SOUTHEASTERN UNIVERSITIES RESEARCH ASSOCIATION

SUMMARY PLAN DESCRIPTION
FOR THE
CAFETERIA PLAN
HEALTH FLEXIBLE SPENDING ACCOUNT PLAN
DEPENDENT CARE ASSISTANCE PLAN

Effective as of January 1, 2005

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INTRODUCTION

Southeastern Universities Research Association sponsors an employee benefits program known as a "Cafeteria Plan." The Plan consists of three component plans: a premium conversion plan, a Health Flexible Spending Account Plan, and a Dependent Care Assistance Plan. These are referred to collectively in this Summary Plan Description as the "Plan." If you become a participant in the Plan, you will have the opportunity to choose benefits provided through the component plans and to pay your part of the cost for them using "pre-tax dollars." This means that you authorize your employer to reduce your salary by the amount of your contributions for benefits. This arrangement is advantageous to you because you save Social Security and income taxes an the amounts you pay for your benefits by salary reduction.

Your Summary Plan Description

This Summary Plan Description describes the basic features of the Southeastern Universities Research Association Cafeteria Plan, Health Flexible Spending Account Plan, and Dependent Care Assistance Plan and explains the way the Plans operate. It replaces and supersedes any and all booklets or Summary Plan Descriptions of the Plans that you may have received in the past. The Summary Plan Description is intended only as a brief summary of the key provisions of the Plans, not as a detailed comprehensive description of all of the Plans' provisions. Complete information is contained in the written Plan documents, maintained by the company. In the event of an inadvertent discrepancy between the information in this Summary Plan Description and the actual provisions of a Plan, the terms of the written Plan document will govern.

Throughout this Summary Plan Description, the words "we," "our," "us" and "the company" mean Southeastern Universities Research Association "You" and "your" mean the employee who is eligible to participate in the Plan.

Eligibility

Each employee who is eligible to participate in a medical insurance benefit plan sponsored by the company, and who is responsible for paying all or a portion of the premiums for such benefits, is eligible to participate in the premium conversion component of the Plan. The eligibility requirements for each type of insurance benefit are described in the separate insurance policy, booklet or summary plan description for that benefit. An eligible employee will become a participant in the premium conversion component of the Plan on the first day of the month coinciding with or immediately following the date he or she satisfies the eligibility requirements for the applicable benefit.

An employee who is scheduled to work at least 20 hours per week and who has been employed by the company for at least 30 days may elect to participate in the Flexible Spending Account portions of the Plan. Participation will begin on the 1st day of the Plan year or, for newly hired employees, the 1st day of the month coinciding with or immediately following the date the employee satisfies the eligibility requirements.

If you have completed the applicable eligibility requirement, you may elect and enroll for any benefits offered through the Plan for which you are eligible.

Components of the Plan

The Cafeteria Plan has two main components, "Premium Conversion" and "Flexible Spending Accounts."

The **Premium Conversion** component of the Plan allows you to elect to pay your part of the premium cost on a pre-tax basis for medical and dental insurance premiums.

The **Flexible Spending Accounts** component allows you to establish a Health Care Flexible Spending Account and/or a Dependent Care Assistance Flexible Spending Account. A Flexible Spending Account or "FSA" is an arrangement that allows you to make pre-tax contributions to an account each payday, and then to be reimbursed from that account for certain types of expenses incurred during the year. A Health Care FSA is used to reimburse you for your family's medical care expenses. A Dependent Care FSA is used to reimburse you for expenses you incur for dependent care needed so that you can work. Health Care and Dependent Care FSAs are described in more detail later in this Summary Plan Description.

BENEFIT ELECTIONS

Electing Your Benefits for the Plan Year

The Plans operate during a Plan year that begins on April 1st and ends on March 31st each year. However, the Plan will be administered with a short Plan Year for the period from January 1, 2005 to March 31, 2005. The Plan Elections for benefits are made on a Plan-year basis. Once you have made your elections for a Plan year, they pertain to the entire Plan year and cannot be changed or cancelled during that time except in certain limited situations, which are described in this Summary Plan Description.

