JEFFERSON SCIENCE ASSOCIATES, LLC
HEALTH FLEXIBLE SPENDING ACCOUNT PLAN

Originally Effective: March 27, 1991
Amended and Restated Effective: June 1, 2006

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SECTION 1
INTRODUCTION

This Plan is intended to qualify as a health flexible spending arrangement, as defined in Treasury Regulation Section 1.125-2, Q and A-7, and Internal Revenue Code Sections 105(b) and 106(c), and as a medical reimbursement plan under Internal Revenue Code Section 105(b), and is to be interpreted in a manner consistent with the requirements of these Code Sections.

SECTION 2
DEFINITIONS

Whenever used herein, the following terms have the following meanings unless a different meaning is clearly required by the context:

2.1 Administrator. The Company or such other person or committee as may be appointed from time to time by the Company to supervise the administration of the Plan.

2.2 Cafeteria Plan. The Jefferson Science Associates, LLC Cafeteria Plan, as amended from time to time.

2.3 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.

2.4 Company. Jefferson Science Associates, LLC, a Virginia Limited Liability Company. Prior to June 1, 2006, the Company name was Southeastern Universities Research Association, a Virginia non-stock corporation.

2.5 Coverage Amount. The amount of medical reimbursement coverage elected by the Participant for the Plan Year under Section 4.2.

2.6 Dependent. Any person who is a dependent of the Participant within the meaning of Section 152 (as modified for purposes of Code Sections 105(b) and 106). For this purpose, any child to whom Code Section 152(e) applies shall be treated as a Dependent of both parents.

2.7 Effective Date. The original effective date is March 27, 1991. The effective date of this amendment and restatement is June 1, 2006.

2.8 Employee. Any individual employed by the Company.

2.9 ERISA. The Employee Retirement Income Security Act of 1974, as amended from time to time. Reference to any section or subsection of ERISA includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

2.10 Health Flexible Spending Account. The account described in Plan Section 5.

2.11 Participant. Each Employee who participates in the Plan in accordance with Plan Section 3.

2.12 Plan. The Jefferson Science Associates, LLC Health Flexible Spending Account Plan as set forth herein, together with any and all amendments and supplements hereto. Prior to this

amendment and restatement, the Plan was named the Southeastern Universities Research Association Medical Reimbursement Plan.

2.13 Plan Year. The 12-month period beginning on April 1 and ending on March 31 each year.

2.14 Qualifying Medical Care Expense. An expense incurred by a Participant, or by the spouse or Dependent of such Participant, for medical care as defined in Code Section 213(d), (including, without limitation, amounts paid for hospital bills, doctor and dental bills, prescription drugs, and expenses for medical care within the meaning of Code Section 213(d)(1) and Treasury Regulation Section 1.213-1(e)(2), but only to the extent that the Participant or other person incurring the expense is not reimbursed (or entitled to reimbursement) for the expense through insurance or otherwise (other than under the Plan). "Qualifying Medical Care Expense" does not include any premium paid for health coverage under any plan maintained by the Company or any other employer. Qualifying Medical Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

2.15 Required Premium. The Participant's Coverage Amount for the Plan Year divided by twelve (12) (or, if greater than twelve (12), the number of regular compensation payments, if any, currently received by the Participant per year).

SECTION 3
PARTICIPATION

3.1 Date of Participation. Each Employee who normally works at least twenty (20) hours per week is eligible to participate in the Plan after he has completed thirty (30) days of employment with the Company. Each eligible Employee who has elected under the Cafeteria Plan to reduce his salary and have the Company reimburse him under this Plan will participate in the Plan. An Employee will become a Participant on the first day of the month coinciding with or immediately following the date the employee becomes eligible to participate under the preceding sentence.

3.2 Cessation of Participation. A Participant will cease to be a Participant as of the earliest of:

(a) the date the Participant terminates employment,

(b) the end of the Plan Year, unless the Participant makes another election to receive benefits under this Plan for the next Plan Year,

(c) the date coinciding with the date on which he or she ceases to be an Employee eligible to participate under Section 3.1,

(d) the date on which he or she fails to pay any Required Premium (including payment by salary reduction), or

(e) the date the Plan terminates.

3.3 Reinstatement of Former Participant. If a former Participant who is eligible under Section 3.1 elects again under the Cafeteria Plan to receive benefits under this Plan for any Plan Year, or if such an election is reinstated under the Cafeteria Plan, he or she will again become a Participant in this Plan on the effective date of such election or reinstatement.

