more of the following: you, Plans, persons, providers, insurance companies, or other organizations.

These reimbursement rules 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 you as compensation for the injury or sickness this Plan is entitled to reimbursement from you (or anyone who received such payment on your behalf) in an amount equal to the benefits paid by this Plan for treatment of the injury or sickness, or the amount paid to you or on your behalf, whichever is less.

These reimbursement rules do not prevent the Plan from obtaining full reimbursement from you or, in the Plan's sole discretion, any other person who received payment on your behalf by, for example, apportioning the obligation to reimburse the Plan among you and any other person, such as your 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 your legal counsel) other than you (or the Person, such as a parent or legal guardian, who received payment on your behalf) where the Plan can be made whole entirely from amounts actually received by you (or the Person, such as a parent or legal guardian, who received such amounts on your behalf). 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 you or on your behalf for an injury or sickness for which an Other Plan or Person is or may be liable, and you incur (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, are excluded from coverage under the Plan to the extent of the excess (if any) of the compensation received by you or on your behalf, over the covered expenses which the Plan has already paid for treatment of the injury or sickness.

This Plan is not responsible for any costs or expenses (including attorneys' fees) incurred by you or on your behalf 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 you or on your behalf, whether in a settlement agreement or otherwise, do not affect this Plan's right to reimbursement and to characterize otherwise covered charges as excludable covered expenses pursuant to these rules.

Subrogation

To the extent permitted by law, the Plan is 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 you whole. The Plan is not responsible for any costs or expenses, including attorneys' fees, incurred by you or on your behalf 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

you or on your behalf, whether under a settlement agreement or otherwise, does not affect this Plan's right to subrogation and to claim, pursuant to such right, all or a portion of the 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 you (or, in the Plan's sole discretion) any other Person who received payment on your behalf, such as a parent or guardian) by, for example, apportioning liability for satisfaction of the subrogation lien among you and any other Person, such as your legal counsel.

This Plan is also subrogated (to the extent of benefits paid under this Plan) to any claim you may have against any Other Plan or Person for the injury or sickness that occasioned the payment of benefits under this Plan. This Plan will 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 you as soon as administratively practical.

The Plan Administrator shall determine which of the Plan's rights and remedies it is within the best interests of this Plan to pursue.

To the extent permitted by law, if you incur an injury or sickness under circumstances where compensation may be payable to you 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 you or someone legally qualified and authorized to act for you in writing:

- Consents to the Plan's subrogation of any recovery or right of recovery you have with respect to the injury or sickness;
- Promises not to take any action that would prejudice the Plan's subrogation rights;
- Promises to reimburse the Plan for any such benefits payments to the extent that you receive 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 you whole. This reimbursement must be made within 30 days after you (or anyone on your behalf) receive the payment; and
- 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 you fail or refuse to execute whatever assignment, form or document requested by the Plan Administrator, the Plan shall be relieved of any and all legal, equitable or contractual obligation for any benefits or covered expense incurred by you and each member of your family, including claims then incurred but unpaid.

In the event the Plan is entitled by these rules to be reimbursed for benefits it has paid for treatment of your sickness or injury, and where you or someone (including an individual, estate

or trust) on your behalf receives or is entitled to receive compensation for such sickness or injury from some other source, the Plan has a constructive trust on such compensation to the extent of the benefits paid by this Plan. The constructive trust is imposed upon the person or entity then in possession of the compensation.

For purposes of these reimbursement and subrogation rules, the following special definitions apply:

- "Covered Person" means a person covered under a Component Program providing health benefits, 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.
- "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 the insurance);
  (ix) Settlement or judgment proceeds (regardless of the manner in which the proceeds are characterized).

  The term "Other Plan" is 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.

- "Person" means any individual, association, partnership, corporation or any other organization.

CLAIM PROVISIONS

Claim Filing Deadlines

You must apply for Plan benefits in writing on a form provided by the Plan Administrator or other appropriate person, unless a claim is filed directly by a provider of benefits. A claim for reimbursement of expenses under a particular Component Program must be submitted in a manner and within the time period specified in the contracts, booklets or certificates governing that Program. Claims shall be evaluated by the Plan Administrator or another person specified in

the applicable Component Program documents and be approved or denied in accordance with the terms of the Plan, including the Component Program documents.

Payment of any claim will be made to you unless you authorized payment to any entity rendering covered services, treatment or supplies. If you die before all benefits have been paid, the remaining benefits may be paid to any relative of yours or to any person appearing to the Plan Administrator to be entitled to payment.

Action on Submitted Claims

Any time a claim for benefits receives an adverse determination (that is, the claim is denied in whole or in part), you or your Dependent (as the case may be) will receive written notice of such action.

Categories of Claims, "Applicable Periods," and Extensions.

- ***"Urgent care claims"***. Urgent care claims are requests for verification or approval of coverage for medical, dental or vision 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 Claim Supervisor will notify the Claimant within 24 hours of the specific information needed to complete the claim. The Claimant will have 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 Claim Supervisor will notify the Claimant of the Plan's benefit determination. The Claimant may agree, upon request of the Plan, to extend the deadlines applicable to the Plan.

- ***"Pre-Service Claims"***. A pre-service claim is any request for approval of coverage for a medical, dental or vision care service or item that under the terms of the Plan requires advance approval. The "applicable period" for a pre-service medical, dental or vision claim is 15 days after receipt of the claim by the Plan. The Claim Supervisor may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Claim Supervisor will 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 Claim Supervisor will 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 will describe the specific information needed to complete the claim; the Claimant will have 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, upon request of the Plan, to extend the deadlines applicable to the Plan.