If you first become eligible to participate in the Plan during a Plan year in progress, your initial elections pertain to the remaining part of that Plan year. Then, before each new Plan year begins, you will have an opportunity to change or cancel your elections during the annual election period. The annual election period is described below.

Making Your Elections

In making your elections, you may:

- elect and enroll for some or all of the benefits available under the Premium Conversion component of the Plan; and

- elect a Health Care FSA and/or a Dependent Care FSA.

You may also elect not to participate in the portion of the Cafeteria Plan for which annual elections are then being made.

Election of the premium conversion benefits for medical and dental insurance premiums is automatic for all eligible employees unless they are declined in writing during the annual election period. All other benefits are elected by completing and submitting an election form before the end of the annual election period. When you make your elections, you also authorize the necessary salary reductions for paying your part of the cost of the benefits you elect.

Once you are a participant in the Plan, if you become eligible for additional benefits during a Plan year, you will be given an opportunity to elect and enroll for the benefits for which you are newly eligible. Also, if you have elected benefits under the Premium Conversion portion of the Plan and the cost of the benefits changes during the Plan year, the amount of your salary reduction contributions will be automatically adjusted.

Annual Election Period

Before the beginning of each Plan year, the company will hold an annual election period. The company will notify you of the dates for the annual election period will occur each year. During

this time, you may make new elections for the upcoming Plan year. If you do not complete and submit an election form during the annual election period, you will be deemed to have:

- made the same election for the upcoming Plan year as you made for the previous Plan year for the benefits included in the Premium Conversion component of the Plan;

- elected not to participate in the Flexible Spending Accounts component of the Plan for the upcoming Plan year, regardless of your election for the preceding Plan year; and

- authorized salary reduction contributions for the upcoming Plan year equal to your share of the cost of each benefit deemed to have been elected.

Changing Your Elections During a Plan Year

You generally may not change or revoke your benefits elections during the Plan year except in accordance with the following rules:

Changes to Health Care Flexible Spending Accounts Elections. Except for changes due to HIPAA Special Enrollment Rights or Eligible Status Change, no changes may be made to your Health Care Flexible Spending Account benefit elections during a Plan year.

Mid-Year Election Changes Due to HIPAA Special Enrollment Rights. If you become covered, or your spouse or dependent child becomes covered, under our group health plan or Health Care Flexible Spending Account during a "Special Enrollment Period" required by the Health Insurance Portability and Accountability Act ("HIPAA"), you may prospectively make a corresponding change in your Cafeteria Plan election so that you may pay your contributions for the group health plan or Health Care Flexible Spending Account benefits on a pre-tax basis.

Under HIPAA, Special Enrollment Periods are generally allowed due to certain losses of other group health coverage and changes in family status. A Special Enrollment Period is allowed due to a loss of other group health coverage if you:

- declined coverage under our group health plan when you first became eligible for it;

- stated in writing that you did so because you had other group (or "COBRA") coverage; and

- lose the other group coverage and request enrollment in our group health plan within 30 days.

A Special Enrollment Period is allowed due to a change in family status if you are eligible for coverage under our group health plan and you gain a dependent through marriage, birth, adoption, or placement for adoption.

Mid-Year Election Changes Due to Eligible Status Changes. If you experience an Eligible Status Change, you may prospectively revoke or change your previous benefits elections in a

manner that is consistent with the Eligible Status Change. Eligible Status Changes are changes in a person's eligibility status due to at least one of the following events:

- a change in your legal marital status through marriage, the death of your spouse, divorce, legal separation (as determined under state law), or annulment.

- a change in the number of your dependents for federal income tax purposes through birth, adoption, placement for adoption, or the death of a dependent.

- the beginning or termination of your employment or your spouse or dependent's employment.

