SUMMARY PLAN DESCRIPTION OF THE

JEFFERSON SCIENCE ASSOCIATES, LLC CAFETERIA PLAN

PLEASE READ THIS CAREFULLY
AND KEEP FOR FUTURE REFERENCE.

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1. INTRODUCTION

Jefferson Science Associates, LLC ("JSA" or the "Company") sponsors the Jefferson Science Associates, LLC Cafeteria Plan (the "Plan"). This Plan provides tax savings by giving you the ability to pay premiums for the insurance benefits that you choose or certain health or dependent care expenses with pre-tax contributions. By paying for these benefits with a portion of your pay before Federal income or Social Security taxes are withheld, you will pay less tax and have more money to spend and save.

This booklet is a Summary Plan Description, or "SPD" that describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

This booklet is intended to give you an overview of the Plan. It does not cover all the Plan provisions. You may review a copy of the actual Plan document at the Plan Administrator's office. If there are any differences between this SPD and the Plan, the provisions of the Plan will control and you should disregard this SPD.

If you have any questions concerning the applicable benefit programs or your rights and obligations as a participant, please feel free to contact Human Resources at 628 Hofstadter Road, Suite 2, Newport News, Virginia 23606. The phone number is (757) 269-7576.

The effective date of this SPD is April 1, 2011.

2. BECOMING A MEMBER

2.1 WHAT BENEFITS MAY BE ELECTED UNDER THE PLAN?

The Plan offers a way for you to pay for your insurance benefits premiums or certain health or dependent care expenses with pre-tax contributions. Under our Plan, you can choose to receive your entire compensation or use a portion to pay for the insurance benefit premiums or certain health or dependent care expenses during the year. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return for that expense.

Paying for your benefits with pre-tax contributions will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance), which are based on taxable

compensation. However, the tax savings that you realize through Plan participation will often more than offset any reduction in other benefits.

There are three components to the Plan which are described below: (1) Premium Payment Component; (2) Medical Reimbursement Component; and (3) Dependent Care Reimbursement Component.

Premium Payment Component:

The Premium Payment Component allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer you. These premium expenses include:

1. Health care premiums under our insured group medical plan

2. Dental insurance premiums

In this SPD the term "Medical Insurance Benefits" means both 1 and 2 above.

Medical Reimbursement Component:

The Medical Reimbursement Flexible Spending Account (FSA) enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan and save taxes at the same time. The Medical Reimbursement FSA allows you to be reimbursed for out-of-pocket medical, dental and/or vision expenses incurred by you and your dependents from your Medical Reimbursement Account. The maximum amount you can contribute to your Medical Reimbursement Account is $5,000 for the 2011 plan year. For future years, the maximum contribution limits will be determined by the Plan Administrator each year and will be specified in your enrollment materials.

A list of covered expenses is available from the Plan Administrator. You may not, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. In addition, effective January 1, 2011, reimbursement for over-the-counter items will be limited to over-the-counter medicines and drugs that are prescribed, insulin, and medical items, equipment, supplies or diagnostic devices, such as bandages, crutches or blood sugar test kits. Expenses for over-the-counter items incurred before January 1, 2011 may be reimbursable, provided they are submitted before the claim deadline (see Section 4 "Benefit Payments").

In order to be reimbursed for a health care expense, you must submit to the Plan Administrator an itemized bill from the service provider. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from your account will be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

Dependent Care Reimbursement Component:

The Dependent Care Reimbursement Flexible Spending Account (FSA) enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

(a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws:

(b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and

(c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Reimbursement
FSA. Generally, your reimbursements may not exceed the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation; and (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents). Also, in order for the reimbursements made to you from this account to be excluded from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Reimbursement FSA under our Plan. Ask your tax adviser which is better for you.

Tax Consequences of Domestic Partner Coverage:

Under federal tax law, if your (non-spouse) domestic partner does not qualify as your tax dependent for health coverage purposes, then you will be unable to pay for your domestic partner's coverage on a pre-tax basis under the Plan. The value of your domestic partner's coverage, less the amount you pay for the coverage on an after-tax basis, will be included in your gross income, subject to federal income tax withholding and employment taxes, and will be reported on your Form W-2 . This includes any portion of the premiums that the Company

pays for your domestic partner's health coverage. You will also be unable to claim expenses for your domestic partner under the Medical Reimbursement FSA.