3.4 Participant of Spouses or Dependents. If and to the extent required by law, coverage under this Plan shall be made available to the spouse or a Dependent of a Participant or former Participant in lieu of (or in addition to) the Participant. In that event, such spouse or Dependent shall be treated as a Participant under this Plan, but only to such extent and for such period as the law requires. No salary reduction agreement shall be required for such a spouse or Dependent, but Required Premiums must be paid to the Company on a monthly basis (or within such other time limit as may be provided for by law), and coverage shall cease upon nonpayment of any such Required Premium.

SECTION 4
ELECTION TO RECEIVE MEDICAL CARE EXPENSE REIMBURSEMENTS

4.1 Election Procedure. A Participant may elect to receive reimbursements of his or her Qualifying Medical Care Expenses under this Plan by filing an election and compensation reduction agreement in accordance with the procedures established under the Cafeteria Plan. An election to receive reimbursements of Qualifying Medical Care Expenses may not be revoked by the Participant during the Plan Year, except in the case of a permitted election change under Treasury Regulation Section 1.125-4, as provided in the Cafeteria Plan.

4.2 Coverage Amount. A Participant may elect to receive payments or reimbursements of Qualifying Medical Care Expenses incurred in any Plan Year up to any dollar amount specified by the Participant, but not exceeding $5,000. Notwithstanding the preceding sentence, the Coverage Amount for any Participant who enters the Plan during a Plan Year shall not exceed $208.33 multiplied by the number of pay periods for which amounts are deducted from his pay in his period of participation in such Plan Year, and the Coverage Amount for any such Participant for any Plan Year consisting of fewer than twelve (12) months shall not exceed $208.33 multiplied by the number of pay periods for which amounts are deducted from his pay in such Plan Year.

SECTION 5
HEALTH FLEXIBLE SPENDING ACCOUNTS

5.1 Establishment of Accounts. The Company will establish and maintain on its books a Health Flexible Spending Account for each Plan Year with respect to each Participant who has elected to receive reimbursement of Qualifying Medical Care Expenses incurred during the Plan Year.

5.2 Crediting of Accounts. There shall be credited to a Participant's Health Flexible Spending Account for each Plan Year, as of the beginning of such Plan Year, an amount equal to the Participant's Coverage Amount for such Plan Year. Except as otherwise required by law, the amount credited for each Plan Year shall be the property of the Company until paid out pursuant to Section 6.

5.3 Debiting of Accounts. A Participant's Health Flexible Spending Account for each Plan Year shall be debited from time to time in the amount of any payment under Plan Section 6 to or for the benefit of the Participant for Qualifying Medical Care Expenses incurred during such Plan Year.

5.4 Forfeiture of Accounts. The amount credited to a Participant's Health Flexible Spending Account for any Plan Year shall be used only to reimburse the Participant for Qualifying Medical Care Expenses incurred during such Plan Year while a Participant, and only if the Participant applies for reimbursement on or before June 30 following the close of the Plan Year. If any balance remains in the Participant's Health Flexible Spending Account for a Plan Year after all reimbursements hereunder, such balance shall not be carried over to reimburse the Participant for any Qualifying Medical Care Expenses incurred during a subsequent Plan Year, and shall not be available to the Participant in any other form or manner, but shall remain the property of the Company, to the extent permitted by law, and the Participant shall forfeit all rights with respect to such balance. The Company may, at its sole discretion, return such amounts to Participants as permitted by law.

SECTION 6
PAYMENT OF MEDICAL CARE EXPENSE REIMBURSEMENTS

6.1 Claims for Reimbursement. A Participant who has elected to receive medical care reimbursement for a Plan Year may apply to the Company for reimbursement of Qualifying Medical Care Expenses incurred while a Participant during the Plan Year by making application in writing to the Company, in such form as the Company may prescribe, setting forth:

(a) the amount, date and nature of each expense;

(b) the name of the person, organization or entity to which the expense was or is to be paid;

(c) the name of the person for whom the expense was incurred and, if such person is not the Participant requesting the benefit, the relationship of such person to the Participant;

(d) the amount recovered or expected to be recovered, under any insurance arrangement or other plan, with respect to the expense; and

(e) a statement that the expense (or the portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage.

