

**SOUTHEASTERN UNIVERSITIES
RESEARCH ASSOCIATION,
INC./JEFFERSON LAB**

**COMPREHENSIVE HEALTH AND
WELFARE BENEFIT PLAN**

Summary Plan Description

**As Amended and Restated
Effective April 1, 2004**

YOUR SUMMARY PLAN DESCRIPTION

This document is the principal document, but only one of several documents, that comprise the “summary plan description” of your Southeastern Universities Research Association, Inc./Jefferson Lab 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./Jefferson Lab. 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./Jefferson Lab:

Southeastern Universities Research Association, Inc./Jefferson Lab 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
Group Universal Life Voluntary Program

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 Southeastern Universities Research Association, Inc./Jefferson Lab 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:

- Southeastern Universities Research Association, Inc./Jefferson Lab Comprehensive Medical Benefit Program
- Southeastern Universities Research Association, Inc./Jefferson Lab Dental Benefit Program
- Southeastern Universities Research Association, Inc./Jefferson Lab Long-Term Disability Benefit Program
- Southeastern Universities Research Association, Inc./Jefferson Lab Short-Term Disability Benefit Program
- Southeastern Universities Research Association, Inc./Jefferson Lab Group Term Life Insurance Benefit Program
- Southeastern Universities Research Association, Inc./Jefferson Lab Accidental Death and Dismemberment Insurance Benefit Program
- Southeastern Universities Research Association, Inc. Group Universal Life Voluntary 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 Compensation And Benefits Department 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 Southeastern Universities Research Association, Inc./Jefferson Lab 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 Compensation And Benefits Department 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

Southeastern Universities Research Association, Inc. Group Universal Life Voluntary Program

Employee Eligibility Classification: All Employees who work at least 50% of full-time hours

Employee Effective Date: Date of hire

Dependent Effective Date: Date of Employee's hire date

Coverage Termination Date: End of period for which premiums paid

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 Compensation And Benefits Department 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 Compensation And Benefits Department 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 Compensation And Benefits Department) 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:

- Southeastern Universities Research Association, Inc./Jefferson Lab Comprehensive Medical Benefit Program
- Southeastern Universities Research Association, Inc./Jefferson Lab 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

Dental benefits:
The Plan Administrator

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 Southeastern Universities Research Association, Inc./Jefferson Lab, 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:

Benefits Administrator
12000 Jefferson Lab
Newport News, VA 23606
(757) 269-7608

Dental coverage:

Benefits Administrator
12000 Jefferson Lab
Newport News, VA 23606
(757) 269-7608

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 **18 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 Southeastern Universities Research Association, Inc./Jefferson Lab Compensation And Benefits Department for additional information. You must contact the Compensation And Benefits Department 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 Southeastern Universities Research Association, Inc./Jefferson Lab Compensation And Benefits Department 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
- Group life voluntary 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 Compensation And Benefits Department 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 Compensation And Benefits Department.

Procedures for Obtaining Health Care Services

As a general rule, 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 Southeastern Universities Research Association, Inc./Jefferson Lab 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 a reasonable time before the coverage for treatments will stop; however, the Claimant does not have 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
- Group Universal Life Voluntary Program 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 suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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:	Southeastern Universities Research Association, Inc./Jefferson Lab 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 Group life voluntary program.
Plan Year:	12-month period beginning April 1 and ending March 31.
Plan Sponsor:	Southeastern Universities Research Association, Inc./Jefferson Lab 12000 Jefferson Avenue Newport News, VA 23606 (757) 269-7068 Employer ID No.: 54-1156453
Plan Administrator:	Southeastern Universities Research Association, Inc./Jefferson Lab 12000 Jefferson Avenue Newport News, VA 23606 (757) 269-7068
Named Fiduciary:	Compensation and Benefits Manager
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 -Southeastern Universities Research Association,
Inc. Health Care Program**

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 - Southeastern Universities Research Association, Inc. Dental
Insurance Program**

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 - Southeastern Universities Research Association,
Inc. Long Term Disability Program**

Benefits provided under an insured arrangement with:

Life Insurance Company Of North America
1601 Chestnut Street
Philadelphia, PA 19192-2235
(800) 732-1603

Group Short-Term Disability Benefits - Southeastern Universities Research Association, Inc. Short Term Disability Program

Benefits provided under an insured arrangement with:

Life Insurance Company Of North America
1601 Chestnut Street
Philadelphia, PA 19192-2235
(800) 732-1603

Group Term Life Insurance Benefits - Southeastern Universities Research Association, Inc. Life Insurance Program

Benefits provided under an insured arrangement with:

Life Insurance Company Of North America
1601 Chestnut Street
Philadelphia, PA 19192-2235
(800) 732-1603

Group Accidental Death and Dismemberment Benefits - Southeastern Universities Research Association, Inc. Accidental Death & Dismemberment Program

Benefits provided under an insured arrangement with:

Life Insurance Company Of North America
1601 Chestnut Street
Philadelphia, PA 19192-2235
(800) 732-1603

Group Life Voluntary Program - Southeastern Universities Research Association, Inc. Group Universal Life Voluntary Program

Benefits provided under an insured arrangement with:

Life Insurance Company Of North America
1601 Chestnut Street
Philadelphia, PA 19192-2235
(800) 732-1603

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

This Notice 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:

- Southeastern Universities Research Association, Inc./Jefferson Lab comprehensive medical benefit program
- Southeastern Universities Research Association, Inc./Jefferson Lab dental benefit program

This notice generally explains COBRA continuation coverage, when it may become available, and what one needs to do to protect the right to receive it. This notice 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 the Employer. 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

Dental benefits:

The Plan Administrator

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 Southeastern Universities Research Association, Inc./Jefferson Lab, 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:

Benefits Administrator
12000 Jefferson Lab
Newport News, VA 23606
(757) 269-7608

Dental coverage:

Benefits Administrator
12000 Jefferson Lab
Newport News, VA 23606
(757) 269-7608

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 **18 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 Southeastern Universities Research Association, Inc./Jefferson Lab Compensation And Benefits Department for additional information. You must contact the Compensation And Benefits Department 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 Southeastern Universities Research Association, Inc./Jefferson Lab Compensation And Benefits Department 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.

Insurance premiums:

SURA/Jlab pays 75% of the medical and dental premiums. Current costs:

BlueCare Plan

Employee Only	\$244.52
Employee + 1 minor	\$353.68
Employee + Spouse	\$511.14
Family	\$668.64

KeyCare PPO

Employee Only	\$244.56
Employee + minor	\$353.68
Employee + Spouse	\$511.17
Family	\$668.68

VA HealthKeepers HMO

Employee Only	\$202.53
Employee + 1 minor	\$292.50
Employee + Spouse	\$422.70
Family	\$552.60

Optima Health Plan HMO

Employee	\$201.61
Employee + 1 minor	\$292.95
Employee + Spouse	\$423.21
Family	\$554.77

Delta Dental

Self Only	\$29.57
Self Plus 1 minor/Spouse	\$49.96
Family	\$79.94

**SURA/Jefferson Lab
Defined Contribution Retirement Plan
403(b)**

Summary Plan Description

Restated as of January 1, 2004

This document provides each Participant with a description of the Institution's
Defined Contribution Retirement Plan

Table of Contents

Part I: Information About The Plan.	4
Part II: Information About The Fund Sponsors.	11
Part III: Additional Information	14

This summary was prepared for participants in the **SURA/Jefferson Lab Defined Contribution Retirement Plan**. If there is any ambiguity or inconsistency between this summary and the Plan Document, the terms of the Plan Document will govern. With respect to benefits provided by TIAA-CREF annuity contracts or certificates, all rights of a participant under the contracts or certificates will be determined only by the terms of such contracts or certificates.

Employer Identification Number: 54-1156453
Plan Number: 001

1. What is the SURA/Jefferson Lab Retirement Plan?
2. Who is eligible to participate in the Plan?
3. When do I become eligible to participate in the Plan?
4. What contributions will be made?
5. Is there a limit on contributions?
6. Do contributions continue during a paid leave of absence?
7. Do contributions continue while I'm on active duty in the Armed Forces?
8. When do my plan contributions become vested (i.e., owned by me)?
9. How are years of service counted?
10. What is the normal retirement age under the Plan?
11. When does my retirement income begin?
12. What options are available for receiving retirement income?
13. What are my spouse's rights under this plan to survivor benefits?
14. Is there a way I can receive income while preserving my accumulation?
15. May I receive a portion of my income in a single payment after termination of employment?
16. May I receive benefits for a fixed-period after termination of employment?
17. May I receive a cash withdrawal from the Plan after termination of employment?
18. If I only have a small accumulation in my TIAA-CREF contracts after termination of employment, may I "repurchase" my accumulation and receive it in a single sum?
19. May I receive a cash withdrawal from the Plan while still employed?
20. May I receive benefits while still employed if I become disabled?
21. May I receive a cash withdrawal while still employed if I incur a hardship?
22. May I roll over my accumulations?
23. What if I die before starting to receive benefits?
24. What fund sponsors and funding vehicles are available under the Plan?
25. How do the retirement contracts work?
26. How do I allocate my contributions?
27. May I transfer my accumulations?
28. May I begin my retirement income at different times?
29. May I receive my retirement accumulations under different income options?
30. What information do I regularly receive about my contracts?
31. How is the Plan administered?
32. May the terms of the Plan be changed?
33. How do I get more information about the Plan?
34. What is the Plan's claims procedure?
35. What are my rights under Law?
36. Is the Plan insured by the Pension Benefit Guaranty Corporation (PBGC)?
37. Who is the agent for service of legal process?

Part I: Information About The Plan

1. What is the SURA/Jefferson Lab Retirement Plan?

The SURA/Jefferson Lab (the 'Institution') Retirement Plan (the "Plan") is a defined contribution plan that operates under Section 403(b) of the Internal Revenue Code (IRC). The Plan was established on July 1, 1984 and restated as of January 1, 2004. The purpose of the Plan is to provide retirement benefits for participating employees. Benefits are provided through:

A. Teachers Insurance and Annuity Association (TIAA). TIAA provides a traditional annuity and a variable annuity through its real estate account. You can receive more information about TIAA by writing to: TIAA, 730 Third Avenue, New York, NY 10017. You also can receive information by calling 1 800 842-2733.

B. College Retirement Equities Fund (CREF). CREF is TIAA's companion organization, providing variable annuities. You can receive more information about CREF by writing to: CREF, 730 Third Avenue, New York, NY 10017. You also can receive information by calling 1 800 842-2733.

The Institution is the administrator of the Plan and is responsible for plan operation. The plan year begins on January 1 and ends on December 31.

2. Who is eligible to participate in the Plan?

All eligible employees of the Institution can participate in the Plan. Eligible employee means all employees.

Individuals deemed by the Plan Administrator to be independent contractors are not eligible to participate in the Plan. If an individual is classified as an independent contractor by the Plan Administrator, such individual will be deemed to be ineligible, even if the individual is determined to be a common law employee pursuant to a government audit or litigation.

3. When do I become eligible to participate in the Plan?

If you are an eligible employee, you must as a condition of employment begin participation in this Plan on the first day after you begin employment at the institution.

The enrollment forms must be completed and returned to the Institution. The Institution will notify you when you've completed the requirements needed to participate in the Plan. All determinations about eligibility and participation will be made by the Institution. The Institution will base its determinations on its records and the official plan document on file with the plan administrator.

You will continue to be eligible for the plan until one of the following conditions occur:

- you cease to be an eligible employee;
- the plan is terminated.

4. **What contributions will be made?**

When you begin participation in the Plan, contributions will be made automatically to the funding vehicles that you've chosen. The contributions are based on a percentage of your compensation, according to the schedule shown below. If you participate in the Plan for only a part of a year, your allocation will be based on the portion of compensation earned during the period in which you participate. Plan contributions by you must be made on a before-tax (salary reduction) basis as a condition of employment.