If your domestic partner qualifies as your tax dependent for health coverage purposes, then you will be able to pay for your domestic partner's coverage on a pre-tax basis under the Plan and no portion of the premiums paid by the Company will be included in your income or be subject to federal withholding or employment taxes. You will also be able to claim eligible medical expenses for your domestic partner under the Medical Reimbursement FSA.

Note that if your domestic partner fails to qualify as your tax dependent for health coverage purposes for the entire year because of a change of abode, household, or support during the year, the value of your domestic partner's coverage for the portion of the year prior to the change will be included in your gross income and related income tax and employment tax withholding will be charged to your pay as rapidly as possible. The catch-up on withholding will reduce your take-home pay for some periods.

You should also note that state tax treatment of domestic partner health coverage may differ. For example, some states exclude domestic partner coverage from gross income for state income tax purposes, even if the domestic partner is not a tax dependent for health coverage purposes. See Human Resources for more information about state tax treatment.

Although coverage is also available for children of an eligible employee's domestic partner under the Medical Insurance Benefits, a domestic partner's child is unlikely to qualify as an employee's tax dependent for health coverage purposes. Thus, the value of such coverage generally must be included in gross income. You should contact Human Resources if you believe your domestic partner's child may qualify as your tax dependent for health coverage purposes.

2.2 WHO CAN PARTICIPATE IN THE PLAN?

Premium Payment Component—You are eligible for the Premium Payment Component once you are eligible to receive insurance benefits as described in the applicable insurance benefit summaries. The insurance benefit summaries describe when eligible employees may enroll in the benefit.

Medical Reimbursement Component—You are eligible for the Medical Reimbursement FSA if you are a Regular Employee who is regularly scheduled to work 20 or more hours per week during the year as defined by the Company. You may enroll in the Medical Reimbursement FSA on the first day of the month on or after completion of 30 days of active employment.

Dependent Care Reimbursement Component—You are eligible for the Dependent Care Reimbursement FSA if you are a Regular Employee who is regularly scheduled to work 20 or more hours per week during the year as defined by the Company. You may enroll in the Dependent Care Reimbursement FSA on the first day of the month on or after completion of 30 days of active employment.

2.3 ONCE I HAVE MET THE REQUIREMENTS TO JOIN THE PLAN, HOW DO I JOIN THE PLAN?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected. For more information on enrollment, see Section 3 of this booklet.

However, if you are already covered under any of the insured benefits, you will automatically participate in this Plan to the extent of your premiums unless you elect not to participate in this Plan.

2.4 WHAT HAPPENS IF MY EMPLOYMENT ENDS DURING THE PLAN YEAR OR I LOSE ELIGIBILITY FOR OTHER REASONS?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

(a) You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your Dependent Care Reimbursement Account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit claims by June 30 of the Plan Year following the year in which termination occurs.

(b) For the Medical Reimbursement FSA on termination of employment, you may have continuation coverage under COBRA. Upon your termination of employment, your participation in the Medical Reimbursement FSA will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Medical Reimbursement FSA have already been made. You must submit claims by June 30 of the Plan Year following the year in which termination occurs. Your further participation will be governed by your continuation coverage rights under COBRA.

2.5 HOW DO LEAVES OF ABSENCE AFFECT MY BENEFITS?

FMLA Leaves of Absence. If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for the Premium Payment Contributions and the Medical Reimbursement FSA. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Medical Reimbursement FSA, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its

original level and make payments for the time that you are on leave. Alternatively your maximum amount will be reduced proportionately for the time that you were gone.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

Uniformed Services Employment and Reemployment Rights Act (USERRA). If you are going into or returning from military service, you may have special rights to health care coverage under the Medical Reimbursement FSA due to the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

3. MAKING YOUR ELECTIONS

3.1 HOW DO I ENROLL IN THE PLAN?

At your initial enrollment and before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

Each year, we will automatically contribute on your behalf enough of your compensation to pay for the insurance coverage provided unless you elect not to receive any or all of such coverage. You may also elect to have us contribute on your behalf enough of your compensation to pay for any other benefits that you elect under the Plan. These salary reduction amounts will be deducted from your pay over the course of the year.