- a reduction or increase in your working hours, those of your spouse or dependent, including work-hour changes resulting from a switch between part-time and full-time employment, strike, lockout, or the beginning or end of an unpaid leave of absence.

- your dependent satisfying or ceasing to satisfy the requirements for eligibility (for example, by attaining the limiting age or by losing full-time student status).

- a change in your workplace or residence or that of your spouse or dependent.

An election change is "consistent with" an Eligible Status Change only if it is related to and corresponds with the particular Eligible Status Change that has occurred, For example, you may not cancel coverage for your spouse who has become eligible for coverage under another plan due to an Eligible Status Change unless he or she actually becomes covered under the other plan., However, if you are permitted to add coverage under our group health plan for a spouse or dependent child due to an Eligible Status Change, you may also, at the same time, add group health plan benefits for your other eligible family members.

Mid-Year Election Changes Due to Entitlement to COBRA. You may change your election with respect to health benefits if you become, or your spouse or dependent child becomes, entitled to continued coverage under our group health plan under:

- the federal law known as "COBRA;" or

- a state-mandated continuation of group health plan coverage.

Mid-Year Election Changes Due to a Qualified Medical Child Support Order. A Qualified Medical Child Support Order (or "QMCSO") is a court judgment, decree, or order (including a court's approval of a domestic relations settlement agreement) that requires health benefit coverage of your child. If you are required to provide health coverage to your child(ren) by a QMCSO issued due to a divorce, legal separation, annulment or change in legal custody, you may change your benefits elections with respect to our group health plan benefits.

Mid-Year Election Changes Due to Changes in Medicare and Medicaid Entitlement. If you become entitled to or cease to be entitled to Medicare or Medicaid, or if your spouse or dependent child does so, you may change your benefits elections with respect to health benefits.

Mid-Year Election Changes Due to Eligible Changes in Coverage under the Plan. If coverage under any benefit provided through the Plan is significantly curtailed or terminated during the Plan year and you are affected by the change, you may make an election change to elect another option providing similar coverage. Coverage under group health plan benefits is "significantly curtailed" only if there is an overall reduction in coverage that affects all covered participants. If benefits are significantly curtailed and no alternative option is available under the Plan, revocation of the election is permitted.

If benefits are added to or eliminated from the Plan during the Plan year and you are affected, you may make an election change to elect the new benefits or replace the eliminated benefits with another benefit (other than Health Care Flexible Spending Account benefits) providing similar coverage, if one is available under the Plan.

Mid-Year Election Changes Due to Eligible Changes in Coverage under a Family Member's Plan. In certain situations, you may make a prospective election change due to and consistent with a change in coverage under a Cafeteria Plan sponsored by the employer of your spouse, former spouse, or dependent. You can do so when the change in coverage results from either: (i) an election change permitted under that plan due to an Eligible Status Change or an eligible change in coverage; or (2) an election change made during that plan's annual election period, if its plan year does not coincide with the Plan year of our Cafeteria Plan.

Mid-Year Election Changes Due to Changes in Coverage Costs. If the cost that is charged to all participants for a benefit is significantly increased during the Plan year and you are affected, you may prospectively change your election to elect another benefit option providing similar coverage, if one is available under the Plan. If no such alternative option is available, revocation of the election is permitted.

Mid-Year Election Changes in Dependent Care Flexible Spending Account Benefits Due to Changes in Dependent Care Providers or Hours of Care Provided. You may change your Dependent Care Flexible Spending Account election due to a change in your dependent care provider. You may also change your election if there is a reduction in the number of hours of dependent care services provided.

Mid-Year Election Changes in Dependent Care Flexible Spending Account Benefits Due to Changes in Dependent Care Expenses. You may change your Dependent Care Flexible Spending Account election due to a cost change imposed by your dependent care provider, unless that provider is your relative.