Plan contributions made by you on a before-tax basis will be made under a written salary reduction agreement with the Institution. Under the agreement, your salary paid after the agreement is signed is reduced and the amount of the reduction is applied as premiums to one or more of the funding vehicles you select that are available under this Plan. You may terminate your salary reduction agreement at any time. Your ability to modify your agreement may be subject to such reasonable restrictions as established by the Plan Administrator. The salary reduction agreement will be legally binding and irrevocable with respect to salary paid while the agreement is in effect.

Plan Contributions as a Percentage of Compensation

By the <u>Institution:</u>	<u>By You:</u>
10%	5%

Compensation means the basic annual earnings excluding overtime pay, bonuses, and any other forms of supplemental remuneration. It also includes compensation that is not currently includable in your gross income because of the application of IRC Sections 125, 457(b), 132(f)(4) or 403(b) through a salary reduction agreement.

Compensation taken into account under the Plan cannot exceed the limits of IRC Section 401(a)(17). The limit under Section 401(a)(17) for 2002 is \$200,000. This limit is adjusted by the Internal Revenue Service for increases in cost-of-living.

5. **Is there a limit on contributions?**

Yes. The total amount of contributions made on your behalf for any year will not exceed the limits imposed by IRC Section 415. These limits may be adjusted from time to time. For more information on these limits, contact your plan administrator or fund sponsor.

6. **Do contributions continue during a paid leave of absence?**

During a paid leave of absence, Plan Contributions will continue to be made based on your compensation paid during your leave of absence. No contributions will be made during an unpaid leave of absence.

7. **Do contributions continue while I'm on active duty in the Armed Forces?**

If you are absent from employment by reason of service in the uniformed services of the United States, once you return to actual employment, the Institution will make those contributions to the Plan that would have been made if you had remained employed at the Institution during your period of military service to the extent required by law.

8. **When do my plan contributions become vested (i.e., owned by me)?**

You are fully and immediately vested in the benefits arising from contributions made under this Plan. Such amounts are non-forfeitable.

9. **How are years of service counted?**

You are credited with a year of service for each 12-month period (computation period) during which you complete 1,000 or more hours of service.

Hours of service will be determined on the basis of actual hours that you are paid or entitled to payment.

10. **What is the normal retirement age under the Plan?**

The normal retirement age under the Plan is age 65. Annuity income usually begins on the first of the month following that date.

11. **When does my retirement income begin?**

Although income usually begins at normal retirement age, you may begin to receive annuity income at any time, which may be either earlier or later than the normal retirement age.

Retirement benefits must normally begin no later than April 1 of the calendar year following the year in which you attain age 70 ½ or, if later, April 1 following the calendar year in which you retire. Failure to begin annuity income by the required beginning date may subject you to a substantial federal tax penalty.

If you die before the distribution of benefits has begun, your entire interest must normally be distributed by December 31 of the fifth calendar year after your death. Under a special rule, death benefits may be payable over the life or life expectancy of a designated beneficiary if the distribution of benefits begins not later than December 31 of the calendar year immediately

following the calendar year of your death. If the designated beneficiary is your spouse, the commencement of benefits may be deferred until December 31 of the calendar year that you would have attained age 70 ½ had you continued to live.

The payment of benefits according to the above rules is extremely important. Federal tax law imposes a 50 percent excise tax on the difference between the amount of benefits required by law to be distributed and the amount actually distributed if it is less than the required minimum amount.

Your fund sponsor will normally contact you several months before the date you scheduled your benefits to begin on your application. You may decide, however, to begin receiving income sooner, in which case you should notify the fund sponsor in advance of that date. Usually, the later you begin to receive payments, the larger each payment will be.

12. **What options are available for receiving retirement income?**

You may choose from among several income options when you retire. However, if you're married, your right to choose an income option will be subject to your spouse's right (under federal pension law) to survivor benefits as discussed in the next question, unless this right is waived by you and your spouse. The following income options are available:

A Single Life Annuity. This option pays you an income for as long as you live, with payments stopping at your death. A single life annuity provides you with a larger monthly income than other options. This option is also available with a 10, 15, or 20 year guaranteed payment period (but not exceeding your life expectancy at the time you begin annuity income). If you die during the guaranteed period, payments in the same amount that you would have received continue to your beneficiary(ies) for the rest of the guaranteed period.

A Survivor Annuity. This option pays you a lifetime income, and if your annuity partner lives longer than you, he or she continues to receive an income for life. The amount continuing to the survivor depends on which of the following three options you choose:

- *Two-thirds Benefit to Survivor.* At the death of either you or your annuity partner, the payments are reduced to two-thirds the amount that would have been paid if both had lived, and are continued to the survivor for life.
- *Full Benefit to Survivor.* The full income continues as long as either you or your annuity partner is living.
- *Half Benefit to Second Annuitant.* The full income continues as long as you live. If your annuity partner survives you, he or she receives, for life, one-half the income you would have received if you had lived. If your annuity partner dies before you, the full income continues to you for life.

All survivor annuities are available with a 10, 15, or 20 year guaranteed period, but not exceeding the joint life expectancies of you and your annuity partner. The period may be limited by federal tax law.

A Minimum Distribution Option (MDO). The MDO enables participants to automatically comply with federal tax law distribution requirements. With the MDO, you'll receive the minimum distribution that is required by federal tax law while preserving as much of your accumulation as possible. The minimum distribution will be paid to you annually unless you elect otherwise. This option is generally available in the year you attain age 70 ½ or retire, if later.

13. **What are my spouse's rights under this plan to survivor benefits?**

If you are married and benefits commenced before your death, your surviving spouse will continue to receive income that is at least half of the annuity income payable during the joint lives of you and your spouse (joint and survivor annuity). If you die before annuity income begins, your surviving spouse will receive a benefit that is at least half of the full current value of your annuity accumulation, payable in a single sum or under one of the income options offered by the fund sponsor (pre-retirement survivor annuity).

If you are married, benefits must be paid to you as described above, unless your written waiver of the benefits and your spouse's written consent to the waiver is filed with the fund sponsor on a form approved by the fund sponsor.

A waiver of the joint and survivor annuity may be made only during the 90-day period before the commencement of benefits. The waiver also may be revoked during the same period. It may not be revoked after annuity income begins.

The period during which you may elect to waive the pre-retirement survivor benefit begins on the first day of the plan year in which you attain age 35. The period continues until the earlier of your death or the date you start receiving annuity income. If you die before attaining age 35—that is, before you've had the option to make a waiver—at least half of the full current value of the annuity accumulation is payable automatically to your surviving spouse in a single sum, or under one of the income options offered by the fund sponsor. If you terminate employment before age 35, the period for waiving the pre-retirement survivor benefit begins no later than the date of termination. The waiver also may be revoked during the same period.

All spousal consents must be in writing and either notarized or witnessed by a plan representative and contain an acknowledgment by your spouse as to the effect of the consent. All such consents shall be irrevocable. A spousal consent is not required if you can establish to the institution's satisfaction that you have no spouse or that he or she cannot be located. Unless a Qualified Domestic Relations Order (QDRO), as defined in Code Section 414(p), requires otherwise, your spouse's consent shall not be required if you are legally separated or you have been abandoned (within the meaning of local law) and you have a court order to such effect.

The spousal consent must specifically designate the beneficiary or otherwise expressly permit designation of the beneficiary by you without any further consent by your spouse. If a designated beneficiary dies, unless the express right to designate a new one has been consented to, a new consent is necessary.

14.

A consent to an alternative form of benefit must either specify a specific form or expressly permit designation by you without further consent.

A consent is only valid so long as your spouse at the time of your death, or earlier benefit commencement, is the same person as the one who signed the consent.

If a QDRO establishes the rights of another person to your benefits under this Plan, then payments will be made according to that order. A QDRO may preempt the usual requirements that your spouse be considered your primary beneficiary for a portion of the accumulation. Participants and beneficiaries can obtain, without charge, a copy of the plan's procedures governing QDRO determinations from the Plan Administrator.

15. **Is there a way I can receive income while preserving my accumulation?**

Yes, subject to your spouse's right to survivor benefits, for TIAA participants between ages 55 and 69 ½ with a TIAA Traditional Annuity accumulation of at least \$10,000. Under the TIAA Interest Payment Retirement Option (IPRO), you will receive monthly payments equal to the interest (guaranteed plus dividends) that would otherwise be credited to your TIAA Traditional Annuity. Payments will be made at the end of each month. Your accumulation is not reduced while you are receiving interest payments.

Payments under the IPRO will consist of the contractual interest rate (currently 3 percent), plus dividends as declared by TIAA's Board of Trustees. Dividends are declared each March for the following 12-month period and are not guaranteed after the 12-month period has expired. If you elect the IPRO, these rates will be used to determine your monthly payment rather than be credited to your annuities.

Interest payments made under the IPRO must continue for at least 12 months. Once you start receiving interest income payments, you must continue receiving them until you begin receiving your accumulation under an annuity income option. Usually, you may delay beginning your annuity income benefits as late as permitted under federal law. When you do begin annuity income from your TIAA Traditional Annuity accumulation, you may choose any of the lifetime annuity income options available under your TIAA contract.

If you die while receiving interest payments under the IPRO, your beneficiary will receive the amount of your starting accumulation, plus interest earned but not yet paid. If you die after you've begun receiving your accumulation as an annuity, your beneficiary will receive the benefits provided under the annuity income option you've selected.

16. **May I receive a portion of my income in a single payment after termination of employment?**

Yes, subject to your spouse's right to survivor benefits, you may receive a portion of your income in a single sum after termination of employment if you choose the Retirement Transition Benefit option. This option lets you receive a one-sum payment of up to 10 percent of your TIAA and CREF accumulations at the time you start to receive your income as an annuity. The

one-sum payment cannot exceed 10 percent of each account's accumulation then being converted to annuity payments.

17. May I receive benefits for a fixed-period after termination of employment?

Yes, subject to your spouse's right to survivor benefits, you may receive benefits for a fixed-period after termination of employment. For your CREF and TIAA Real Estate Account accumulations, the fixed-period option pays you an income over a fixed-period of between two and 30 years. For your TIAA Traditional Annuity accumulations, you may receive benefits over a 10-year period under the Transfer Payout Annuity (TPA). At the end of the selected period, all benefits will end. If you die during the period, payments will continue in the same amount to your beneficiary for the duration.

Tax law requires that the period you choose not exceed your life expectancy or the joint life expectancy of you and your beneficiary.

18. May I receive a cash withdrawal from the Plan after termination of employment?

Yes, subject to your spouse's right to survivor benefits, you may receive all of your CREF and TIAA Real Estate Account accumulations as a cash withdrawal after you terminate employment. TIAA Traditional Annuity accumulations may be received only through the Transfer Payout Annuity (TPA), in substantially equal annual payments over a period of 10 years after you terminate employment. Payments made under the TPA are subject to the terms of that contract.

You can elect to receive your cash withdrawal of CREF and TIAA Real Estate Account accumulations through a series of systematic payments using TIAA-CREF's Systematic Withdrawal service. This service allows you to specify the amount and frequency of payments. Currently, the initial amount must be at least \$100 per account. Once payments begin, they will continue for the period you specify. You can change the amount and frequency of payments, as well as stop and restart payments as your needs dictate. There is no charge for this service.

19. If I only have a small accumulation in my TIAA-CREF contracts after termination of employment, may I "repurchase" my accumulation and receive it in a single sum?

Yes, subject to your spouse's right to survivor benefits, you may "repurchase" your TIAA-CREF Retirement Annuities (RAs) in a single sum provided you have terminated employment. In addition, all of the following conditions must apply at the time you request a repurchase:

1. The total TIAA Traditional Annuity accumulation in all your RAs (including contributions to RAs under plans of other employers) is \$2,000 or less.
2. You don't have a TIAA Transfer Payout Annuity (TPA).