3.2 WHAT IS THE OPEN ENROLLMENT PERIOD AND THE PLAN YEAR?

You will make your initial election at the time of your plan entry date. Then, for each following Plan Year, the election period is established by the Plan Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Plan Administrator will inform you each year about the election period.

3.3 CAN I CHANGE MY ELECTIONS DURING THE PLAN YEAR?

Generally, you cannot change your election to participate in the Plan or change the salary reduction amounts that you have selected during the Plan Year (known as the irrevocability rule). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but those election changes will apply only for the following Plan Year. During the Plan Year, however, there are several important exceptions to the irrevocability rule (see Section 3.4).

The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual as defined by the Internal Revenue Code ("the Code"), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law. Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

3.4 WHAT ARE THE SPECIAL CIRCUMSTANCES THAT WOULD ALLOW ME TO CHANGE MY ELECTIONS DURING THE PLAN YEAR?

You are permitted to change elections if you have a "change in election event" and you make an election change that is consistent with the change in status. For details, see the various Change in Election Events headings below for the specific type of Change in Election Event: Leaves of Absence, including FMLA leave; Change in Status; Special Enrollment Rights; Certain Judgments, Decrees, and Orders; Medicare, Medicaid, or State Children's Health Insurance Program ("SCHIP); Change in Cost; and Change in Coverage. Note that the Change in Election Events do not apply for all Benefits—applicable exclusions are described under the relevant headings. In addition, the Plan Administrator can change certain elections on its own initiative.

Generally, if any Change in Election Event occurs, you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days after the occurrence. However, if the Change in Election Event is due to the gain or loss of coverage under Medicare, Medicaid or SCHIP, then you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 60 days after the occurrence. If the change involves a loss of your Spouse's or Dependent's eligibility for Medical Insurance Benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

1. **Leaves of Absence.** (Applies to Premium Payment Component and Medical Reimbursement Benefits.) You may change your salary reduction election under the Plan upon FMLA and non-FMLA leave as described in Section 2.5. Election changes for Dependent Care Reimbursement Benefits must meet the Change in Status rules described in items 2 and 3 below.

2. **Change in Status.** (Applies to Premium Payment Component, to Medical Reimbursement Benefits as limited below, and to Dependent Care Reimbursement Benefits.) If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described in item 3 below). Those occurrences that qualify as a Change in Status include the events described

below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

- a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation, or annulment);

- a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);

- any of the following events that change the employment status of you, your Spouse, or your Dependent and that affect benefits eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of you, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;

- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, ceasing to be a student, or a similar circumstance); or

- a change in your, your Spouse's, or your Dependent's place of residence.

3. **Change in Status—Other Requirements.** (Applies to Premium Payment Component, Medical Reimbursement Benefits as limited below, and Dependent Care Reimbursement Benefits.) If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for Dependent Care Reimbursement Benefits, the event may also affect eligibility of Dependent Care Expenses for the dependent care tax exclusion). Any increase or decrease in coverage for group term life, accidental death & dismemberment or other disability coverage because of a Change in Status satisfies this rule.

   Election changes may not be made to reduce Medical Reimbursement coverage during a Plan Year; however, election changes may be made to cancel Medical Reimbursement coverage completely due to the occurrence of any of the following events: death of your Spouse, divorce, legal separation, or annulment; death of your Dependent; change in employment status such that you become ineligible for Medical Reimbursement coverage; or your Dependent's ceasing to satisfy eligibility requirements for Medical Reimbursement coverage (e.g., on account of attaining a specific age). But if you cancel coverage, it cannot result in your contributions for the year being less than the amount for which you have already been reimbursed. For

example, assume that you elected to contribute $100 per month to the Medical Reimbursement and in February you were reimbursed for expenses in the amount of $700. If a Change in Status occurs in March that allows you to cancel coverage, your cancellation will not take effect until you have contributed a total of $700 for the year.

