SOUTHEASTERN UNIVERSITIES RESEARCH ASSOCIATION
CAFETERIA PLAN

Originally Effective: March 27, 1991
Amended and Restated Effective: January 1, 2005

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SECTION 1
INTRODUCTION

1.1 Purpose of Plan. The purpose of this Plan is to provide employees of Southeastern Universities Research Association a choice between cash and qualified benefits under the dependent care, medical care and health flexible spending account plans maintained by Southeastern Universities Research Association.

1.2 Cafeteria Plan Status. This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Code Section 125.

SECTION 2
DEFINITIONS

2.1 Administrator. The Company or the person or committee appointed by the Board to supervise the administration of the Plan.

2.2 Board. The Board of Directors of Southeastern Universities Research Association

2.3 Change in Status Event. An event described in Plan Section 4.7(b) and any other event described in Treasury Regulation Section 1.125-4(c) that, under the facts and circumstances, entitles a Participant to revoke an election and make a new election for the remaining Period of Coverage.

2.4 Code. The Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements, or replaces such section or subsection.

2.5 Company. Southeastern Universities Research Association, a Virginia non-stock corporation.

2.6 Dependent Care Assistance Plan. The Southeastern Universities Research Association Dependent Care Assistance Plan, as amended from time to time

2.7 Effective Date. The original effective date is March 27, 1991. The effective date of this amendment and restatement is January 1, 2005.

2.8 Employee. An individual employed by the Company.

2.9 Health Flexible Spending Account Plan. The Southeastern Universities Research Association Health Flexible Spending Account Plan, as amended from time to time.

2.10 Key Employee. Any person who is a key employee, as defined in Code Section 416(i)(1), with respect to the Company.

2.11 Medical Care Plan. The Southeastern Universities Research Association Medical Care Plan, as amended from time to time, including, without limitation, any health maintenance organization and any individual medical insurance policies for which the Company has deducted premium payments under Code Section 106.

2.12 Participant. Any individual who participates in the Plan in accordance with Plan Section 3.

2.13 Period of Coverage. With respect to the Medical Care Plan, the twelve (12) month period with respect to which coverage is provided pursuant to an insurance contract or otherwise under the Medical Care Plan. "Period of Coverage" for the Health Flexible Spending Account Plan and the Dependent Care Assistance Plan shall be the Plan Year.

2.14 Plan. The Southeastern Universities Research Association Cafeteria Plan as set forth herein, together with any and all amendments and supplements hereto.

2.15 Plan Year. The period beginning on April 1 and ending on March 31 each year, provided, however, that the Plan will be administered with a short Plan Year beginning on January 1, 2005 and ending on March 31, 2005.

SECTION 3
PARTICIPATION

3.1 Commencement of Participation. Each Full-Time Employee who is either a regular or a term employee is eligible to participate in the Plan . A Full-Time Employee for this purpose is defined to mean a person who is scheduled to work at least twenty (20) hours per week for the Company. An Employee will become a Participant in the this Plan effective as of his or her date of hire.

3.2 Cessation of Participation. A Participant will cease to be a Participant in the Medical Care insurance portion of the Plan as of the earlier of (a) the date on which the Plan terminates or (b) the last day of the month in which he or she ceases to be an Employee eligible to participate under Section 3.1. A Participant will cease to be a Participant in the Health Flexible Spending Account and Dependent Care Assistance portions of the Plan as of the earlier of (a) the date on which the Plan terminates or (b) the Participant's last pay date as an Employee of the Company.

3.3 Reinstatement of Former Participant. A former Participant will become a Participant again if and when he or she meets the eligibility requirements of Section 3.1.

SECTION 4
OPTIONAL BENEFITS COVERAGE

4.1 Coverage Options. Each Participant may choose under this Plan to receive his or her full compensation for any Period of Coverage in cash or to have a portion of it applied by the Company toward the cost of coverage available to the Participant under one or more of the following plans: the Dependent Care Assistance Plan, the Medical Care Plan, and the Health Flexible Spending Account Plan.