A mid-year election change due to any of the above events must be made as soon as practicable after the occurrence of the event. It will take effect on the 1st of the month following the date you submit your election change. However, if you are enrolling a dependent child pursuant to the

HIPAA Special Enrollment Rights and you notify the company within 60 days of the dependent's birth or adoption, your election change will apply retroactive to the date of birth or adoption.

CONTRIBUTIONS FOR BENEFITS

Contributions for Your Benefits

Your contributions toward the costs of benefits are paid by salary reduction. Your compensation will be reduced by the total amount of your contributions for the benefits you elect. Your pay in each pay period will be reduced by a proportionate amount of the total annual contribution. The reduction in your pay will be adjusted automatically in the event of a change in your cost for the benefits you have elected during the Plan year. Benefits provided to you will end if you fail to make the required contributions for the benefits. If benefits end for this reason, you may not resume premium payments and make new benefit elections within the Plan during the remaining portion of the Plan year.

The company may make periodic contributions toward the cost of some or all of the benefits provided under the Plan. We reserve the right to increase, decrease, or eliminate our contribution for any benefit available under the Plan at any time.

Contributions During an FMLA Leave of Absence

If you have elected and are covered under group health plan benefits (Including Health Care Flexible Spending Account benefits) through the Cafeteria Plan, you are permitted to maintain your coverage during qualified leaves of absence under the Family and Medical Leave Act ("FMLA"). If you choose to do so, you are responsible for paying the portion of the cost of the group health plan benefits that had been contributed via salary reduction contributions while you were working. We will explain the available methods for paying your contributions for coverage during a qualified FMLA leave of absence. Our contributions, if any, will be continued by us during the qualified leave of absence.

Flexible Spending Account Benefits

Flexible Spending Account ("FSA") benefits are made available to you through the Cafeteria Plan. An FSA is an arrangement whereby you may be reimbursed for certain types of eligible expenses incurred during the Plan year up to a specified amount you have elected. You make salary reduction contributions during the Plan year totaling your annual FSA benefit amount. As eligible expenses are incurred during the Plan year, you may then be reimbursed by filing of a valid request for reimbursement.

FSA benefits consist of Dependent Care Flexible Spending Account benefits and Health Care Flexible Spending Account benefits. The two types of FSA benefits are separate and distinct from one another. Your contributions for each FSA are allocated separately and cannot be combined or intermingled. Reimbursements from each type of FSA are limited to those allowable under the applicable section of the Internal Revenue Code.

Cut-off Date for Filing Expenses for the Plan Year

You must submit all requests for reimbursement of eligible expenses incurred during the Plan year no later than 90 days after the end of the Plan year.

Forfeiture of Unused Balances

In accordance with federal rules governing FSA's, any unused balance remaining in an FSA at the end of a Plan year is forfeited by you. This means that at the end of the period designated for submitting eligible expenses incurred during the Plan year, you will lose any amount left unused in your FSA. Because of this "use-it-or-lose-it" rule, it is very important that you estimate your eligible expenses carefully in deciding the FSA benefit amount you will elect for each Plan year.

Highly Compensated and Key Employees

Under the Internal Revenue Code, the amount of contributions to and benefits under FSAs may be limited for participants who are classified as "highly compensated" or "key employees." The company will notify you if you are affected by these limitations and will adjust your contribution elections accordingly.

HEALTH CARE FLEXIBLE SPENDING ACCOUNTS BENEFITS

Benefit Limits

If you elect Health Care FSA benefits, the annual benefit amount you may elect is subject to a maximum limit of $5,000. If you are employed for less than the full Plan year this amount is pro-rated by the number of pay periods for which you are paid. You may not be reimbursed for medical expenses incurred after your last pay date.

Eligible Health Care Expenses

Expenses reimbursable through a Health Care FSA are limited to those which:

- are incurred by you, your spouse, or your dependent;
- are incurred during a Plan year for which you elected Health Care FSA benefits;
- are not eligible for reimbursement from any other source, including any health insurance plan;
- are for services or supplies that fall within the definition of "medical care" in Section 213 of the Internal Revenue Code; and
- are not otherwise precluded from reimbursement because of federal law or regulations or Treasury Department guidelines, rulings, or opinions.