In addition, you must satisfy the following specific requirements in order to alter your election based on that Change in Status:

- Loss of Spouse or Dependent Eligibility; Special COBRA Rules. For Medical Insurance Benefits and Medical Reimbursement Benefits, a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

  Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar-year cafeteria plan that allows employees to elect any of the following: no medical coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no medical coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel medical coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

  However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage.

- Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status

only if coverage for that individual becomes effective or is increased under the other employer's plan.

- Dependent Care Reimbursement Benefits. With respect to the Dependent Care Reimbursement Benefits, you may change or terminate your election with respect to a Change in Status event only if (a) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the Dependent Care Reimbursement; or (b) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

4. **Special Enrollment Rights.** (Applies to Medical Insurance Benefits, but not to Medical Reimbursement Benefits or Dependent Care Reimbursement Benefits.) In certain circumstances, enrollment for Medical Insurance Benefits may occur outside the Open Enrollment Period, as explained in materials provided to you separately describing the Medical Insurance Benefits. (The Employer's Special Enrollment Notice also contains important information about the special enrollment rights that you may have, a copy of which was previously furnished to you. Contact Human Resources if you need another copy.) When a special enrollment right explained in those separate documents applies to your Medical Insurance Benefits, you may change your election under the Plan to correspond with the special enrollment right.

5. **Certain Judgments, Decrees, and Orders.** (Applies to Medical Insurance Benefits and Medical Reimbursement Benefits, but not to Dependent Care Reimbursement Benefits.) If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your child (including a foster child who is your Dependent) to be covered under the Medical Insurance Benefits or Medical Reimbursement Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

6. **Medicare, Medicaid or SCHIP.** (Applies to Medical Insurance Benefits, to Medical Reimbursement Benefits as limited below, but not to Dependent Care Reimbursement Benefits.) If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare, Medicaid or SCHIP, then you may reduce or cancel that person's Medical Insurance Benefits coverage, and/or your Medical Reimbursement Benefits coverage may be canceled completely but not reduced. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare, Medicaid or SCHIP loses eligibility for such coverage, then you may elect to commence or increase that person's Medical Insurance Benefits and/or Medical Reimbursement Benefits, as applicable.

7. **Change in Cost.** (Applies to Premium Payment Component and to Dependent Care Reimbursement Benefits as limited below, but not to Medical Reimbursement Benefits.) If the cost charged to you for your Medical Insurance Benefits or Dependent Care Reimbursement Benefits significantly increases during the Plan Year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under

another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if no other benefit package option provides similar coverage. (For these purposes, the Medical Reimbursement Component is not similar coverage with respect to the Medical Insurance Benefits, an HMO and a PPO are considered to be similar coverage (the Company currently offers an HMO and a PPO), and coverage under another employer plan, such as the plan of a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.) If the cost of Medical Insurance Benefits or Dependent Care Reimbursement Benefits significantly decreases during the Plan Year, then the Plan Administrator may permit the following election changes: (a) if you are enrolled in the benefit package option that has decreased in cost, you may make a corresponding decrease in your contributions; (b) if you are enrolled in another benefit package option (such as the HMO option under the Medical Insurance Plan), you may change your election on a prospective basis to elect the benefit package option that has decreased in cost (such as the PPO option under the Medical Insurance Benefits); or (c) if you are otherwise eligible, you may elect the benefit package option that has decreased in cost on a prospective basis, subject to the terms and limitations of the benefit package option.

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost.

The Plan Administrator generally will notify you of increases or decreases in the cost of Medical Insurance benefits; you generally will have to notify the Plan Administrator of increases or decreases in the cost of Dependent Care Reimbursement benefits.

The change in cost provision applies to Dependent Care Reimbursement Benefits only if the cost change is imposed by a dependent care provider who is not your relative.

8. **Change in Coverage.** (Applies to Premium Payment Component and Dependent Care Reimbursement Benefits, but not to Medical Reimbursement Benefits.) You may also change your election if one of the following events occurs:

   - Significant Curtailment of Coverage. If your Premium Payment Component or Dependent Care Reimbursement Benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally—loss of one particular physician in a network does not constitute significant curtailment.) If your Medical Insurance Benefits or Dependent Care Reimbursement Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election

and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Medical Insurance Benefits coverage; you generally will have to notify the Plan Administrator of significant curtailments in Dependent Care Reimbursement Benefits coverage.)