Amounts paid to you upon repurchase will be in full satisfaction of your rights and your spouse's rights to retirement or survivor benefits from TIAA-CREF on such amounts.

Also, as explained earlier, you may elect to receive a cash withdrawal of your CREF and TIAA

Real Estate Account accumulations when you terminate employment from the Institution.

20. **May I receive a cash withdrawal from the Plan while still employed?**

Yes, subject to your spouse's right to survivor benefits, you may receive a cash withdrawal of annuity contract accumulations while employed by the Institution if you are age 59 ½ or older. However, except for the requirement that you terminate employment, all other conditions described in the question "May I receive a cash withdrawal from the Plan after termination of employment?" will apply.

21. **May I receive benefits while still employed if I become disabled?**

You may receive benefits before you terminate employment if you become disabled. You'll be considered disabled if you're unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to be of long-continued and indefinite duration. You won't be considered disabled unless you provide proof of the existence of your disability in a form and manner that the Plan administrator may require.

22. **May I receive a cash withdrawal while still employed if I incur a hardship?**

Yes. If you incur a hardship before you terminate employment, you may receive a lump-sum cash payment, subject to the restrictions of the funding vehicle.

Hardship distributions will be permitted only if you incur a immediate and heavy financial need and the distribution is necessary to meet the financial need. To be considered for a hardship distributions, you'll need to complete an application form and supply supporting documentation required by the Plan administrator.

23. **May I roll over my accumulations?**

If you're entitled to receive a distribution from your contract which is an eligible "rollover distribution," you may roll over all or a portion of it either directly or within 60 days after receipt into another Section 403(b) retirement plan or into an IRA. An eligible rollover distribution, in general, is any cash distribution other than an annuity payment, a minimum distribution payment, a payment which is part of a fixed period payment over ten or more years; or distributions made on account of hardship. The distribution will be subject to a 20 percent federal withholding tax unless it's rolled over directly into another retirement plan or into an IRA, this process is called a "direct" rollover.

If you have the distribution paid to you, then 20 percent of the distribution must be withheld even if you intend to roll over the money into another retirement plan or into an IRA within 60 days. To avoid withholding, instruct the fund sponsor to directly roll over the money for you.

24. **What if I die before starting to receive benefits?**

If you die before beginning retirement benefits, the full current value of your annuity accumulation is payable as a death benefit. You may choose one or more of the options listed in your annuity contracts for payment of the death benefit, or you may leave the choice to your beneficiary. The payment options include:

- Income for the lifetime of the beneficiary with payments ceasing at his or her death.
- Income for the lifetime of the beneficiary, with a minimum period of payments of either 10, 15, or 20 years, as selected.
- Income for a fixed period of not less than two nor more than 30 years for CREF and TIAA Real Estate accumulations, as elected, but not longer than the life expectancy of the beneficiary.
- A single sum payment.
- A minimum distribution option. This option pays the required federal minimum distribution each year.
- The accumulation may be left on deposit, for up to one year, for later payment under any of the options.

Federal tax law puts limitations on when and how beneficiaries receive their death benefits. TIAA-CREF will notify your beneficiary of the applicable requirements at the time he or she applies for benefits.

You should review your beneficiary designation periodically to make sure the person you want to receive the benefits is properly designated. You may change your beneficiary by completing the "Designation of Beneficiary" form available from TIAA-CREF. If you die without having named a beneficiary and you are married at the time of your death, your spouse will automatically receive half of your accumulation. Your estate will receive the other half. If you're not married, your estate receives the entire accumulation.

In addition, see the answer to the question "What are my spouse's rights under this plan to survivor benefits?" for a discussion of your spouse's rights to a survivor benefit if you are married at the time of your death.

Part II: Information About The Fund Sponsors

25. What fund sponsors and funding vehicles are available under the Plan?

Contributions may be invested in one or more of the following fund sponsors and their funding vehicles that are currently available under this Plan:

A. Teachers Insurance and Annuity Association (TIAA):

TIAA Retirement Annuity (RA)

Traditional Annuity
Real Estate Account

B. College Retirement Equities Fund (CREF):

CREF Retirement Unit-Annuity (RA)

Stock Account
Money Market Account
Bond Market Account
Social Choice Account
Global Equities Account
Growth Account
Equity Index Account
Inflation-Linked Bond Account

Any additional Accounts offered by TIAA-CREF will automatically be made available to you under this plan unless the Institution elects otherwise.

The Institution's current selection of fund sponsors and funding vehicles isn't intended to limit future additions or deletions of fund sponsors and funding vehicles. You'll be notified of any additions or deletions.

26. How do the retirement contracts work?

TIAA Traditional Annuity: Contributions to the TIAA Traditional Annuity are used to purchase a contractual or guaranteed amount of future retirement benefits for you. Once purchased, the guaranteed benefit of principal plus interest cannot be decreased, but it can be increased by dividends. Once you begin receiving annuity income, your accumulation will provide an income consisting of the contractual, guaranteed amount plus dividends that are declared each year and which are not guaranteed for the future. Dividends may increase or decrease, but changes in dividends are usually gradual. For a recorded message of the current interest rate for

contributions to the TIAA Traditional Annuity, call the Automated Telephone Service (ATS) at 1 800 842-2252. The ATS is available 24 hours a day, seven days a week.

CREF and the TIAA Real Estate Account: You have the flexibility to accumulate retirement benefits in any of the CREF variable annuity accounts approved for use under the Plan, as indicated above, and the TIAA Real Estate Account. Each account has its own investment objective and portfolio of securities. Contributions to a CREF account and the TIAA Real Estate Account are used to buy accumulation units, or shares of participation in an underlying investment portfolio. The value of the Accumulation Units changes each business day. You may also choose to receive annuity income under any of the CREF accounts and the TIAA Real Estate Account. There is no guaranteed baseline income or declared dividends when you receive annuity income from these accounts. Instead, your income is based on the value of the annuity units you own, a value that changes yearly, up or down. For more information on the CREF accounts, you should refer to the CREF prospectus. For more information about the TIAA Real Estate Account, refer to the TIAA Real Estate Account prospectus.

For a recorded message of the latest accumulation unit values for the CREF Accounts and the TIAA Real Estate Account, as well as the seven-day yield for the CREF Money Market Account, call the ATS at 1 800 842-2252. The recording is updated each business day.

27. How do I allocate my contributions?

You may allocate contributions among the TIAA Traditional Annuity, the TIAA Real Estate Account, and the CREF Accounts in any whole-number proportion, including full allocation to any Account. You specify the percentage of contributions to be directed to the TIAA Traditional Annuity, the TIAA Real Estate Account, and/or the CREF Accounts on the "Application for TIAA-CREF Retirement Annuity Contracts" when you begin participation. You may change your allocation of future contributions after participation begins by writing to TIAA-CREF's home office at 730 Third Avenue, New York, New York 10017, by phone using TIAA-CREF's Automated Telephone Service (ATS) toll free at 1 800 842-2252, or via the Internet using TIAA-CREF's Account Access System at www.tiaa-cref.org. However, TIAA-CREF reserves the right to suspend or terminate participants' right to change allocations by phone or the Internet. When you receive your contract, you'll also be sent a Personal Identification Number (PIN). The PIN enables you to change your allocation by using the ATS or the Internet. For more information on allocations, ask for the TIAA-CREF booklet Building Your Portfolio.

28. May I transfer my accumulations?

Accumulations may be transferred among the CREF accounts and the TIAA Real Estate Account. Accumulations in the CREF Accounts and the TIAA Real Estate Account also may be transferred to the TIAA Traditional Annuity. Partial transfers may be made from a CREF Account or the TIAA Real Estate Account to the TIAA Traditional Annuity, or among the CREF accounts and the TIAA Real Estate Account, as long as at least \$1,000 is transferred each time. There's no charge for transferring accumulations in the TIAA-CREF system, but TIAA-CREF reserves the right to limit transfer frequency.

TIAA Traditional Annuity accumulations may be transferred to any of the CREF accounts and the TIAA Real Estate Account through the Transfer Payout Annuity (TPA). Transfers will be made in substantially equal annual amounts over a period of 10 years. Transfers made under the TPA contract are subject to the terms of that contract. The minimum transfer from the TIAA Traditional Annuity to a CREF account or the TIAA Real Estate Account is \$10,000 (or the entire accumulation if it totals less than \$10,000). However, if your total TIAA Traditional Annuity accumulation is \$2,000 or less, you can transfer your entire TIAA Traditional Annuity accumulation in a single sum to any of the CREF accounts or the TIAA Real Estate Account, as long as you do not have an existing TIAA TPA contract in force. TIAA-CREF reserves the right to limit transfer frequency.

You may complete transfers within the TIAA-CREF system either by phone, the Internet, or in writing. CREF, and TIAA Real Estate Account transfers, as well as premium allocation changes, will be effective as of the close of the New York Stock Exchange (usually 4:00 p.m. Eastern time) generally, on the day the instructions are received by TIAA-CREF, unless you choose the last day of the current month or any future month. Instructions received after the close of the New York Stock Exchange are effective as of the close of the Stock Exchange on the next business day. The toll-free number to reach the ATS is 1 800 842-2252. The Account Access System is accessible on the Internet at www.tiaa-cref.org.

29. May I begin my retirement income at different times?

Yes. Once you decide to receive your benefits as income, you have the flexibility to begin income from the TIAA Traditional Annuity, the TIAA Real Estate Account, and CREF accounts on different dates. You may begin income from each CREF account, the TIAA Real Estate Account, on more than one date provided you begin income from at least \$10,000 of accumulation in that account.

30. May I receive my retirement accumulations under different income options?

Yes, under current administrative practice, you can elect to receive income from your TIAA and CREF annuities under more than one income option to meet your specific retirement needs. However, you must begin income from at least \$10,000 of accumulation under each option.

31. What information do I regularly receive about my contracts?

Each year, you will receive an annual Annual Retirement Planner from TIAA-CREF that shows the total accumulation value at year-end for your contracts. This is the amount of death benefits your spouse or other beneficiary would have received on that date. It also includes an illustration of the annuity income you would receive at retirement under certain stated assumptions as to future premiums, your retirement age, the income option and payment method selected, TIAA Traditional Annuity dividends, and the investment experience of, the TIAA Real Estate Account, and the CREF accounts. These factors affect the amount of your retirement income.

TIAA-CREF also sends you a Quarterly Review. This report shows the accumulation totals, a summary of transactions made during the period, TIAA interest credited, and the number and value of, the TIAA Real Estate Account and CREF account accumulation units. You also may receive Premium Adjustment Notices. These notices summarize any adjustments made to your annuities and are sent at the time the adjustments are processed.

And once a year, you'll receive the TIAA-CREF Annual Report. The Annual Report summarizes the year's activity, including details on TIAA and CREF investments, earnings, and investment performance.

Part III: Additional Information

32. **How is the Plan administered?**

Benefits under the plan are provided by annuity contracts. The Institution has been designated the Plan Administrator. The Plan Administrator is responsible for enrolling participants, forwarding Plan contributions for each participant to the fund sponsors selected, and performing other duties required for operating the Plan.

33. **May the terms of the Plan be changed?**

While it's expected that the Plan will continue indefinitely, the Institution reserves the right to modify or discontinue the Plan at any time. The Institution, by action of its Board, also may delegate any of its power and duties with respect to the Plan or its amendments to one or more officers or other employees of the Institution. Any such delegation shall be stated in writing. The Institution will exercise good faith, apply standards of uniform application, and refrain from arbitrary action.