Generally, most expenses that can be itemized as medical care expenses for federal income tax purposes and certain non-prescription drugs are eligible for reimbursement from your FSA. However, if it is unclear that a particular type of expense is eligible, it is your responsibility to confirm that the expense is reimbursable before submitting a request for reimbursement. This can be done by seeking advice from the Plan Administrator or by reading IRS publications available to you at www.irs.gov.

Required Documentation of Expenses

Reimbursements will be issued on the 15th and 30th day of each month. Certain types of documentation are required when you file a request for reimbursement. Each request must be accompanied by a written statement from the provider of the health care services or supplies stating that the expense has been incurred and indicating the amount of the expense. In addition, you must provide a written statement that the expense has not been reimbursed, and is not reimbursable, from any other source including other health insurance coverage. We may also ask for other types of supporting documentation in order to verify that the expenses you submit for reimbursement are eligible under the IRS rules.

Full Amount of Elected Benefits Available Throughout the Plan Year

The total amount of Health Care FSA benefits you elect for the Plan year is uniformly available for the reimbursement of eligible expenses at all times during the Plan year. This is true regardless of the amount you have contributed to date at any point during the Plan year. The maximum amount of reimbursement available at any time is equal to the amount of your total annual election less the amount of reimbursements already made for eligible expenses during the Plan year, if any.

Written Notice and Review of Claim Denials

You are entitled to written notice and a full and fair review of denials (if any) of reimbursement requests (claims) for Health Care FSA benefits. In order to file an appeal, you or your representative must submit a written request for review to **Employee Benefits Management, L.L.C.** within 180 days after receipt of written notice of the claim denial. It must state the reasons the claim should not be denied and provide any additional documentation you deem appropriate. All facts bearing on the claim will then be reexamined and a final decision will be rendered. You will be notified of the final decision within 60 days unless special circumstances require an extension of the time for completing the review. If an extension is needed, you will be given written notice before the extension begins. The final decision will then be made no later than 120 days after receipt of the review request. The final decision and the specific reasons for it will be provided in writing and will include specific references to the Plan provisions on which it is based;

Effect of Revocation of Election due to Termination of Employment

If you terminate employment before the end of the Plan year, you are only entitled to be reimbursed for medical expenses incurred as of your last pay date and you must submit your reimbursement request within 90 days after the last day of the Plan Year in which you terminated employment.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFITS

The Dependent Care Assistance Plan

The company has established a Dependent Care Assistance Plan ("DCAP") in order to make Dependent Care Flexible Spending Account benefits available through the Cafeteria Plan. If you have elected Dependent Care FSA benefits, you may be reimbursed for eligible dependent care expenses incurred during the Plan year up to a specified amount you have elected. If you terminate employment before the end of the Plan year, you are only entitled to be reimbursed for dependent care expenses incurred as of your last pay date and you must submit your reimbursement request within 90 days after the last day of the Plan Year in which you terminated employment.

Limitations on Benefits

By law, the maximum aggregate benefit available to you is limited to $5,000 per calendar year, or, if you are married and you file a separate income tax return, to $2,500 per calendar year. The aggregate maximum benefit, when taken with other such reimbursements, is further limited to the lesser of your earned income (as defined in Section 32 of the Internal Revenue Code) for the taxable year or that of your spouse. The annual benefit amount you may elect is also subject to certain minimum and maximum limits established by the Plan. We will inform you of the applicable limits for each Plan year before the annual election period.