- Addition or Significant Improvement of Plan Option. If the Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.

- Loss of Other Medical Insurance Benefits Coverage. You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any medical insurance benefits coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).

- Change in Election Under Another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Company or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan, which it does. For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Plan to replace the dropped coverage.

- Dependent Care Reimbursement Coverage Changes. You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

  If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the Plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Medical Reimbursement FSA, and you may not change your election to the Medical Reimbursement FSA if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Reimbursement FSA if the coverage change is imposed by a dependent care provider who is your relative.

If you have further questions: There are detailed rules on when a change in election is deemed to be consistent with a Change in Status. In addition, there are laws that give you rights to change health coverage for you, your Spouse, or your Dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If you have any questions or if you think any of these conditions may apply to you, you should contact the Plan Administrator.

4. BENEFIT PAYMENTS

4.1 WHEN WILL I RECEIVE PAYMENTS FROM MY MEDICAL REIMBURSEMENT AND DEPENDENT CARE REIMBURSEMENT ACCOUNTS?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Plan Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Dependent Care Reimbursement FSA to the extent that there are sufficient funds in the Account to cover your request.

4.2 WHAT HAPPENS IF I DON'T SPEND ALL PLAN CONTRIBUTIONS DURING THE PLAN YEAR?

If you have not spent all the amounts in your Medical Reimbursement Account or Dependent Care Reimbursement Account by the end of the Plan Year, any monies left will be forfeited. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after will be paid first before any amount is forfeited. For the Medical Reimbursement Account, you must submit claims no later than June 30 of the Plan Year following the year in which termination occurs. For the Dependent Care Reimbursement Account, you must submit claims no later than June 30 of the Plan Year following the year in which termination occurs. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

5. PRESENTING A CLAIM

5.1 HOW DO I PRESENT A CLAIM FOR PRE-TAX PREMIUM PAYMENTS OR MEDICAL AND DEPENDENT CARE REIMBURSEMENTS?

When you incur an expense that is eligible for payment from the Medical Reimbursement FSA or Dependent Care Reimbursement FSA, you must submit a claim to the Plan Administrator on the appropriate form that will be supplied to you. If (a) a claim for reimbursement under the Medical Reimbursement FSA or Dependent Care Reimbursement FSA is wholly or partially denied, or (b) you are denied a benefit under the Plan (such as the ability to pay for insurance benefits, Medical Reimbursement FSA, or Dependent Care Reimbursement FSA on a pre-tax basis) due to an issue germane to your coverage under the Plan (for example, a determination of a Change in Status; a "significant" change in contributions charged; or eligibility and participation matters under the Plan document), then the claims procedure described below will apply.

5.2 WHAT IF MY CLAIM IS DENIED?

If your claim is denied in whole or in part, you will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received your claim. This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information and will have the effect of suspending the time for a decision on your claim until the specified information is provided.

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the denial was based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and
- If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

  When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

  The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

  A document, record, or other information shall be considered relevant to a claim if it:

- was relied upon in making the claim determination;
- was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan

documents and Plan provisions have been applied consistently with respect to all claimants; or

- constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

6. PLAN ADMINISTRATION

6.1 HOW IS MY PLAN ADMINISTERED?

Your Plan Administrator is the Company, but an individual may be selected by the Company to administer the day-to-day operations of your Plan.

6.2 HOW DO I CONTACT THE PLAN ADMINISTRATOR?

You may contact the Plan Administrator by contacting the office of the Company at:

Jefferson Science Associates, LLC
628 Hofstadter Road, Suite 2
Newport News, VA 23606
EIN: 20-3974952

The Medical Care Reimbursement FSA and the Dependent Care reimbursement FSA are administered by the Company through Total Administrative Services Corporation, a third party administrator. The address for Total Administrative Services Corporation is:

Total Administrative Services Corporation
2302 International Lane
Madison, WI 53704

The phone number is (800) 422-4661.

6.3 UNDER WHAT CONDITIONS MAY THE PLAN BE AMENDED OR TERMINATED?

The Company has the right to amend or modify the Plan at any time, subject to certain conditions. The Company intends and expects to maintain the Plan and make contributions to it as described above. However, it reserves the right to terminate the Plan. If the Company discontinues the business, or if it merges with or is sold to another Employer and that

Employer does not adopt the Plan within ninety days, the Plan will automatically terminate. The Company will notify you if a decision to terminate the Plan has been made.