34. **How do I get more information about the Plan?**

Requests for information about the Plan and its terms, conditions and interpretations including eligibility, participation, contributions, or other aspects of operating the Plan should be in writing and directed to:

SURA/Jefferson Lab
12000 Jefferson Avenue
Newport News, VA 23606

35. **What is the Plan's claims procedure?**

The following rules describe the claims procedure under the Plan:

- *Filing a claim for benefits:* A claim or request for plan benefits is filed when the requirements of a reasonable claim-filing procedure have been met. A claim is considered filed when a written communication is made to:

SURA/Jefferson Lab, 12000 Jefferson Avenue, Newport News, VA 23606

- *Processing the claim:* The Plan Administrator must process the claim within 90 days after the claim is filed. If an extension of time for processing is required, written notice must be given to you before the end of the initial 90-day period. The extension notice must indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render its final decision. In no event can the extension period

- exceed a period of 90 days from the end of the initial 90-day period.
- *Denial of claim:* If a claim is wholly or partially denied, the Plan Administrator must notify you within 90 days following receipt of the claim (or 180 days in the case of an extension for special circumstances). The notification must state the specific reason or reasons for the denial, specific references to pertinent plan provisions on which the denial is based, a description of any additional material or information necessary to perfect the claim, and appropriate information about the steps to be taken if you wish to submit the claim for review. If notice of the denial of a claim is not furnished within the 90/180-day period, the claim is considered denied and you must be permitted to proceed to the review stage.
 - *Review procedure:* You or your duly authorized representative has at least 60 days after receipt of a claim denial to appeal the denied claim to an appropriate named fiduciary or individual designated by the fiduciary and to receive a full and fair review of the claim. As part of the review, you must be allowed to review all plan documents and other papers that affect the claim and must be allowed to submit issues and comments and argue against the denial in writing.
 - *Decision on review:* The Plan must conduct the review and decide the appeal within 60 days after the request for review is made. If special circumstances require an extension of time for processing (such as the need to hold a hearing if the plan procedure provides for such a hearing), you must be furnished with written notice of the extension, which can be no later than 120 days after receipt of a request for review. The decision on review must be written in clear and understandable language and must include specific reasons for the decision as well as specific references to the pertinent plan provisions on which the decision is based. For a Plan with a committee or board of trustees designated as the appropriate named fiduciary, a decision does not have to be made within the 60-day limit if the committee or board meets at least four times a year (about every 90 days). Instead, it must be made at the first meeting after the request is filed, except that when a request is made less than 30 days before a meeting, the decision can wait until the date of the second meeting following the Plan's receipt of request for review. If a hearing must be held, the committee can wait to decide until the first meeting after the hearing. However, it must notify you and explain the delay, which can be no later than the third meeting of the committee or board following the Plan's receipt of the request for review. If the decision on review is not made within the time limits specified above, the appeal will be considered denied. All interpretations, determinations, and decisions of the reviewing entity with respect to any claim will be its sole decision based upon the Plan documents and will be deemed final and conclusive. If appeal is denied, in whole or in part, however, you have a right to file suit in a state or federal court.

36. **What are my rights under Law?**

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all non-confidential documents governing the Plan, including insurance contracts 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 Pension and Welfare Benefit Administration.
2. Obtain, without written request to the Plan Administrator, copies of all non-confidential documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
 3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
 4. Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

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 SURA/Jefferson Lab, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA. If your claim for a pension benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U. S. Department of Labor, listed in

your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

37. **Is the Plan insured by the Pension Benefit Guaranty Corporation (PBGC)?**

No. Since the Plan is a defined contribution plan, it isn't insured by the PBGC. The PBGC is the government agency that guarantees certain types of benefits under covered plans.

38. **Who is the agent for service of legal process?**

The agent for service of legal process is:

SURA/Jefferson Lab, 12000 Jefferson Avenue, Newport News, VA 23606.

**SURA/Jefferson Lab
Tax-Deferred Annuity Plan
(GSRA)**

Summary Plan Description

Restated as of January 1, 2004

This document provides each Participant with a description of the Institution's
Tax-Deferred Annuity Plan

Table of Contents

Part I: Information About The Plan.	4
Part II: Information About The Fund Sponsors.	11
Part III: Additional Information	14

This summary was prepared for participants in the **SURA/Jefferson Lab Tax-Deferred Annuity Plan**. If there is any ambiguity or inconsistency between this summary and the Plan Document, the terms of the Plan Document will govern. With respect to benefits provided by TIAA-CREF annuity contracts or certificates, all rights of a participant under the contracts or certificates will be determined only by the terms of such contracts or certificates.

Employer Identification Number: 54-1156453
Plan Number: 002

1. What is the SURA/Jefferson Lab Tax-Deferred Annuity (TDA) Plan?
2. Who is eligible to participate in the Plan?
3. When do I become eligible to participate in the Plan?
4. What contributions will be made?
5. Is there a limit on contributions?
6. Do contributions continue during a paid leave of absence?
7. Do contributions continue while I'm on active duty in the Armed Forces?
8. When do my plan contributions become vested (i.e., owned by me)?
9. When may I begin receiving benefits?
10. What options are available for receiving retirement income?
11. What are my spouse's rights under this plan to survivor benefits?
12. May I receive benefits for a fixed-period after termination of employment?
13. May I receive a cash withdrawal from the Plan after termination of employment?
14. May I receive a cash withdrawal from the Plan while still employed?
15. May I receive a cash withdrawal while still employed if I incur a hardship?
16. May I take a loan from the Plan?
17. May I roll over my accumulations?
18. What if I die before starting to receive benefits?
19. What fund sponsors and funding vehicles are available under the Plan?
20. How do the retirement contracts work?
21. How do I allocate my contributions?
22. May I transfer my accumulations?
23. May I begin my retirement income at different times?
24. May I receive my retirement accumulations under different income options?
25. What information do I regularly receive about my contracts?
26. How is the Plan administered?
27. May the terms of the Plan be changed?
28. How do I get more information about the Plan?
29. What is the Plan's claims procedure?
30. What are my rights under Law?
31. Is the Plan insured by the Pension Benefit Guaranty Corporation (PBGC)?
32. Who is the agent for service of legal process?

Part I: Information About The Plan

1. What is the SURA/Jefferson Lab Tax-Deferred Annuity (TDA) Plan?

The SURA/Jefferson Lab (the 'Institution') TDA Plan (the "Plan") is a defined contribution plan that operates under Section 403(b) of the Internal Revenue Code (IRC). The Plan was established on January 1, 1985 and is hereby restated as of January 1, 2004. The Plan is an arrangement allowed under Section 403(b) of the IRC, where employees of tax-exempt organizations can enter into salary reduction agreements with their employers. Under the agreement, a portion of the employee's compensation is applied on a before-tax basis to an annuity contract owned by the employee, rather than being paid directly to the employee. These amounts, together with any earnings, are not subject to federal income tax until they are paid to the employee (or beneficiary) in the form of benefits. Benefits are provided through:

A. Teachers Insurance and Annuity Association (TIAA). TIAA provides a traditional annuity and a variable annuity through its real estate account. You can receive more information about TIAA by writing to: TIAA, 730 Third Avenue, New York, NY 10017. You also can receive information by calling 1 800 842-2733.

B. College Retirement Equities Fund (CREF). CREF is TIAA's companion organization, providing variable annuities. You can receive more information about CREF by writing to: CREF, 730 Third Avenue, New York, NY 10017. You also can receive information by calling 1 800 842-2733.

The Institution is the administrator of the Plan and is responsible for plan operation. The plan year begins on January 1 and ends on December 31.

2. Who is eligible to participate in the Plan?

All eligible employees of the Institution can participate in the Plan. Eligible employee means all employees.

Individuals deemed by the Plan Administrator to be independent contractors are not eligible to participate in the Plan. If an individual is classified as an independent contractor by the Plan Administrator, such individual will be deemed to be ineligible, even if the individual is determined to be a common law employee pursuant to a government audit or litigation.

3. When do I become eligible to participate in the Plan?

If you are an eligible employee, you may begin participation in this Plan on the first of the month following employment at the Institution. To participate in this Plan, you must complete the enrollment forms, as well as a Salary Reduction Agreement, and return them to the Institution.

Participation in this Plan is voluntary. You are not required to join the Plan. If you decide to participate in the Plan, you will continue to be eligible for the plan until (a) you cease to be an eligible employee, (b) the plan is terminated, or (c) you stop contributing to the Plan, whichever occurs first.

4. **What contributions will be made?**

To participate, you must enter into a written salary reduction agreement with the Institution. Under the agreement, your salary paid after the agreement is signed is reduced and the amount of the reduction is applied as premiums to one or more of the funding vehicles you select that are available under this Plan. You may terminate your salary reduction agreement at any time. Your ability to modify your agreement may be subject to such reasonable restrictions as established by the Plan Administrator. The salary reduction agreement will be legally binding and irrevocable with respect to salary paid while the agreement is in effect.

5. **Is there a limit on contributions?**

Yes. The total amount of contributions made on your behalf for any year will not exceed the limits imposed by IRC Section 415. These limits may be adjusted from time to time. For more information on these limits, contact your plan administrator or fund sponsor.

In addition, salary reduction contributions to this Plan will be further limited by the IRC Section 402(g) limit. If you have made salary reduction contributions that exceed the 402(g) limit, you should request a distribution of the excess by notifying the Plan administrator by March 1 of the following year. The excess will be distributed to you by April 15.

6. **Do contributions continue during a paid leave of absence?**

During a paid leave of absence, Plan Contributions will continue to be made in accordance with the salary reduction agreement. No contributions will be made during an unpaid leave of absence.

7. **Do contributions continue while I'm on active duty in the Armed Forces?**

If you are absent from employment by reason of service in the uniformed services of the United States, once you return to actual employment, the Institution will make those contributions to the Plan that would have been made if you had remained employed at the Institution during your period of military service to the extent required by law.

8. **When do my plan contributions become vested (i.e., owned by me)?**

You are fully and immediately vested in the benefits arising from contributions made under this Plan. Such amounts are non-forfeitable.

9. **When may I begin receiving benefits?**

Salary reduction contributions (and any earnings) made to an annuity contract after December 31, 1988, may be withdrawn only when you attain age 59 ½, terminate employment, die, or become disabled. You also may withdraw your contributions (but not earnings credited on or after January 1, 1989) if you encounter hardship.

Retirement benefits must normally begin no later than April 1 of the calendar year following the year in which you attain age 70 ½ or, if later, April 1 following the calendar year in which you retire. Failure to begin annuity income by the required beginning date may subject you to a substantial federal tax penalty.

If you die before the distribution of benefits has begun, your entire interest must normally be distributed by December 31 of the fifth calendar year after your death. Under a special rule, death benefits may be payable over the life or life expectancy of a designated beneficiary if the distribution of benefits begins not later than December 31 of the calendar year immediately following the calendar year of your death. If the designated beneficiary is your spouse, the commencement of benefits may be deferred until December 31 of the calendar year that you would have attained age 70 ½ had you continued to live.

The payment of benefits according to the above rules is extremely important. Federal tax law imposes a 50 percent excise tax on the difference between the amount of benefits required by law to be distributed and the amount actually distributed if it is less than the required minimum amount.

Your fund sponsor will normally contact you several months before the date you scheduled your benefits to begin on your application. You may decide, however, to begin receiving income sooner, in which case you should notify the fund sponsor in advance of that date. Usually, the later you begin to receive payments, the larger each payment will be.

10. **What options are available for receiving retirement income?**

You may choose from among several income options when you retire. However, if you're married, your right to choose an income option will be subject to your spouse's right (under federal pension law) to survivor benefits as discussed in the next question, unless this right is waived by you and your spouse. The following income options are available:

A Single Life Annuity. This option pays you an income for as long as you live, with payments stopping at your death. A single life annuity provides you with a larger monthly income than other options. This option is also available with a 10, 15, or 20 year guaranteed payment period (but not exceeding your life expectancy at the time you begin annuity income). If you die during the guaranteed period, payments in the same amount that you would have received continue to your beneficiary(ies) for the rest of the guaranteed period.