Eligible Dependent Care Expenses

Expenses that may be reimbursed through your Dependent Care FSA are limited to those which:

- are incurred by you or your spouse;
- are incurred during the Plan year for which you elected Dependent Care FSA benefits;
- are incurred to enable you to maintain or seek gainful employment;
- were incurred for the care of "qualifying individuals" (explained below);
- if paid for by you, would be considered "employment-related expenses" as defined in Section 21(b) of the Internal Revenue Code (explained below);
- are not for services provided by your dependent (as described in Section 151(c) of the Internal Revenue Code) or by your child under age 19;
- are not reimbursable from any other source; and
- are not otherwise precluded from reimbursement because of federal law or regulations or Treasury Department guidelines, rulings, or opinions.

It is your responsibility to determine which expenses are eligible for reimbursement from your Dependent Care FSA. Additional information about eligible dependent care expenses is available from the IRS Publication 503.

Qualifying Individuals

A **"qualifying individual"** is:

- a child under 13 years old for whom you are entitled to a dependency deduction on your federal income taxes. Note: A child of divorced parents is a qualifying individual only for the custodial parent of whom he or she is a dependent.

- any other dependent of yours who is physically or mentally incapable of caring for himself or herself, regardless of age, and who shares the same principal place of abode with you for more than one-half of the calendar year; a person may be a dependent for this purpose even if you cannot claim the dependency exemption because the person has gross income in excess of the exemption amount.

- your spouse who is physically or mentally incapable of caring for himself or herself and who shares the same principal place of abode with you for more than one-half of the calendar year.

Employment-related expenses

In general, **"employment-related expenses"** are those that are for the care of a qualifying individual, and that are incurred so that you can maintain gainful employment. They must be expenses that enable you to work, not just expenses that are incurred while you are at work. Expenses for household services that are related to the care of a qualifying individual may also be reimbursed. For example, expenses that are for the care of a qualifying individual and the service of cooking meals for that qualifying individual while he or she is in the care of the dependent care provider are reimbursable. "Care" of a qualifying individual means providing for his or her well-being and protection. Expenses for food, clothing, and education are not reimbursable unless they are inseparable from incidental to the expenses for the dependent care. For example, a babysitter's expenses are covered even if the babysitter also provides lunch to the child as an incidental part of his or her care. IRS Publication 503 provides more detailed information about eligible dependent care services, is available at www.irs.gov.

Required Documentation of Eligible Dependent Care Expenses

Reimbursement checks will be issued on the 15th and 30th day of each month. Requests for reimbursement of dependent care expenses must include a written statement containing information needed to verify the eligibility of the expenses and to operate the Plan in accordance with all legal requirements. You may use the form furnished for submitting your reimbursement requests. You may also be asked for additional information, if necessary to confirm that all IRS requirements are satisfied. Information that is required or that may be requested includes but is not limited to the following:

- the name of each dependent for whom services were provided;
- the relationship of each dependent to you;
- the exact nature of the services performed;
- the amount of the requested reimbursement;
- the relationship of the service provider to you, if any;
- if the services were performed by your child, the age of the child providing the care;
- the place where the services were performed;
- if services were performed outside your household, a statement as to whether the dependent spends the required amount of time in your household;
- if services were performed in a daycare center, information needed to verify that the facility qualifies as a "dependent care center" as defined in the applicable regulations;
- if you are married, a statement of your spouse's earned income, or information needed to verify that an unemployed spouse is either incapacitated or is a full-time student for the required portion of the year; and
- a statement that the expenses have not been reimbursed, and are not reimbursable, from any other source.

Note -- Eligible dependent care expenses are considered incurred when the care is provided, regardless of when the provider of care bills, charges for, or is paid for the services.

Child and Dependent Care Tax Credit

Depending on your income, IRS rules let you claim a tax credit for qualifying dependent care expenses of up to $3,000 for one dependent or up to $6,000 for two or more dependents. Expenses you can apply towards the tax credit are reduced, dollar-for-dollar, by the amount of expenses reimbursed under this Plan. You should review IRS Publication 503, “Child and Dependent Care Expenses,” or consult with your personal financial or tax advisor to help you decide whether the tax credit or the Plan is more favorable to you.