4.2 Description of Optional Coverages. While the election of one or more of the optional coverages described in Section 4.1 may be made under this Plan, the coverages and benefits thereunder will be provided not by this Plan but by the Dependent Care Assistance Plan, the Medical Care Plan, and the Health Flexible Spending Account Plan. The types and amounts of benefits available under each option described in Section 4.1, the requirements for participating in such option, and the other terms and conditions of coverage and benefits under such option are as set forth from time to time in the Dependent Care Assistance Plan, Medical Care Plan and Health Flexible Spending Account Plan, and in the insurance contracts and prepaid health plan contracts that constitute (or are incorporated by reference in) certain of those plans. The benefit descriptions in such plans and contracts, as in effect from time to time, are hereby incorporated by reference into this Plan.

4.3 Election of Optional Coverages in Lieu of Cash. A Participant may elect under this Plan to receive one or more of the optional coverages described in Section 4.1, to the extent available to the Participant under the applicable plans, in accordance with the procedures described in Sections 4.4, 4.5, and 4.6. If a Participant elects coverage for a Period of Coverage under the Dependent Care Assistance Plan, the Participant's regular cash compensation for the Plan Year will be reduced by such amount as the Participant elects (up to the maximum amount of reimbursements available to the Participant under such Plan), and an amount equal to the reduction in each compensation payment will be credited to a reimbursement account in accordance with the Dependent Care Assistance Plan. If a Participant elects coverage for a Period of Coverage under the Health Flexible Spending Account Plan, the Participant's regular cash compensation for the Period of Coverage will be reduced by the coverage amount selected by the Participant under such plan, and the coverage amount will be credited to a reimbursement account in accordance with such plan. If a Participant elects coverage for a Period of Coverage under the Medical Care Plan, the Participant's regular compensation will be reduced for the Period of Coverage, and an amount equal to the reduction in each compensation payment will be contributed by the Company under that plan to cover the Participant's share of the cost of such coverage as determined by the Company. The balance of the cost of coverage, if any, under the Dependent Care Assistance Plan, the Medical Care Plan and the Health Flexible Spending Account Plan shall be paid by the Company directly, outside and not under this Plan.

4.4 Election Procedure. Approximately thirty (30) days prior to the commencement of each Period of Coverage, the Administrator shall provide one or more written election forms and compensation reduction agreements to each Participant and to each other individual who is expected to become a Participant at the beginning of the Period of Coverage. The election forms shall be effective as of the first day of the Period of Coverage. Each Participant who desires one or more optional benefit coverages described in Section 4.1 for the Period of Coverage shall so specify on the appropriate election form or forms and shall agree to a reduction in his or her compensation. The amount of the reduction in the Participant's compensation for the Period of Coverage for coverage elected by the Participant under the Dependent Care Assistance Plan or Health Flexible Spending Account Plan shall be the coverage amount elected by the Participant, subject to the limitations of such plans. The amount of the reduction in the Participant's compensation for the Period of Coverage for coverage under the Medical Care Plan shall equal the Participant's share of the cost of such coverage. Each election form must be completed and returned to the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's compensation reduction agreement will apply.

4.5 New Participants. Before, or as soon as practicable after, an individual becomes a Participant under Plan Section 3.1 or 3.3, the Administrator shall provide the written election forms and compensation reduction agreements described in Section 4.4 to the individual. If the individual desires one or more optional benefit coverages described in Section 4.1 for the balance of the Period of Coverage, the individual shall so specify on the election forms and shall agree to a reduction in his or her compensation as provided in Section 4.4. The election forms must be completed and returned to the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the individual's compensation reduction will apply.

4.6 Failure to Return Election Forms. A Participant's failure to return a completed election form under Section 4.4 or 4.5 to the Administrator on or before the specified due date for the initial Period of Coverage of the Plan, or for the Period of Coverage in which he or she becomes a Participant, shall constitute an election to receive his or her full compensation in cash. A Participant's failure to return a completed election form to the Administrator relating to coverage under the Medical Care Plan on or before the specified due date for any subsequent Period of Coverage shall constitute (a) a reelection of the same coverage or coverages, if any, under such plans as were in effect just prior to the end of the preceding Period of Coverage, and (b) an agreement to a reduction in the Participant's compensation for the subsequent Period of Coverage equal to the Participant's share of the cost during such Period of Coverage of each such coverage. A Participant's failure to return a completed election form to the Administrator under Section 4.4 or 4.5 relating to coverage under the Dependent Care Assistance Plan or Health Flexible Spending Account Plan on or before the specified due date for any Period of Coverage shall constitute an election by the Participant of cash compensation in lieu of such coverage, regardless of any election in effect during the preceding Period of Coverage.