A Survivor Annuity. This option pays you a lifetime income, and if your annuity partner lives longer than you, he or she continues to receive an income for life. The amount continuing to the survivor depends on which of the following three options you choose:

- *Two-thirds Benefit to Survivor.* At the death of either you or your annuity partner, the payments are reduced to two-thirds the amount that would have been paid if both had lived, and are continued to the survivor for life.
- *Full Benefit to Survivor.* The full income continues as long as either you or your annuity partner is living.
- *Half Benefit to Second Annuitant.* The full income continues as long as you live. If your annuity partner survives you, he or she receives, for life, one-half the income you would have received if you had lived. If your annuity partner dies before you, the full income continues to you for life.

All survivor annuities are available with a 10, 15, or 20 year guaranteed period, but not exceeding the joint life expectancies of you and your annuity partner. The period may be limited by federal tax law.

A Minimum Distribution Option (MDO). The MDO enables participants to automatically comply with federal tax law distribution requirements. With the MDO, you'll receive the minimum distribution that is required by federal tax law while preserving as much of your accumulation as possible. The minimum distribution will be paid to you annually unless you elect otherwise. This option is generally available in the year you attain age 70 ½ or retire, if later.

11. **What are my spouse's rights under this plan to survivor benefits?**

If you are married and benefits commenced before your death, your surviving spouse will continue to receive income that is at least half of the annuity income payable during the joint lives of you and your spouse (joint and survivor annuity). If you die before annuity income begins, your surviving spouse will receive a benefit that is at least half of the full current value of your annuity accumulation, payable in a single sum or under one of the income options offered by the fund sponsor (pre-retirement survivor annuity).

If you are married, benefits must be paid to you as described above, unless your written waiver of the benefits and your spouse's written consent to the waiver is filed with the fund sponsor on a form approved by the fund sponsor.

A waiver of the joint and survivor annuity may be made only during the 90-day period before the commencement of benefits. The waiver also may be revoked during the same period. It may not be revoked after annuity income begins.

The period during which you may elect to waive the pre-retirement survivor benefit begins on the first day of the plan year in which you attain age 35. The period continues until the earlier of your death or the date you start receiving annuity income. If you die before attaining age 35-that is, before you've had the option to make a waiver-at least half of the full current value of the annuity accumulation is payable automatically to your surviving spouse in a single sum, or under

one of the income options offered by the fund sponsor. If you terminate employment before age 35, the period for waiving the pre-retirement survivor benefit begins no later than the date of termination. The waiver also may be revoked during the same period.

All spousal consents must be in writing and either notarized or witnessed by a plan representative and contain an acknowledgment by your spouse as to the effect of the consent. All such consents shall be irrevocable. A spousal consent is not required if you can establish to the institution's satisfaction that you have no spouse or that he or she cannot be located. Unless a Qualified Domestic Relations Order (QDRO), as defined in Code Section 414(p), requires otherwise, your spouse's consent shall not be required if you are legally separated or you have been abandoned (within the meaning of local law) and you have a court order to such effect.

The spousal consent must specifically designate the beneficiary or otherwise expressly permit designation of the beneficiary by you without any further consent by your spouse. If a designated beneficiary dies, unless the express right to designate a new one has been consented to, a new consent is necessary.

A consent to an alternative form of benefit must either specify a specific form or expressly permit designation by you without further consent.

A consent is only valid so long as your spouse at the time of your death, or earlier benefit commencement, is the same person as the one who signed the consent.

If a QDRO establishes the rights of another person to your benefits under this Plan, then payments will be made according to that order. A QDRO may preempt the usual requirements that your spouse be considered your primary beneficiary for a portion of the accumulation. Participants and beneficiaries can obtain, without charge, a copy of the plan's procedures governing QDRO determinations from the Plan Administrator.

12. May I receive benefits for a fixed-period after termination of employment?

Yes, subject to your spouse's right to survivor benefits, you may receive benefits for a fixed-period after termination of employment. The fixed-period option pays you an income over a fixed-period of between five and 30 years if you have a GSRA and two and 30 years if you have an SRA. At the end of the selected period, all benefits will end. If you die during the period, payments will continue in the same amount to your beneficiary for the duration.

Tax law requires that the period you choose not exceed your life expectancy or the joint life expectancy of you and your beneficiary.

13. May I receive a cash withdrawal from the Plan after termination of employment?

Yes, subject to your spouse's right to survivor benefits, you may receive all of your TIAA and CREF accumulations as a cash withdrawal after you terminate employment.

You can elect to receive your cash withdrawal through a series of systematic payments using

TIAA-CREF's Systematic Withdrawal service. This service allows you to specify the amount and frequency of payments. Currently, the initial amount must be at least \$100 per account. Once payments begin, they will continue for the period you specify. You can change the amount and frequency of payments, as well as stop and restart payments as your needs dictate. There is no charge for this service.

14. **May I receive a cash withdrawal from the Plan while still employed?**

Yes, subject to your spouse's right to survivor benefits, you may receive a cash withdrawal of salary reduction contributions (and any earnings) made to an annuity contract after December 31, 1988, but only if you are at least age 59 ½, become disabled, or die. You also may withdraw your accumulations while employed if you encounter hardship. See the answer to the question, "May I receive benefits while employed if I incur a hardship?" for details. Annuity contract accumulations credited before January 1, 1989 are not subject to these restrictions and are available for withdrawal at any time. Please keep in mind that, under current tax law, withdrawals received before you are age 59 ½ are generally subject to a 10 percent penalty tax, in addition to ordinary income tax.

15. **May I receive a cash withdrawal while still employed if I incur a hardship?**

Yes. If you incur a hardship before you terminate employment, you may receive a lump-sum cash payment, subject to the restrictions of the funding vehicle.

Hardship distributions will be permitted only if you incur an immediate and heavy financial need and the distribution is necessary to meet the financial need. To be considered for a hardship distribution, you'll need to complete an application form and supply supporting documentation required by the Plan administrator. No earnings credited on or after January 1, 1989 will be available for hardship distributions.

If a hardship distribution is made to you, all employee contributions to any plan maintained by your Institution may be suspended for 6 months after you receive the distribution. As with any withdrawal, you should consult with your tax advisor since there are possible tax consequences.

16. **May I take a loan from the Plan?**

Yes. If you are married at the time you request the loan, your spouse must consent to the loan. The loan will be administered by the applicable fund sponsor. Specific loan provisions for each fund sponsor are described below:

How much you can borrow from TIAA. Generally, the minimum loan amount is \$1,000, and the maximum loan amount is \$50,000. The maximum amount you can borrow may be less, however, depending on two factors: 1) the amount of your GSRA accumulation, and 2) whether you've had any other loans from any of this Institution's plans within the last year.

If you haven't had a plan loan in the previous year, your maximum loan is the least of: 1) \$50,000; or 2) 45 percent of your combined TIAA and CREF GSRA accumulation attributable to participation under this Plan; or 3) 90 percent of your TIAA GSRA Traditional Annuity accumulation attributable to participation under this Plan.

If you've had another loan from any plan of this Institution within the last year, the maximum you can borrow will be reduced by that amount. In addition, if you default on a loan the maximum loan amount will be reduced by the amount in default (plus interest) until TIAA is able to deduct the defaulted amount from your accumulation. Also, if more than one employer contributed to your Annuities, you can only take loans against the amount you accumulated under this Institution's Plan. You should check with your other employers for their rules on loans.

Securing your loan. You have to set aside an amount equal to 110 percent of your loan in your TIAA GSRA Traditional Annuity accumulation as security for your loan. The security will continue to earn guaranteed interest as well as dividends. You can't make a cash withdrawal or begin retirement income from the funds that serve as security for your loan. But as you repay your loan, the amount reserved as security decreases, and more of your accumulation becomes available to you for withdrawal and retirement income.

If you die before repaying your loan, the remaining loan balance will be repaid from the TIAA Traditional Annuity accumulation set aside as security. Your beneficiaries would receive the balance of your accumulation.

Determining the interest rate. The loan interest rate is variable and can increase or decrease every three months. The interest rate you pay initially will be the higher of 1) the Moody's Corporate Bond Yield Average for the calendar month ending two months before your loan is issued; or 2) the interest rate credited before your annuity starting date, as stated in the applicable rate schedule, plus 1 percent. Thereafter, the rate may change quarterly, but only if the new rate differs from your current rate by at least $\frac{1}{2}$ percent.

Repayment. You have from one to five years to repay your loan. There's one exception: if you use the loan solely to purchase your primary residence, you can take up to ten years to repay. The term of the loan usually can't extend past the April 1st of the year after the year you attain age 70 $\frac{1}{2}$.

Your first payment will be due the first day of the third month after your loan is issued, and every three months thereafter. You can repay your loan early with no penalties. You can also make partial prepayments any time. If you do, whatever you prepay will be applied directly to the principal amount of your loan. (Regularly scheduled payments are applied first to interest, then to principal.) Any prepayments will reduce the amount of future repayments, not the number of payments.

TIAA offers a free automatic loan repayment service. Your bank will debit your checking account and send your repayment to TIAA on the date it's due. If you prefer to repay your loan directly, TIAA will send you a bill every three months, at least ten days before the payment is

due.

Defaults. If TIAA doesn't receive your loan repayment by the last day of the month it's due, you will be in default. Currently, the amount in default will be the missed payment plus all interest accrued to date. However, the IRS may determine that your entire loan balance will be considered in default if you miss one payment. If this happens, the entire balance will be reported as income if you miss a single payment.

To the extent permitted by federal tax law, TIAA will deduct the amount in default from the collateral held in the TIAA GSRA Traditional Annuity and apply it toward repaying the loan. It's very important to keep in mind, however, that the IRS requires TIAA to report the default amount as income you actually received. That means defaults are taxable as ordinary income in the year they occur. If you're under age 59 ½, your default may also be subject to an additional 10 percent federal tax penalty. TIAA assumes no responsibility for the tax consequences resulting from loan defaults.

Tax law may prohibit TIAA from deducting the default amount from your accumulation until you reach age 59 ½, terminate employment, become disabled, or die, whichever occurs first. In these cases, you'll be taxed on the default amount as if you received it as income in the year the default occurred. Interest continues to accrue on the total amount in default until TIAA is able to deduct the defaulted amount (plus accrued interest) from your accumulation to repay the loan.

To apply for a loan or for more information. To apply for a loan or to get answers to any questions you may have about loans, call TIAA-CREF's Telephone Counseling Center toll-free at 1 800 842-2776.

17. **May I roll over my accumulations?**

If you're entitled to receive a distribution from your contract which is an eligible "rollover distribution," you may roll over all or a portion of it either directly or within 60 days after receipt into another Section 403(b) retirement plan or into an IRA. An eligible rollover distribution, in general, is any cash distribution other than an annuity payment, a minimum distribution payment, a payment which is part of a fixed period payment over ten or more years; or distributions made on account of hardship. The distribution will be subject to a 20 percent federal withholding tax unless it's rolled over directly into another retirement plan or into an IRA, this process is called a "direct" rollover.

If you have the distribution paid to you, then 20 percent of the distribution must be withheld even if you intend to roll over the money into another retirement plan or into an IRA within 60 days. To avoid withholding, instruct the fund sponsor to directly roll over the money for you.