GENERAL PROVISIONS

Identifying Information

- The legal names of the plans are the Southeastern Universities Research Association Cafeteria Plan, the Southeastern Universities Research Association Health Flexible Spending Account Plan, and the Southeastern Universities Research Association Dependent Care Assistance Plan. The plans share one identifying Plan Number, which is 508 The Plans provide benefits as described in this booklet.

- The Plans are administered by the company through Employee Benefits Management, L.L.C., a third party administrator. The address for Employee Benefits Management, L.L.C. is 8740 Landmark Road, Richmond, Virginia 23228, and its telephone number is (804) 515-8900. Reimbursement claims may be faxed to (804) 515-8910.

- The Plan Sponsor is Southeastern Universities Research Association The designated agent for service of legal process for the Plan is Southeastern Universities Research Association, 12000 Jefferson Avenue, Newport News, Virginia 23606. The company's federal tax identification number is 54-1156453. The Plan year is the 12-month period beginning on April 1 and ending on March 31. The fiscal year for each Plan ends on the last day of the Plan year.

- For purposes of your ERISA rights under the Health Flexible Spending Account Plan, Southeastern Universities Research Association is the "named fiduciary" and "Plan Administrator."

- The Plan provides a means for before-tax contributions to be made for benefits that may be fully insured or self-funded by the company. Insured benefits are provided under separate plan documents and/or insurance policies. Self-funded FSA benefits are provided under this Plan, and the cost of such coverage is borne by the company and by participants, who contribute to the cost by salary reduction contributions.

Company's Right to Change or End the Plan

The right is reserved for the company to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time.

No Guarantee of Non-taxability

The Plan provides benefits intended to be non-taxable; however, the employer, Plan Administrator or any fiduciary or party associated with the Plan shall not be in any way liable for any taxes or any other liability incurred by you or any person claiming through you.

Continuation of Group Health Plan Benefits

Employers who employ twenty or more employees are subject to the group health plan continuation provisions of COBRA. The COBRA continuation requirements apply to the Health FSA and to the group health plan benefits provided through the Cafeteria Plan. Your COBRA rights under the Health FSA are explained in the appendix to this Summary Plan Description. Your COBRA rights for group health plan benefits are provided in the separate written plan document(s) for those benefits.

ERISA Rights

If you are a Participant in the Health Flexible Spending Account Plan, you may be entitled to certain rights and protections under ERISA. Where applicable, ERISA provides that Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents. These include insurance contracts, copies of all documents filed by the Plan with the Department of Labor (such as detailed annual reports), and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information by writing to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

- 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 financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. Plan fiduciaries have a duty to operate benefit plans prudently and in the interest of plan participants.

- No one may terminate a participant's employment or otherwise discriminate against 'a participant in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA.

- If a participant's claim for a welfare benefit is denied in whole or in part, the participant must receive a written explanation of the reason for the denial.

- The participant has the right to have the Plan Administrator review and reconsider his or her claim.

Under ERISA, there are steps participants can take to enforce the above rights. For instance:

- If a participant requests materials from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the participant up to $110 a day until the

materials are received (unless the materials were not sent because of reasons beyond the control of the Administrator).

- If a participant has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or federal court.

- If Plan fiduciaries misuse the Plan's money or if a participant is discriminated against for asserting his or her rights, the participant may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay these costs and fees. If the participant loses, the court may order him or her to pay these costs and fees, if, for example, it finds the claim to be frivolous.

If you have any questions about your benefits, 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 Area Office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

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APPENDIX

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

** CONTINUATION COVERAGE RIGHTS UNDER COBRA **

Introduction

You are receiving this notice because you have recently become covered under the Southeastern Universities Research Association Health Flexible Spending Account Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the 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 your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

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, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Southeastern Universities Research Association Administrative office.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment

terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The disabled individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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.