4.7 Irrevocability of Election by the Participant During the Period of Coverage.

a. Any election made under the Plan (including an election made through inaction under Section 4.6) shall be irrevocable by the Participant during the Period of Coverage except as otherwise provided in paragraphs (b) through (m) below.

b. A Participant may revoke an election in writing for the balance of the Period of Coverage and, if desired, file a new election in writing if both the revocation and the new election are (1) consistent with the terms of any "Qualified Benefits Plan," including, without limitation, the Dependent Care, Medical Care or Health Flexible Spending Account Plan in question, and (2) made on account of and consistent with any of the change in status events specified in this Section 4.7(b). "Qualified Benefits Plan" means an employee benefits plan governing the provision of one or more benefits that are qualified benefits under Code Section 125(f). An employee benefits plan shall not fail to be a Qualified Benefits Plan merely because such plan contains a flexible spending account (FSA), provided that the FSA meets the requirements of Code Section 125 and the regulations thereunder. Such revocation and new election is consistent with such event(s) if and only if it complies with the consistency rule in Treas. Reg. Section 1.125-4(c)(3). The change in status events specified in this Section 4.7(b) are:

(i) An event that changes the Participant's legal marital status, including the marriage, divorce or legal separation of the Participant, the annulment of the Participant's marriage, or the death of the Participant's spouse;

(ii) An event that changes the Participant's number of dependents (as defined under Code Section 152), including the birth, adoption or placement for adoption of a child or other dependent of the Participant;

(iii) An event that changes the employment status of the Participant, the Participant's spouse, or the Participant's dependent, including the termination or commencement of employment of the Participant, the Participant's spouse or the Participant's dependent, the commencement of or return from an unpaid leave of absence by the Participant, the Participant's spouse or the Participant's dependent, a strike, lockout or change in worksite of the Participant, the Participant's spouse or the Participant's dependent;

(iv) A change in the place of residence of the Participant, the Participant's spouse or the Participant's dependent;

(v) With respect to a Qualified Benefits Plan that is an adoption assistance plan, the commencement or termination of an adoption proceeding;

(vi) An event that causes a Participant's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance; and

(vii) A change in eligibility for coverage under the Dependent Care, Medical Care or Health Flexible Spending Account Plan of the Participant, the Participant's spouse or the Participant's dependent attributable to the employment status of the Participant, the Participant's spouse or the Participant's dependent.

c. If the Participant, the Participant's spouse or the Participant's dependent becomes eligible for continuation coverage under the Medical Care Plan or Health Flexible Spending Account Plan as provided in Code Section 4980(b) or any similar state law, the Participant may elect to increase payments under the Plan in order to pay for the continuation coverage.

d. A Participant may revoke an election in writing for the balance of the Period of Coverage and file a new election in writing that corresponds with the HIPAA special enrollment rights under Code Section 9801(f).

e. A Participant may change an election in writing for the balance of the Period of Coverage to provide coverage for a child if a judgement, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant requires the Participant to provide coverage for the child under the Medical care or Health Flexible Spending Account Plan. A Participant may revoke an election in writing for the balance of the Period of Coverage to cancel coverage for a child if a judgement, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant requires another person to provide coverage for the child and the coverage is in fact provided.

f. A Participant who is enrolled, or whose spouse or dependent is enrolled, in the Medical Care Plan, who becomes entitled to coverage under Medicare or Medicaid (other than the program for distribution of pediatric vaccine) may reduce or revoke an election under the Medical Care Plan for the balance of the Period of Coverage. A Participant who is enrolled, or whose spouse or dependent is enrolled, in the Medical Care Plan, who loses coverage under Medicare or Medicaid (other than the program for distribution of pediatric vaccine) may make a new election to commence or increase coverage under the Medical Care Plan for the balance of the Period of Coverage.