18. **What if I die before starting to receive benefits?**

If you die before beginning retirement benefits, the full current value of your annuity accumulation is payable as a death benefit. You may choose one or more of the options listed in your annuity contracts for payment of the death benefit, or you may leave the choice to your

beneficiary. The payment options include:

- Income for the lifetime of the beneficiary with payments ceasing at his or her death.
- Income for the lifetime of the beneficiary, with a minimum period of payments of either 10, 15, or 20 years, as selected.
- Income for a fixed period of not less than, as elected, but not longer than the life expectancy of the beneficiary.
- A single sum payment.
- A minimum distribution option. This option pays the required federal minimum distribution each year.
- The accumulation may be left on deposit, for up to one year, for later payment under any of the options.

Federal tax law puts limitations on when and how beneficiaries receive their death benefits. TIAA-CREF will notify your beneficiary of the applicable requirements at the time he or she applies for benefits.

You should review your beneficiary designation periodically to make sure the person you want to receive the benefits is properly designated. You may change your beneficiary by completing the "Designation of Beneficiary" form available from TIAA-CREF. If you die without having named a beneficiary and you are married at the time of your death, your spouse will automatically receive half of your accumulation. Your estate will receive the other half. If you're not married, your estate receives the entire accumulation.

In addition, see the answer to the question "What are my spouse's rights under this plan to survivor benefits?" for a discussion of your spouse's rights to a survivor benefit if you are married at the time of your death.

Part II: Information About The Fund Sponsors

19. What fund sponsors and funding vehicles are available under the Plan?

Contributions may be invested in one or more of the following fund sponsors and their funding vehicles that are currently available under this Plan:

A. Teachers Insurance and Annuity Association (TIAA):

TIAA Supplemental Retirement Annuity (SRA) and TIAA Group Supplemental Retirement Annuity (GSRA)

Traditional Annuity
Real Estate Account

B. College Retirement Equities Fund (CREF):

CREF Supplemental Retirement Unit-Annuity (SRA) and CREF Group Supplemental Retirement Unit-Annuity (GSRA)

Stock Account
Money Market Account
Bond Market Account
Social Choice Account
Global Equities Account
Growth Account
Equity Index Account
Inflation-Linked Bond Account

Any additional Accounts offered by TIAA-CREF will automatically be made available to you under this plan.

The Institution's current selection of fund sponsors and funding vehicles isn't intended to limit future additions or deletions of fund sponsors and funding vehicles. You'll be notified of any additions or deletions.

20. How do the retirement contracts work?

TIAA Traditional Annuity: Contributions to the TIAA Traditional Annuity are used to purchase a contractual or guaranteed amount of future retirement benefits for you. Once purchased, the guaranteed benefit of principal plus interest cannot be decreased, but it can be increased by dividends. Once you begin receiving annuity income, your accumulation will provide an income consisting of the contractual, guaranteed amount plus dividends that are declared each year and

which are not guaranteed for the future. Dividends may increase or decrease, but changes in dividends are usually gradual. For a recorded message of the current interest rate for contributions to the TIAA Traditional Annuity, call the Automated Telephone Service (ATS) at 1 800 842-2252. The ATS is available 24 hours a day, seven days a week.

CREF and the TIAA Real Estate Account: You have the flexibility to accumulate retirement benefits in any of the CREF variable annuity accounts approved for use under the Plan, as indicated above, and the TIAA Real Estate Account. Each account has its own investment objective and portfolio of securities. Contributions to a CREF account and the TIAA Real Estate Account are used to buy accumulation units, or shares of participation in an underlying investment portfolio. The value of the Accumulation Units changes each business day. You may also choose to receive annuity income under any of the CREF accounts and the TIAA Real Estate Account. There is no guaranteed baseline income or declared dividends when you receive annuity income from these accounts. Instead, your income is based on the value of the annuity units you own, a value that changes yearly, up or down. For more information on the CREF accounts, you should refer to the CREF prospectus. For more information about the TIAA Real Estate Account, refer to the TIAA Real Estate Account prospectus.

For a recorded message of the latest accumulation unit values for the CREF Accounts and the TIAA Real Estate Account, as well as the seven-day yield for the CREF Money Market Account, call the ATS at 1 800 842-2252. The recording is updated each business day.

21. How do I allocate my contributions?

You may allocate contributions among the TIAA Traditional Annuity, the TIAA Real Estate Account, and the CREF Accounts in any whole-number proportion, including full allocation to any Account. You specify the percentage of contributions to be directed to the TIAA Traditional Annuity, the TIAA Real Estate Account, and/or the CREF Accounts on the "Application for TIAA-CREF Supplemental Retirement Annuity Contracts" or "Enrollment Form for TIAA-CREF Group Supplemental Retirement Annuity Certificates" when you begin participation. You may change your allocation of future contributions after participation begins by writing to TIAA-CREF's home office at 730 Third Avenue, New York, New York 10017, by phone using TIAA-CREF's Automated Telephone Service (ATS) toll free at 1 800 842-2252, or via the Internet using TIAA-CREF's Account Access System at www.tiaa-cref.org. However, TIAA-CREF reserves the right to suspend or terminate participants' right to change allocations by phone or the Internet. When you receive your contracts or certificates, you'll also be sent a Personal Identification Number (PIN). The PIN enables you to change your allocation by using the ATS or the Internet. For more information on allocations, ask for the TIAA-CREF booklet Building Your Portfolio.

22. May I transfer my accumulations?

You may transfer your TIAA-CREF accumulations among the TIAA Traditional Annuity, the TIAA Real Estate Account, and the CREF Accounts. Accumulations may also be transferred to TIAA-CREF from another approved fund sponsor (or from TIAA-CREF to another approved fund sponsor), subject to the rules of the other fund sponsor. Partial transfers may be made as

long as at least \$1,000 is transferred each time. There's no charge for transferring accumulations in the TIAA-CREF system, however, TIAA-CREF reserves the right to limit transfer frequency.

You may complete transfers within the TIAA-CREF system either by phone, the Internet, or in writing. CREF, and TIAA Real Estate Account transfers, as well as premium allocation changes, will be effective as of the close of the New York Stock Exchange (usually 4:00 p.m. Eastern time) generally, on the day the instructions are received by TIAA-CREF, unless you choose the last day of the current month or any future month. Instructions received after the close of the New York Stock Exchange are effective as of the close of the Stock Exchange on the next business day. The toll-free number to reach the ATS is 1 800 842-2252. The Account Access System is accessible on the Internet at www.tiaa-cref.org.

23. **May I begin my retirement income at different times?**

Yes. Once you decide to receive your benefits as income, you have the flexibility to begin income from the TIAA Traditional Annuity, the TIAA Real Estate Account, and CREF accounts on different dates. You may begin income from each CREF account, the TIAA Real Estate Account, on more than one date provided you begin income from at least \$10,000 of accumulation in that account.

24. **May I receive my retirement accumulations under different income options?**

Yes, under current administrative practice, you can elect to receive income from your TIAA and CREF annuities under more than one income option to meet your specific retirement needs. However, you must begin income from at least \$10,000 of accumulation under each option.

25. **What information do I regularly receive about my contracts?**

Each year, you will receive an annual Annual Retirement Planner from TIAA-CREF that shows the total accumulation value at year-end for your contracts. This is the amount of death benefits your spouse or other beneficiary would have received on that date. It also includes an illustration of the annuity income you would receive at retirement under certain stated assumptions as to future premiums, your retirement age, the income option and payment method selected, TIAA Traditional Annuity dividends, and the investment experience of, the TIAA Real Estate Account, and the CREF accounts. These factors affect the amount of your retirement income.

TIAA-CREF also sends you a Quarterly Review. This report shows the accumulation totals, a summary of transactions made during the period, TIAA interest credited, and the number and value of, the TIAA Real Estate Account and CREF account accumulation units. You also may receive Premium Adjustment Notices. These notices summarize any adjustments made to your annuities and are sent at the time the adjustments are processed.

And once a year, you'll receive the TIAA-CREF Annual Report. The Annual Report summarizes the year's activity, including details on TIAA and CREF investments, earnings, and investment performance.

Part III: Additional Information

26. **How is the Plan administered?**

Benefits under the plan are provided by annuity contracts. The Institution has been designated the Plan Administrator. The Plan Administrator is responsible for enrolling participants, forwarding Plan contributions for each participant to the fund sponsors selected, and performing other duties required for operating the Plan.

27. **May the terms of the Plan be changed?**

While it's expected that the Plan will continue indefinitely, the Institution reserves the right to modify or discontinue the Plan at any time. The Institution, by action of its Board, also may delegate any of its power and duties with respect to the Plan or its amendments to one or more officers or other employees of the Institution. Any such delegation shall be stated in writing. The Institution will exercise good faith, apply standards of uniform application, and refrain from arbitrary action.

28. **How do I get more information about the Plan?**

Requests for information about the Plan and its terms, conditions and interpretations including eligibility, participation, contributions, or other aspects of operating the Plan should be in writing and directed to:

SURA/Jefferson Lab
12000 Jefferson Avenue
Newport News, VA 23606

29. **What is the Plan's claims procedure?**

The following rules describe the claims procedure under the Plan:

- *Filing a claim for benefits:* A claim or request for plan benefits is filed when the requirements of a reasonable claim-filing procedure have been met. A claim is considered filed when a written communication is made to:

SURA/Jefferson Lab, 12000 Jefferson Avenue, Newport News, VA 23606

- *Processing the claim:* The Plan Administrator must process the claim within 90 days after the claim is filed. If an extension of time for processing is required, written notice must be given to you before the end of the initial 90-day period. The extension notice must indicate the special circumstances requiring an extension of time and the date by

which the Plan expects to render its final decision. In no event can the extension period exceed a period of 90 days from the end of the initial 90-day period.

- *Denial of claim:* If a claim is wholly or partially denied, the Plan Administrator must notify you within 90 days following receipt of the claim (or 180 days in the case of an extension for special circumstances). The notification must state the specific reason or reasons for the denial, specific references to pertinent plan provisions on which the denial is based, a description of any additional material or information necessary to perfect the claim, and appropriate information about the steps to be taken if you wish to submit the claim for review. If notice of the denial of a claim is not furnished within the 90/180-day period, the claim is considered denied and you must be permitted to proceed to the review stage.
- *Review procedure:* You or your duly authorized representative has at least 60 days after receipt of a claim denial to appeal the denied claim to an appropriate named fiduciary or individual designated by the fiduciary and to receive a full and fair review of the claim. As part of the review, you must be allowed to review all plan documents and other papers that affect the claim and must be allowed to submit issues and comments and argue against the denial in writing.
- *Decision on review:* The Plan must conduct the review and decide the appeal within 60 days after the request for review is made. If special circumstances require an extension of time for processing (such as the need to hold a hearing if the plan procedure provides for such a hearing), you must be furnished with written notice of the extension, which can be no later than 120 days after receipt of a request for review. The decision on review must be written in clear and understandable language and must include specific reasons for the decision as well as specific references to the pertinent plan provisions on which the decision is based. For a Plan with a committee or board of trustees designated as the appropriate named fiduciary, a decision does not have to be made within the 60-day limit if the committee or board meets at least four times a year (about every 90 days). Instead, it must be made at the first meeting after the request is filed, except that when a request is made less than 30 days before a meeting, the decision can wait until the date of the second meeting following the Plan's receipt of request for review. If a hearing must be held, the committee can wait to decide until the first meeting after the hearing. However, it must notify you and explain the delay, which can be no later than the third meeting of the committee or board following the Plan's receipt of the request for review. If the decision on review is not made within the time limits specified above, the appeal will be considered denied. All interpretations, determinations, and decisions of the reviewing entity with respect to any claim will be its sole decision based upon the Plan documents and will be deemed final and conclusive. If appeal is denied, in whole or in part, however, you have a right to file suit in a state or federal court.