- ***"Concurrent Care Claims"***. A concurrent care claim may be either an urgent care claim or a pre-service claim. Generally, it is a claim for an ongoing course of medical, dental or vision care treatment to be provided over a period of time or number of treatments. An adverse determination involving concurrent care will be made sufficiently in advance of any reduction or termination in treatment to allow the Claimant 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 will be decided as soon as possible, but not later than 24 hours after receipt of the request by the Claim Supervisor, 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 this section. 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 will be provided within a reasonable time before the coverage for treatments will stop; however, the Claimant will have up to 180 days to appeal the Plan's decision, before the Plan may terminate the treatment (see the rules below, concerning the time a Claimant normally has to appeal an adverse benefit determination.)

- ***"Post-Service Claims"***. A post-service claim is a medical, dental or vision care 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 Claim Supervisor may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Claim Supervisor will 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 will describe the specific information needed to complete the claim. The Claimant will have at least 45 days from receipt of the notice to provide the required information. The Plan will then have 15 days from the date of receiving the Claimant's information to render its decision. The Claimant may agree, upon request of the Plan, to extend the deadlines applicable to the Plan.

- ***Disability Benefit Claims***. If the Plan includes short-term or long-term disability benefits, the "applicable period" for deciding such claims 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 Claim Supervisor will notify the Claimant of the need for the extension prior to the beginning of any such extension period.

If the Plan cannot render a decision within 45 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 will describe the specific information needed to complete the claim. The Claimant will have at least 45 days from receipt of the notice to provide the required information. The Plan will then have 30 days from the date of receiving the Claimant's information to render its decision. The Claimant may agree, upon request of the Plan, to extend the deadlines applicable to the Plan.

Please note that if the Claim Supervisor does not administer claims for disability benefits, references in this paragraph, and below, to the "Claim Supervisor" means the person or entity who administers such claims.

- ***Claims for Benefits Other than Medical, Dental, Vision or Disability Benefits***. If the Plan includes benefits other than medical, dental, vision, or disability, the "applicable period" for deciding such claims 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 one (1) ninety-day extension, but the Claim Supervisor will notify the Claimant of the need for the extension prior to the beginning of any such extension period.

  Please note that if the Claim Supervisor does not administer claims for benefits described above, references in this paragraph, and below, to the "Claim Supervisor" means the person or entity who administers such claims.

Form and Content of Notice of Adverse Determination on Claims
If a claim is denied in whole or in part, notice of the adverse determination will be provided to the claimant.

The notice will include the following:

- the specific reason or reasons for the adverse determination;
- reference to the specific Component Program 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;
- 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
- in the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims.

Right to Request Review

Any claimant who has had a claim for benefits denied in whole or in part, or is otherwise adversely affected by action on a claim, has the right to request review. Such request must be in writing, and must be made within a specified number of days after the claimant is advised of the initial adverse action. If written request for review is not made within such appeal period, the claimant will forfeit his or her right to review. The appeal periods vary depending on the Component Program involved:

- Group Comprehensive Medical Benefits ..... 180 days
- Group Dental Benefits ..... 180 days
- Long-Term Disability Benefits ..... 180 days
- Short-Term Disability Benefits ..... 180 days
- Group Term Life Insurance Benefits ..... 90 days
- Accidental Death and Dismemberment Benefits ..... 90 days

Review of Claim

The claim will be reviewed as provided under the applicable Component Program documents, and a copy of the decision will be furnished to the claimant.

See the complaint procedures portion of your Component Program booklet or certificate for specific rights and duties you may have regarding claims and appeals.

ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- 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.
- 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.
- 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.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- 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 pre-existing condition exclusion for 12 months (18 months for Late Enrollees) after your enrollment date in your new coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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.

If you have a claim for benefits that 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.

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.

HIPAA PRIVACY

The Plan may be required by federal, state and/or local law to keep confidential certain medical information about you that it acquires in the course of providing benefits to you. Any such obligation on the Plan and/or your Employer, and any rights you have, in this regard will be described in the various Component Program documents or in separate notices provided to you.

PLAN INFORMATION

Plan Name:	SURA/Jefferson Science Associates, LLC Comprehensive Health and Welfare Benefit Plan
Plan Number:	501
Type of Plan:	Welfare benefit plan providing 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 elsewhere in this summary, purchased with contributions by the Participating Employers and with specified Employee contributions, as applicable.
Type of Administration:	Some benefits under the Plan are insured by one or more insurance companies. The third-party administrators and/or insurance companies are listed in the Appendix at the back of this booklet.
Agent for Legal Process:	Service of legal process may be made upon the Plan Administrator.

IMPORTANT NOTICE

This document (and the booklets and certificates it incorporates by reference) is only a summary of your Plan. The actual Plan document and, particularly the Component Program documents it incorporates by reference, and any appendices to those documents, set forth your rights and obligations under the Plan (unless those documents purport to merely summarize those benefits). In the event this summary is in any way ambiguous or inconsistent with the terms of the actual Plan document or one or more Component Program documents that the Plan incorporates by reference, those documents control over this summary.

APPENDIX
OF
CLAIM ADMINISTRATORS AND INSURERS

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

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

Group Long-Term Disability Benefits

Benefits provided under an insured arrangement with:

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

Group Short-Term Disability Benefits

Benefits provided under an insured arrangement with:

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

Group Term Life Insurance Benefits

Benefits provided under an insured arrangement with:

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

Group Accidental Death and Dismemberment Benefits

Benefits provided under an insured arrangement with:

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