g. A Participant taking leave under the Family and Medical Leave Act may revoke an election under the Medical Care Plan and make such other election for the balance of the Period of Coverage as may be permitted under the Family and Medical Leave Act.

h. In the case of coverage under the Medical Care Plan and the Dependent Care Assistance Plan, if the Participant's share of the cost of such coverage increases or decreases during a Period of Coverage and the Participants are required to make a corresponding change in their payments, the Administrator may, on a reasonable and consistent basis,

automatically make prospective increases or decreases in the Participant's elections for the balance of the Period of Coverage.

i. In the case of coverage under the Medical Care Plan and the Dependent Care Assistance Plan, if the Participant's share of the cost of a Benefit Package Option significantly increases or significantly decreases during a Period of Coverage, the Administrator may permit all Participants electing such coverage for the Period of Coverage to make a corresponding change in election under the Plan. Changes that may be made include, in the case of an increase in cost, making a prospective increase in their payments or revoking their elections for the balance of the Period of Coverage, and electing another Benefit Package Option under the Medical Care Plan or the Dependent Care Assistance Plan for the balance of the Period of Coverage or dropping coverage if no other Benefit Package Option providing similar coverage is available. Changes that may be made include, in the case of a decrease in cost, commencing participation in the Plan. "Benefit Package Option" means a qualified benefit under Code Section 125(f) that is offered under this Plan or an option for coverage under the Medical Care Plan. The terms "cost increase(s) and "cost decrease(s)" in this Section 4.7(i) refer to an increase or decrease in the amount of the elective contributions under the Plan, whether the increase or decrease results from an action taken by the Employee or from an action taken by the Employer. However, such revocation and new election is permitted under the Dependent Care Assistance Plan only if the dependent care provider is not a relative of the Participant within the meaning of Code Section 152(a)(1) through (8), incorporating the rules of Code Section 152(b)(1) and (2).

j. In the case of coverage under the Medical Care Plan and the Dependent Care Assistance Plan, if such coverage is significantly curtailed but there is no Loss of Coverage as defined in Section 4.7(k), the Administrator may permit all Participants electing such coverage for the Period of Coverage to revoke their elections for the balance of the Period of Coverage and elect another Benefit Package Option providing similar coverage under the Medical Care Plan for the balance of the Period of Coverage. Coverage under the Medical Care Plan is significantly curtailed only if there is an overall reduction in coverage provided to participants under that plan so as to constitute reduced coverage to participants generally.

k. In the case of coverage under the Medical Care Plan and the Dependent Care Assistance Plan, if such coverage is significantly curtailed such that there is a loss of coverage, the Administrator may permit all Participants electing such coverage for the Period of Coverage to revoke their elections for the balance of the Period of Coverage and elect another Benefit Package Option providing similar coverage under the Medical Care Plan for the balance of the Period of Coverage or to drop coverage if no similar Benefit Package Option is available. Loss of Coverage under the Medical Care Plan means a complete loss of coverage under the Benefit Package Option or other coverage option provided to participants under that plan (including the elimination of a Benefits Package Option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation). The Administrator may also, in its sole discretion (provided that the Administrator does not discriminate in favor of any highly compensated employee (as defined in Code Section 414(q)), treat the following as Loss of Coverage:

(i) A substantial decrease in the medical care providers available under the option;

(ii) A reduction in the benefits for a specific type of medical condition or treatment with respect to which the Participant or the Participant's spouse or dependent is currently in a course of treatment; or

(iii) Any other similar fundamental loss of coverage.

l. If the Medical Care Plan adds a new Benefit Package Option or other coverage option or significantly improves coverage under an existing Benefit Package Option or other coverage option during a Period of Coverage, the Administrator may permit all eligible Participants (whether or not such eligible Participant previously made an election under the Plan) to revoke their elections for the balance of the Period of Coverage and elect the newly added or improved Benefit Package Option on a pretax basis for the balance of the Period of Coverage.