30. **What are my rights under Law?**

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all non-confidential documents governing the Plan, including insurance

- contracts 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 Pension and Welfare Benefit Administration.
2. Obtain, without written request to the Plan Administrator, copies of all non-confidential documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
 3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
 4. Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

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 SURA/Jefferson Lab, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA. If your claim for a pension benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest

office of the Pension and Welfare Benefits Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

31. **Is the Plan insured by the Pension Benefit Guaranty Corporation (PBGC)?**

No. Since the Plan is a defined contribution plan, it isn't insured by the PBGC. The PBGC is the government agency that guarantees certain types of benefits under covered plans.

32. **Who is the agent for service of legal process?**

The agent for service of legal process is:

SURA/Jefferson Lab, 12000 Jefferson Avenue, Newport News, VA 23606.

VACATION: Accrual rates for *exempt* employees:

<u>Years of Service</u>	<u>Accrual Per Month</u>	<u>Annual Accrual</u>
<i>Up to 2</i>	<i>10 hours</i>	<i>3 weeks</i>
<i>Over 2 and up to 10</i>	<i>13-1/3 hours</i>	<i>4 weeks</i>
<i>Over 10</i>	<i>16-2/3 hours</i>	<i>5 weeks</i>

VACATION: Accrual rates for *nonexempt* employees:

<u>Years of Service</u>	<u>Accrual Per Month</u>	<u>Annual Accrual</u>
<i>Up to 1</i>	<i>6-2/3 hours</i>	<i>2 weeks</i>
<i>Over 1 and up to 10</i>	<i>10 hours</i>	<i>3 weeks</i>
<i>Over 10</i>	<i>13-1/3 hours</i>	<i>4 weeks</i>

No more than 48 days of vacation may be carried over from one year to the next. Vacation leave accrual begins with the first full pay period. Leave does not accrue while on leave without pay status.

SICK LEAVE: Sick leave accrues at a rate of 4 hours per pay period beginning with the first full pay period worked. Leave does not accrue while on leave without pay status.

HOLIDAYS: Jefferson Lab recognizes 11 days per year as paid holidays.

HOLIDAY
New Year's Day
Martin Luther King, Jr. Day
President's Day
Memorial Day
Independence Day
Labor Day
Thanksgiving Day
Day After Thanksgiving
Christmas Eve
Day After Christmas
New Year's Eve

COURT LEAVE

A. POLICY

SURA employees are encouraged to fulfill court obligations. When summoned for jury duty or subpoenaed as a witness in certain circumstances, eligible employees shall be excused from work and paid for regularly scheduled hours as specified below.

B. ELIGIBILITY

1. Jury Duty

All regular or term full-time or part-time, one-half-time or more (having a regular work schedule of 20 hours per week or more) employees are eligible for court leave for jury duty, including grand jury duty.

2. Work-Connected Subpoenaed Witness

All employees, including State employees, are eligible for court leave for appearing in connection with SURA's work as a witness in court or other hearing or giving a deposition for one of the following:

- a. For SURA or at the request of its attorneys.
- b. For DOE or at the request of its attorneys.
- c. For the Government or its agencies when requested or approved by the Contracting Officer.

C. ENTITLEMENTS

1. Jury Duty

- a. Pay for actual time in court and related travel time not to exceed the number of hours in the employee's regularly scheduled workday and workweek up to maximums of eight hours per day and 40 hours per week. Jury duty leave is paid at the employee's *straight-time* rate.
- b. Time paid while serving on jury duty shall not count as time worked in the computation of overtime.

2. Work-Connected Subpoenaed Witness

- a. Pay for actual time in court or time spent giving a deposition and related travel time at the rate the employee would have been paid had he/she worked the same amount of time at his/her regular assignment (i.e., paid at the employee's *straight-time* rate).
- b. Related travel costs in accordance with SURA's business travel policy.
- c. Time paid while serving as a witness shall count as time worked for calculating overtime only when the employee serves as a witness for DOE or another government agency, when approved by the Contracting Officer.

MILITARY LEAVE

A. POLICY

SURA shall provide time off with pay, as specified below, for eligible employees who are members of the Armed Forces or the National Guard and are called to active duty. SURA also shall provide time off with pay for eligible employees ordered for physical examinations in connection with selective service or military reserve obligations.

B. ELIGIBILITY

1. Regular or term (one year or more) full-time and part-time, one-half-time or more employees are eligible for paid Military Leave if they are members of the United States Armed Forces and are ordered to temporary active duty for annual training purposes.
2. Regular, probationary, and term (one year or more) employees who work a schedule of one-half-time or more, are eligible for paid Military Leave, when they are ordered for physical examinations in connection with a selective service or reserve obligation.
3. Regular, probationary, and term (one year or more) employees who work a schedule of one-half-time or more, who are members of the National Guard and are called to active duty to serve during periods of emergency as declared by the
4. Governor of the Commonwealth or State, are eligible for paid Military Leave.

C. ENTITLEMENTS

5. An eligible employee shall be granted a maximum of ten (10) work days of paid leave during a calendar year when ordered to temporary active duty for training.
6. An eligible employee shall be granted paid leave, which may be in addition to the ten (10) days specified in C.1., when ordered for a physical examination in connection with a selective service or reserve obligation.
7. An eligible employee who is a member of the National Guard and is called to active duty to serve during a period of emergency, as declared by the Governor of the Commonwealth or State, shall be paid his/her normal salary (straight-time) rate during his/her absence for such duty.
8. An employee on paid Military Leave shall receive pay in accordance with his/her regular work schedule (i.e., straight-time rate), minus an offset for military pay received.
9. An employee on paid Military Leave shall continue to receive the same SURA benefits he/she would receive if he/she were in a work status.

FAMILY AND MEDICAL LEAVE ACT

A. GENERAL PROVISIONS

1. In accordance with FMLA, SURA provides job protected time away from work for up to 12 weeks in a 12-month period for certain approved reasons. The 12-week period is defined separately from other SURA-provided leave, and other SURA-provided leave may be used simultaneously and/or sequentially with FMLA leave, depending on the circumstances.
2. In keeping with SURA's policy that requires employees to exhaust all applicable paid leave before going on leave without pay, except when receiving short-term disability benefits (see Policy 205.06 Disability Insurance Plans), staff members with FMLA-qualifying events must use accrued sick and/or vacation leave to cover necessary absences.

B. ELIGIBILITY

To be eligible for FMLA leave, an employee must have been employed by SURA:

1. For at least 12 months, and
2. For at least 1250 hours of work during the 12-month period immediately preceding the leave.

C. TYPE OF LEAVE COVERED

1. SURA shall grant FMLA leave to eligible employees in only four circumstances:
 - a. The birth of a son or daughter and to care for the newborn child;
 - b. The placement with the employee of a son or a daughter for adoption or foster care;
 - c. To care for the employee's spouse, son, daughter, or parent with a serious health condition; or
 - d. The employee is unable to perform essential functions of his/her position due to a serious health condition.
2. Employees with questions about what circumstances are covered under this FMLA policy and/or under the Lab's sick leave policy are encouraged to consult with the Employee Relations Manager in Human Resources.
3. SURA requires an employee to provide a doctor's certification of the serious health condition.

PROFESSIONAL ADVANCEMENT LEAVE

A. POLICY

It is the policy of SURA to encourage the professional growth of employees. While such leaves generally shall be unpaid leaves of absence, SURA has the option of providing fully or partially paid leave to a limited number of employees.

B. ENTITLEMENTS

1. Upon recommendation by an employee's Associate Director and with prior approval by DOE, up to 12 months of leave for professional advancement may be granted by the Director.
2. Leaves may be granted for assignment to other institutions within the United States or abroad for teaching, research or professional activities.
3. Partial salaries may be paid only upon approval of the Director, in which event some benefits also may be prorated.

C. QUALIFICATIONS OF CANDIDATE

1. The candidate shall be a regular, full-time employee of SURA, who is a senior level scientist or engineer or a person having major administrative responsibility.
2. The candidate shall be one of distinctly outstanding professional ability, with a firm plan of teaching, research or professional activities, which is clearly relevant to the interests of SURA and to the individual's competence.

D. APPLICATION FOR PROFESSIONAL LEAVE

1. The employee who wishes to take such leave shall describe in writing the opportunity, the length of leave desired, and whether salary is requested.
2. The written request shall be forwarded to the respective supervisor for assessment.
3. The supervisor shall forward the request through the chain-of-supervision to the respective Associate Director, with reasons for recommending approval or rejection and a guarantee that the employee's position shall remain vacant for the duration of the leave, or that a comparable position shall be made available.
4. If the Associate Director approves the request, he/she shall forward it to the Director for final SURA approval. If the Director approves the request, he/she shall forward it to the HR&S Director, who holds responsibility for gaining Contracting Officer (DOE) approval.

E. GENERAL TERMS AND PROVISIONS

1. The number of leaves granted at any time is limited to five, to ensure adequate staff to meet the operational needs of SURA.
2. Except in extremely unusual circumstances, and only with the prior approval of DOE, an employee shall not be granted leave more than once in a five-year period nor shall such leave exceed twelve (12) months.
3. The employee's position shall be held open during the entire period of the leave, or the division shall ensure that there is a comparable position the employee may return to.
4. SURA shall not reimburse travel costs.
5. Vacation and sick leave shall not accrue to the individual while on Professional Advancement Leave.
6. Group benefit insurance coverage shall continue for the leave period if the employee arranges to make all premium payments normally paid by SURA and the employee.
7. The employee shall remain in the SURA retirement plan, but all contributions to his/her account will be calculated at the rate of pay effective during the leave.
8. The basis for salary reimbursement during a Professional Advancement Leave shall be:
 - a. Salary payments made by SURA to an employee on Professional Advancement Leave shall not exceed two-thirds (2/3) of the employee's current *base salary*.
 - b. The total of SURA salary payments plus any stipend, grant or other income which the employee may receive in connection with the leave shall not exceed the employee's current *base salary*.
9. A performance appraisal is not normally required for a performance period in which the majority of the time is spent on Professional Advancement Leave. However, based on the eligibility criteria that only employees with distinctly outstanding ability qualify for Professional Advancement Leave, a salary increase will be provided based on the Lab-wide average percentage merit increase.
10. The Associate Director will determine whether an employee on professional advancement leave will receive a performance appraisal and be eligible for a merit-based salary increase based on the nature of the Professional Advancement Leave assignment. The employee will be informed of the decision prior to beginning a Professional Advancement Leave.
11. In the event the employee does not return to SURA from a Professional Advancement Leave, the reasons for the employee not returning shall be reviewed by the appropriate Associate Director and the HR&S Director to determine whether the employee shall be required to reimburse SURA for any salary paid, retirement contributions made, or additional benefits provided during the leave.

OTHER PAID LEAVE

A. POLICY

SURA recognizes that certain other types of paid administrative leave are required to: support civic involvement by its employees, lessen the impact of public and weather emergencies on its employees, and provide a short period of paid time off for employees who make significant sacrifices of personal time for which they are otherwise uncompensated.

B. CIVIC INVOLVEMENT LEAVE

1. Voting

Upon request, a supervisor may grant any employee whom he/she supervises up to two (2) hours of paid leave to vote in national, state, or local elections, when travel conditions or other circumstances fully justify the need.

2. Blood Donations

Any employee who volunteers as a donor of blood, without payment for such donation, may be granted paid leave by his/her respective supervisor for the period of time necessary to give the blood.

3. Search and Rescue or Disaster Control

A regular or term employee working a schedule of 20 hours per week or more who performs search and rescue or disaster control work as a member of an organized civil unit may be granted work time off with pay to participate in an actual operation. Leave with pay shall not be granted for training, drills, or practice exercises. The HR&S Director or his/her designee is the approval authority for all requested leave for search and rescue or disaster control work.

4. Community Service Volunteers

In support of an organized volunteer effort sponsored by local, not-for-profit, charitable organizations, the Director may designate one day per year as a community service day. Each employee, up to a maximum of 20 employees per year, who works that day as a community service volunteer may be authorized administrative leave with pay for the day. The employees' supervisors, with the prior concurrence of the HR&S Director, approve all paid leave for Community Service Volunteers.