Such application shall be accompanied by a written statement from an independent third party, stating that the expense has been incurred and the amount of the expense, and by such other bills, invoices, receipts, cancelled checks or other statements or documents that the Company may request. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

6.2 Reimbursement or Payment of Expenses. The Company shall reimburse the Participant from the Participant's Health Flexible Spending Account, at such time and in such manner as the Administrator may prescribe for Qualifying Medical Care Expenses incurred during the Plan Year while a Participant, for which the Participant makes written application and submits documentation in accordance with Section 6.1. No reimbursement will be made if the Participant's claim is for an amount less than $50 or such lesser minimum reimbursable amount as may be established by the Administrator. The amount of any Qualifying Medical Care Expenses not reimbursed as a result of the minimum reimbursable amount shall be carried over and reimbursed only if and when the Participant's unreimbursed claims equal or exceed such minimum. Notwithstanding the preceding sentence, claims for expenses incurred during a Plan Year that are submitted for reimbursement during the last month of the Plan Year or by June 30 following the close of the Plan Year shall be paid regardless of whether they equal or exceed the minimum reimbursable amount, provided they do not exceed the remaining balance of the Participant's Health Flexible Spending Account.

6.3 Limitation on Reimbursements or Payments with Respect to Certain Participants. Notwithstanding any other provision of this Plan, the Administrator may limit the amounts reimbursed or paid with respect to any Participant who is a highly compensated individual (within the meaning of Code Section 105(h)(5) or 125(e)) to the extent the Administrator deems such limitation to be advisable to assure compliance with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Plan Section 5.4.

SECTION 7
CESSATION OF COVERAGE

7.1 Cessation of Participation. In the event that a Participant ceases to be a Participant in this Plan for any reason during a Plan Year, the Participant's compensation reduction agreement relating to this Plan shall terminate. Except as provided in Plan Section 7.2, the Participant shall be entitled to reimbursement only for Qualifying Medical Care Expenses incurred within the same Plan Year and on or before the Participant's last pay date.

7.2 Continuation of Coverage. If and to the extent required by law (including, without limitation, Code Sections 105, 125, and 4980B and regulations thereunder), in the event a Participant ceases to be an Employee and undertakes to pay Required Premiums to the Company on a monthly basis (or within such other time limit as may be provided for by law), coverage under the Plan shall continue so long as such Required Premiums are paid, but not beyond the end of the period for which such coverage is required by law. In addition, the former Participant shall be treated as a Participant under the Plan to such extent as is required by law, and shall be entitled to reimbursement for Qualifying Medical Care Expenses incurred during such period of continued coverage, subject to Plan Section 7.3.

7.3 Limits on Time and Amount of Reimbursements. Reimbursements shall be made for any Plan Year under this Plan Section 7 only if the Participant applies for such reimbursement in accordance with Plan Section 6.1 on or before June 30 following the close of the Plan Year. In the event of the Participant's death, the Participant's spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements permitted under this Section 7. No reimbursement under this Plan Section 7 shall exceed the remaining balance, if any, in the Participant's Health Flexible Spending Account for the Plan Year in which the expenses were incurred.

SECTION 8
ADMINISTRATION

8.1 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, however, to the requirements of ERISA. 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 compute the amount of benefits which will be payable to any Participant or other person in accordance with the provisions of the Plan, and to determine the person or persons to whom such benefits will be paid;

(e) To authorize the payment of benefits;

(f) To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan;

(g) 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 by written instrument and in accordance with Section 405 of ERISA; and

(h) To make all decisions involving interpretation of the Plan, including, but not limited to, determination of entitlement of Participants to benefits. The Administrator's decisions shall be final unless determined by a court of competent jurisdiction to be arbitrary and capricious, an abuse of discretion or contrary to law.

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

8.3 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 any accountant, counsel or other expert who is employed or engaged by the Administrator.

8.4 Named Fiduciary. The Administrator will be a "named fiduciary" for purposes of Section 402(a)(1) of ERISA with authority to control and manage the operation and administration of the Plan, and will be responsible for complying with all of the reporting and disclosure requirements of Part 1 of Subtitle B of Title I of ERISA.

8.5 Claims and Review Procedures.

(a) Claims Procedure. If any person believes he or she is being denied any rights or benefits under the Plan, such person may file a claim in writing with the Administrator. If any such claim is wholly or partially denied, the Administrator will notify such person of its decision in writing. Such notification will be written in a manner calculated to be understood by such person and will contain (i) specific reasons for the denial, (ii) specific reference to pertinent Plan provisions on which the benefit determination is based, (iii) a description of any additional material or information necessary for the person to perfect the claim and an explanation of why such material or information is necessary; (iv) a description of the review procedures set out in this Section 8.5 and the time limits applicable to such procedures, including a statement of the person's right to bring a civil action under ERISA §502(a) following an claim denial on review; (v) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the person upon request; and (vi) if the denial of the claim is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the person's medical circumstances, or a statement that such explanation will be provided free of charge upon request. Such notification will be given within thirty (30) days after the claim is received by the Administrator (or within forty-five (45) days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to such person within the initial thirty (30) day period). If such notification is not given within such period, the claim will be considered denied as of the last day of such period and such person may request a review of his or her claim.