m. The Administrator may permit a Participant to make a prospective election change (other than a change under the Health Flexible Spending Account Plan) that is on account of and corresponds with a change made under the Cafeteria Plan or Qualified Benefits Plan of another employer (including a plan of the same employer or of another employer) if either (a) such plan(s) permits participants to make an election change that would be permitted under Section 4.7 of this Plan (other than this Section 4.7(m)), or (b) this Plan permits participants to make an election for a Period of Coverage that is different from the period of coverage under the other Cafeteria Plan or Qualified Benefits Plan.

n. The Administrator may permit a Participant to make a prospective election to add coverage under the Plan for the Participant, the Participant's spouse or the Participant's dependent(s) if the Participant, the Participant's spouse or the Participant's dependent(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including the following:

(i) A State's children's health insurance program (SCHIP) under Title XXI of the Social Security Act;

(ii) A medical care program of an Indian Tribal Government (as defined in Code Section 7701(a)(40)), the Indian Health Service or a tribal organization;

(iii) A State health benefits risk pool; or

(iv) A foreign government group health plan.

o. A Participant may also revoke an election in writing for the balance of the Period of Coverage and, if desired, file a new election in writing if and only if both the revocation and the new election are made pursuant to regulations and rulings of the Internal

Revenue Service that permit the revocation of an election (and, if applicable, the filing of a new election) during a Period of Coverage.

p. Any revocation and new election under this Section 4.7 shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the revocation and new election.

4.8 Changes by Administrator.

a. If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Key Employees, the Administrator shall take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by highly compensated Employees (as defined by the Code for purposes of the nondiscrimination requirement in question) or Key Employees without the consent of such Employees.

b. If a judgement, decree or order resulting from a divorce, legal separation, annulment or change in legal custody requires the Participant to provide accident or health coverage for an Participant's child or for a foster child who is a dependent of the participant, the Administrator may change the Participant's election to provide coverage for the child.

4.9 Adjustment of Compensation Reductions. If the cost of coverage provided by an independent third-party provider under the Medical Care Plan increases or decreases during a Period of Coverage, a corresponding change shall be made in the compensation reductions of all Participants receiving such coverage in an amount to be determined by the Administrator.

4.10 Automatic Termination of Election. Any election made under this Plan (including an election made through inaction under Section 4.6) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or benefits under the Dependent Care Assistance, Medical Care or Health Flexible Spending Account Plan in question may continue if and to the extent provided by such plan. In the event such a former Participant again becomes a Participant before the end of the same Plan Year, the elections previously in effect for the Participant shall automatically be reinstated for the balance of the Plan Year.

4.11 Maximum Elective Contributions. The maximum amount of employer contributions under the Plan for any Participant shall be the maximum amounts which the Participant may receive in the form of dependent care assistance under the Dependent Care Assistance Plan and as medical reimbursements under the Health Flexible Spending Account Plan, as set forth in such Plans, and (b) the costs from time to time of the most expensive benefits available to and elected by the Participant under the Medical Care Plan.

4.12 Cessation of Required Contributions. Nothing in this Plan shall prevent the cessation of coverage or benefits under the Dependent Care Assistance, Health Flexible Spending Account or Medical Care Plan, in accordance with the terms of such Plan, on account of a Participant's failure to pay the Participant's share of the cost of such coverage or benefits, through compensation reduction or otherwise.

SECTION 5
ADMINISTRATION OF PLAN

5.1 Plan Administrator. The administration of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. The Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Administrator's powers will include, but will not be limited to, the following authority, in addition to all other powers provided by this Plan:

a. To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

b. To interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

c. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

d. To appoint such agents, counsel, accountants, consultants, and other persons as may be required to assist in administering the Plan; and

e. To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation, or designation to be in writing.

Notwithstanding the foregoing, any claim which arises under the Dependent Care Assistance Plan, Health Flexible Spending Account Plan or Medical Care plan shall not be subject to review under this Plan, and the Administrator's authority under this Section 5.1 shall not extend to any matter as to which an administrator under any such other plan is empowered to make determinations under such plan.

5.2 Examination of Records. The Administrator will make available to each Participant such of its records under the Plan as pertain to the Participant, for examination at reasonable times during normal business hours.