C. SHORT-TERM PAID LEAVE OF ABSENCE

The Director or an Associate Director may grant leaves of absence with pay to any employee who makes a significant sacrifice of personal time to complete work related to SURA's contract with DOE and is not otherwise compensated for his/her work. Such leave shall be granted only for special projects outside of the scope of the employee's normal duties and typical work schedule. The maximum annual amount of this type of leave which may be granted to any individual employee is three days.

D. PUBLIC EMERGENCY LEAVE

1. General

Any employee may be granted time off with pay during a public emergency which effectively prevents attendance at work or the continuation of work in a normal and orderly manner. A public emergency may be either a natural disaster (fire, flood, hurricane, earthquake, etc.) or a man-made disorder (demonstration, riot, act of sabotage, etc.). Authorization for time off with pay for such emergencies shall be made by either the Director, the Associate Director for Administration, or their designee. The HR&S Director shall publish guidance on time reporting immediately following a public emergency.

2. Weather Emergency

The most common type of public emergency experienced at JLab is a weather emergency which seriously affects employees' ability to get to or from work. Even when a weather emergency is not severe enough to force the closure of the facility, it may necessitate either an early dismissal or late start, or both, for nonessential employees.

a. Designation of Nonessential Employees

Associate Directors will designate nonessential employees for their division.

b. Eligibility for Paid Leave

- 1) All employees are eligible for paid leave in the event of a weather emergency.
- 2) Part-time employees will receive paid leave only for those hours they actually were scheduled to work.
- 3) Only nonessential employees who are at work and remain at work until the designated time of closing will be granted paid leave during an early dismissal situation.

4) When an official late start has been declared, nonessential employees will receive up to a maximum of three hours of paid leave, subject to their supervisor's approval. Official late starts will be announced on the local news media. The JLab Public Information Officer is responsible for announcing official late starts.

c. Employee Responsibilities

1) Employees who, on their own, decide that weather conditions preclude their attendance or require their early departure may take vacation leave provided they obtain the advance approval of their supervisor.

2) Employees who fail to meet their regular work schedule because of a personal decision regarding weather conditions and who fail to obtain the advance approval of their supervisor to take vacation leave shall be in a leave without pay status for any and all scheduled work hours they miss.

d. Guidance on Time Reporting

The HR&S Director shall issue guidance on time reporting immediately following each weather emergency situation.

SEVERANCE PAYMENTS

A. POLICY

It is the policy of SURA that full-time and part-time regular employees, who are separated from SURA employment *due to layoffs*, are eligible for severance payments in accordance with the following provisions.

B. DEFINITIONS

The following definitions shall apply for purposes of severance payments.

1. *Continuous Service* - Service is continuous if an employee is on pay status each month without a break in service. A break in service occurs when there is a separation from laboratory employment status.
 - a. Periods of approved leave without pay of 30 calendar days or less shall count as continuous service for purpose of severance pay. Additionally, periods of at least 90 calendar days, or more if approved by DOE, of approved leave without pay for military service, illness, injury compensable by Workers' compensation, or assignment to another organization at the direction of the Laboratory, shall count as periods of continuous service for the purposes of severance pay. Periods on pay

- status before and after any approved leave without pay shall count toward the total amount of continuous service.
- b. Employees on Inactive-Disability status (see Policy 206.01 A.13) shall not accrue service credits for severance calculations.
 - c. Continuous service is reestablished when an employee is rehired from preferential rehire status. The break, which occurred due to layoff, is credited toward the period of continuous service.
2. *Equivalent Job* - An equivalent job is any position with the Laboratory at a beginning salary at least equal to the salary paid the employee in the job from which that employee was laid off.

C. ELIGIBILITY

1. Severance payments shall be made only to regular employees who separate due to layoffs, with the following exceptions:
 - a. An employee who resigns after receiving formal notification of layoff, but prior to the effective date of layoff, may be provided severance payments with the approval of the Associate Director for Administration.
 - b. An employee who resigns in lieu of another employee who would have been laid off may be provided severance payments with the approval of the Associate Director for Administration. Normally, such approval shall be given only if the resignation will not have a detrimental effect on work in progress and the employee concerned had not announced plans to resign or retire prior to the announcement of a layoff within the employee's Division.
2. Severance payments shall not be provided to an employee who transfers to another Laboratory position nor to an employee who refuses a transfer to an equivalent job within the employee's Division.
3. A term employee is ineligible to receive severance pay and requires no notice of termination unless he/she has six months or more of service and is laid off at least six months prior to completion of the planned term of employment.
4. Employees on Inactive-Disability status (See Policy 206.01 A.13) are ineligible for severance payments.
5. If SURA is replaced as the prime contractor at JLab, no employee who elects to remain at JLab or who is offered employment under comparable conditions by the new prime contractor shall be eligible for severance pay.

D. SEVERANCE PAYMENT CALCULATIONS AND METHODS OF PAYMENT

1. Calculations

- a. The severance payment shall be made in multiples of one week's pay in accordance with the following schedule:

SEVERANCE PAYMENT ALLOWANCE

<u>Length of Continuous Service</u>	<u>Payment Allowance</u>
6 months to 2 years	1-1/2 weeks
over 2, but less than 3 years	3 weeks
over 3, but less than 4 years	4-1/2 weeks
over 4, but less than 5 years	6 weeks
over 5, but less than 6 years	7-1/2 weeks
over 6, but less than 7 years	9 weeks
over 7, but less than 8 years	10-1/2 weeks
over 8, but less than 9 years	12 weeks
over 9, but less than 10 years	13-1/2 weeks
over 10 years	15 weeks

- b. Severance payments for part-time employees shall be calculated based on their scheduled weekly part-time salary.

2. Method of Payment

The employee shall receive a lump sum payment at or near the time of separation.

E. LIMITATIONS

1. Period of Employment

Severance payments shall not extend the period of employment beyond the date of termination due to layoff.

2. Previous Service Payment

Severance payments made to an employee shall not include payment for any period of service for which the employee has previously received such payment.

EAP

What services are available?

Your EAP can help you and your eligible family members deal with many situations, including the following:

- **Stress**
- **Marital and family problems**
- **Emotional problems**
- **Addictive behaviors**
- **Drug and alcohol abuse**
- **Job-related problems**
- **Legal and financial referrals**

Who is eligible for EAP services?

All employees, their spouses, and family members who reside in the employee's household, and all other legal dependents who are covered by the employee's health benefit plan.

Why does your organization have an Employee Assistance Program?

Because employees are its most important resource. Your organization elected to provide an EAP because it cares about you and about your job performance. Your employer also realizes that everyone occasionally experiences personal, family or emotional difficulties or encounters loss or illness.

In most cases, you are able to resolve these problems independently. However, sometimes these difficulties may be so intense, or may last so long, that your personal happiness, your family relations, your health, and your job performance are affected, and you may need some outside help.

The goal of the program is to assist valued employees and their families in coping with problems that could result in serious deterioration of health, family life and job performance.

How much does It cost?

The EAP provides you and your eligible family members with assessments and short-term problem resolution at no cost to you. If the problem cannot be resolved with short-term resolution, and inpatient or outpatient treatment is needed, your healthcare plan may pay all or part of the cost involved. Your EAP will help find the most cost-effective, affordable services for you.

Insurance Information for Jefferson Lab's Travelers

Automobile Rentals & Insurance

SURA/Jefferson Lab purchases insurance that will cover the repair costs of rental cars and other vehicles should you be involved in an accident. Our policies also provide for medical expenses and liability coverage.

Injury or Illness while Traveling

Jefferson Lab Staff

Injuries:

Injuries that occur while you are on business-related travel are generally no different from injuries that occur at the Lab. If they are work-related, medical treatment is provided at no cost to you by Workers' Compensation insurance.

SUMMARY OF CLASSIFICATIONS AND RANGES

Fiscal Year 2005 - Effective 10/1/2004

				Salary Range			
Series	Code	Classification	Abrev.	Min.	Mid.	Max.	Spread
000 - Associate Director	01X	Associate Director	AD	**	**	**	**
100 - Exempt Administrators	11X	Staff Administrator I	SA I	37,600	47,000	56,400	50%
	12X	Staff Administrator II	SA II	49,500	61,900	74,300	50%
	13X	Staff Administrator III	SA III	65,200	81,500	97,800	50%
	14X	Sr. Staff Administrator	SSA	86,000	107,500	129,000	50%
200 - Exempt Scientists	20X	Post Doctoral Fellow	PD	43,400	54,300	65,200	50%
	21X	Staff Scientist I	SS I	48,500	62,600	76,700	58%
	22X	Staff Scientist II	SS II	61,000	78,700	96,400	58%
	23X	Staff Scientist III	SS III	76,500	98,600	120,700	58%
	24X	Senior Staff Scientist	SSS	92,600	119,500	146,400	58%
	25X	Principal Staff Scientist	PSS	112,200	144,800	177,400	58%
	26X	Special Scientist	SPS	**	**	**	**
300 - Exempt Engineers	31X	Staff Engineer I	SE I	48,500	62,600	76,700	58%
	32X	Staff Engineer II	SE II	61,000	78,700	96,400	58%
	33X	Staff Engineer III	SE III	76,500	98,600	120,700	58%
	34X	Senior Staff Engineer	SSE	92,600	119,500	146,400	58%
	35X	Principal Staff Engineer	PSE	112,200	144,800	177,400	58%
	36X	Special Engineer	SPE	**	**	**	**
400 - Exempt Assoc./Coord.	41X	Associate/Coordinator	A/C I	48,500	62,600	76,700	58%
	42X	Senior Assoc./Coordinator	A/C II	61,000	78,700	96,400	58%
	43X	Engineering Support Mgr.	ESM	68,700	88,600	108,500	58%
500 - Nonexempt Administrative Support/ Secretarial	51X	Admin.Support/Sec. I	A/S I	21,900	25,800	29,700	36%
	52X	Admin.Support/Sec. II	A/S II	24,600	29,100	33,600	36%
	53X	Admin.Support/Sec. III	A/S III	29,700	35,100	40,500	36%
	54X	Admin.Support/Sec. IV	A/S IV	34,800	41,000	47,200	36%
600 - Nonexempt Const./Facilities Support	61X	Const./Facilities Sup. I	C/F I	12,600	14,900	17,200	36%
	62X	Const./Facilities Sup. II	C/F II	19,200	22,700	26,200	36%
	63X	Const./Facilities Sup. III	C/F III	25,200	29,800	34,400	36%
700 - Nonexempt Tech./Drafters/ Accelerator Operators	71X	Technician/Drafter	T/D I	31,500	37,200	42,900	36%
	72X	Techno./Design Drafter	T/D II	41,400	48,900	56,400	36%
	73X	Sr. Technologist/Designer	T/D III	50,900	60,100	69,300	36%
	79X	Accelerator Operator	AO	43,500	51,300	59,100	36%

800 - Nonexempt Skilled Trades	81X 82X	Skilled Trades Sr. Skilled Trades	ST I ST II	33,100 40,900	39,100 48,200	45,100 55,500	36% 36%
900 - Nonexempt Student Interns & Exempt Graduate Stu. Research Ast. COURP Program	91X 92X 93X 94X 95X	H.S. Student Intern Under grad. Student Intern Graduate Student Intern Grad. Stu. Research Ast. Under Grad. Stu. Res. Ast.	SI I SI II SI III GSRA USRA	13,000 14,800 18,800 19,900 14,200	16,000 20,500 25,300 25,800 19,600	19,000 26,200 31,800 31,700 25,000	

** Salary is outside a standard range. Includes SPS/SPE who are at TJNAF by arrangement with another institution that pays a portion of their salary.