(b) Review Procedure. Within one hundred eighty (180) days after the date on which a person receives a written notice of a denied claim (or, if applicable, within one hundred eighty (180) days after the date on which such denial is considered to have occurred) such person (or his or her duly authorized representative) may (i) file a written request with the Administrator for a review of the denied claim and of pertinent documents and (ii) submit written issues and comments to the Administrator. Upon its receipt of a notice for a request for a review, the Administrator shall make a prompt decision on the review. The individual who conducts the review shall not be the same individual who made the initial decision to deny the claim. If the claim denial is appealed on the basis of medical judgment, the Administrator shall consult with an independent health care professional (a physician or other health care professional licensed, accredited or certified to provide specified health services consistent with state law) who is

qualified in the areas of dispute who shall not have been involved in the initial claim denial. The Administrator will notify the person making the appeal of its decision in writing. Such notification will be written in a manner calculated to be understood by such person and will contain (i) specific reasons for the decision; (ii) specific references to the pertinent Plan provisions on which the determination was based; (iii) a statement that the person is entitled to receive without charge reasonable access to any document (1) relied on in making the determination, (2) submitted, considered or generated in the course of making the benefit determination, (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on; (iv) 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 person's medical condition, or a statement that this will be provided without charge on request; (v) a statement describing the person's right to bring a civil action under ERISA § 502(a); and (vi) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency." The decision on review will be made within sixty (60) days after the request for review is received by the Administrator (or within one hundred twenty (120) days, if special circumstances require an extension of time for processing the request, such as an election by the Administrator to hold a hearing, and if written notice of such extension and circumstances is given to such person within the initial sixty (60) day period).

8.6 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.

8.7 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 9
AMENDMENT OR TERMINATION OF PLAN

9.1 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 bring the Plan into compliance with applicable law.

9.2 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. Upon termination or discontinuance of the Plan, all elections and reductions in compensation related to the Plan shall terminate, and reimbursements shall be made only in accordance with Plan Section 7.

SECTION 10
PRIVACY STANDARDS

10.1 General. The Plan shall not disclose Protected Health Information to any member of the Company's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

10.2 Permitted Uses and Disclosures. Protected Health Information disclosed to members of the Company's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

10.3 Authorized Employees. The Plan shall disclose Protected Health Information only to members of the Company's workforce who are designated on Schedule A hereto and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. For purposes of this Section, "members of the Company's workforce" shall refer to all employees and other persons under the control of the Company.

(a) Updates Required. The Company shall amend Schedule I promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) Use And Disclosure Restricted. An authorized member of the Company's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) Resolution of issues of noncompliance. In the event that any member of the Company's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

(1) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(2) Appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(3) Mitigation of any harm caused by the breach, to the extent practicable; and

(4) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

10.4 Certification of Company. The Company must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Company with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with CFR § 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with § 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with CFR § 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Company still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(j) Ensure the adequate separation between the Plan and members of the Company's workforce, as required by CFR § 164.504(f)(2)(iii) of the Privacy Standards and set out in Section 10.3 hereof.

SECTION 11
MISCELLANEOUS

11.1 Communication to Employees. Promptly after the Plan is adopted or amended, the Company will notify all Employees of the availability and terms of the Plan.

11.2 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against the Administrator or the Company, except as expressly provided herein, and in no event will the terms of employment or service of any Participant be modified or in any way be affected hereby.

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

(a) the benefits provided hereunder will be paid solely from 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 assets of the Company from which any payment under the Plan may be made.

11.4 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.

11.5 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. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Company if the Participant has reason to believe that any such payment is not so excludable.

11.6 Indemnification of Company by Participants. If any Participant receives one or more payments or reimbursements under this Plan that are not for Qualifying Medical Care Expenses, such Participant shall indemnify and reimburse the Company for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation,

plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

11.7 Governing Law. The Plan will be construed, administered and enforced according to the laws of the Commonwealth of Virginia except to the extent such laws are superseded by federal law.

11.8 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 ERISA and the Code.

IN WITNESS WHEREOF, the Company has caused this Plan to be executed in its name and on its behalf by its duly authorized officer this ____ day of _____, 2006.

JEFFERSON SCIENCE ASSOCIATES, LLC

By:_____

Its:_____

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