5.3 Reliance on Tables, etc. In administering the Plan, the Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions, and reports which are furnished by, or in accordance with the instructions of, the administrators of the Dependent Care Assistance, Medical Care, and Health Flexible Spending Account Plans, or by accountants, counsel or other experts employed or engaged by the Administrator.

5.4 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

5.5 Indemnification of Administrator. The Company agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs, and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Company) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

SECTION 6
AMENDMENT AND TERMINATION OF PLAN

6.1 Amendment of Plan. The Company, by resolution of its Board, reserves the power at any time or times to amend the provisions of the Plan to any extent and in any manner that it may deem advisable. An amendment may be made retroactively if it is necessary to the Plan into compliance with applicable law.

6.2 Termination of Plan. The Company has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the Company will have no obligation whatsoever to maintain the Plan for any given length of time and, by resolution of its Board, may discontinue or terminate the Plan at any time without liability.

SECTION 7
CLAIMS PROCEDURE

7.1 Claims Under Medical Plan Underwritten by Insurer or Administered by Third-Party Administrator. Any claim for benefits under a medical plan underwritten by an insurer or administered by a third-party administrator shall be made to the insurer or third-party administrator, whichever is applicable, in accordance with the procedures specified in the insurance contract or third-party administration agreement. These procedures are hereby incorporated into this document by this reference and shall govern all other claims for benefits.

7.2 Other Claims. Any other claims for benefits shall be submitted in writing to the Company. If forms are made available, those forms must be used; otherwise, all claims for benefits shall be made in writing and shall set forth the facts that the claimant believes to be sufficient to entitle him to the benefit claimed.

7.3 Claims Procedure. The claims procedures under the Medical Care Plan are hereby incorporated into this document by this reference and shall govern all claims. If the claims procedures in the following portion of this Section 7.3 conflict with the claims procedures under the Medical Care Plan, the claims procedures under the Medical Care Plan shall apply and shall supersede the claims procedures in the following portion of this Section 7.3. On receipt of a post-service claim, the Company shall respond in writing within 30 days. If necessary, the first notice must indicate any special circumstances requiring an extension of time for the Company s decision. The extension notice must indicate the date by which a decision is expected to be rendered. A one-time extension of time for processing may not exceed 15 days after the end of the initial period. Upon denial of a claim, the claimant may submit a written application to the Company requesting a review of the claim. The claimant also may review pertinent documents and submit issues and comments in writing. A review may be requested at any time within 180 days following the date of denial of the claim. Any action required or authorized to be taken by the claimant may be taken by a representative authorized in writing by the claimant to represent him. The decision on review shall be in writing and shall be issued within 60 days following receipt of the request for review. The decision on review shall be made by an individual or individuals who are not the same individual or individuals who made the initial claim decision and shall include specific reasons for the decision and specific references to the pertinent Plan provisions on which the decision is based.

7.4 No Requirement to Review or Challenge. The Company is not required to review or challenge a claim denied by an insurer or a third-party administrator unless that denial is obviously contrary to the terms of the medical plan.

SECTION 8
MISCELLANEOUS PROVISIONS

8.1 Information to be Furnished. Participants shall provide the Company and Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

8.2 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Company or Administrator, except as provided herein.

8.3 Benefits Solely from General Assets. Except as may otherwise be required by law,

a. any amount by which a Participant's compensation is reduced under this Plan will remain part of the general assets of the Company;

b. nothing herein will be construed to require the Company or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant; and

c. no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of the Company from which any payment under the Plan may be made.

8.4 Nonassignability of Rights. The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and will not be subject to be taken by his creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

8.5 No Guarantee of Tax Consequences. Neither the Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant.

8.6 Governing Law. This Plan shall be construed, administered, and enforced according to the laws of Virginia, except to the extent such laws are superseded by federal law.

8.7 Mistaken Contributions. If any contribution is made by the Company because of a mistake of fact, the portion of that contribution due to the mistake of fact shall be returned to the contributor as permitted by the Code.

IN WITNESS WHEREOF, the Company has caused this Plan to be executed in its name and behalf this ___ day of _____, 2005, by its duly authorized officer.

SOUTHEASTERN UNIVERSITIES RESEARCH ASSOCIATION

By:_____

Its:_____

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