6.4 WILL I PAY ANY ADMINISTRATIVE COSTS UNDER THE PLAN?

No. The cost is paid in part by the use of forfeitures, if any. The rest of the cost of administering the Plan is paid entirely by the Company.

6.5 WHAT ARE FORFEITURES?

Federal law requires that if the Medical Expenses and/or Dependent Care Expenses that you incur during the Plan Year are less than the annual amount that you elected for the Medical and/or Dependent Care Reimbursement FSA, you will forfeit the rest of that amount in your Medical and/or Dependent Care Reimbursement Account. Also, any Medical or Dependent Care Reimbursement FSA payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Medical Care Expense was incurred shall be forfeited and applied as described below.

6.6 WHAT HAPPENS TO FORFEITURES?

Forfeitures of Company contributions are used first, to offset any losses experienced by the Company as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the Plan during the Plan Year and subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations.

7. YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Company's principal office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Human Resources Manager of the Company, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Company may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Company, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Company, as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

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

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Human Resources Manager of the Company. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

8. YOUR CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), allows certain employees and their families participating in the Medical Care Reimbursement FSA the opportunity to elect a temporary extension of health care coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means the Medical Reimbursement FSA.

8.1 WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Medical Reimbursement Account Participants. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

8.2 HOW IS MY PARTICIPATION IN THE MEDICAL REIMBURSEMENT ACCOUNT AFFECTED?

You can elect to continue your participation in the Medical Reimbursement FSA for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Medical Reimbursement FSA if you have elected to contribute more money than you have taken out in claims. For example, if you elected to contribute an annual amount of $500 and, at the time you terminate employment, you have contributed $300 but only claimed $150, you may elect to continue coverage under the Medical Reimbursement FSA. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the $500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. 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). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR 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 or its designee.

9. OTHER IMPORTANT PLAN INFORMATION

Plan Sponsor

The Company who sponsors this Plan is:

Jefferson Science Associates, LLC
628 Hofstadter Road, Suite 2
Newport News, VA 23606

Plan Sponsor's Employer Identification Number

The Company's employer identification number (EIN) is 20-3974952.

Type of Plan

The Medical Care Reimbursement FSA is a group health and welfare benefit plan that is subject to the provisions of ERISA. The Plan is also a cafeteria plan, as defined by Section 125 of the Internal Revenue Code.

Funding Medium and Type of Plan Administration

Medical Insurance premiums for employees and their families are paid in part by the Plan Sponsor out of its general assets, and in part by employee pre-tax payroll deductions under this Plan. Employee pre-tax payroll deductions shall be used in their entirety prior to using Plan Sponsor contributions to pay for premiums under this Plan. Any refund, rebate, dividend, experience adjustment, or other similar payment under the group insurance contract entered into between the Company and the applicable insurance company shall be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse the Company for premiums that it has paid.

The Medical Reimbursement and Dependent Care Reimbursement FSAs provided under the Plan are self-insured by JSA, funded from the Company's general assets. The Medical and Dependent Care Reimbursement Accounts under the Plan are bookkeeping entries and no assets or funds are ever paid to, held in, or invested in any separate trust or account and no interest is paid or credited to any "reimbursement account."

Plan Year

The Plan Year is April 1 to March 31

Plan Number

The Plan Number assigned to this Plan for Form 5500 purposes is 508.

Effective Date

The Plan's original effective date is March 27, 1991. The Plan was most recently restated effective April 1, 2011 (or, if later, the date the restatement was executed by the Company).

Named Fiduciary

The named fiduciary is the Company.

Agent for Service of Legal Process

The name and address of the Plan's agent for service of legal process is the Company.

Qualified Medical Child Support Order

The insured benefits and the Medical Reimbursement Component will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Plan has detailed procedures for determining whether an order qualifies as a

QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

This Summary Plan Description is intended to provide you with easy-to-understand general explanations of the more significant provisions of this Plan. Every effort has been made to make this explanation as accurate as possible; however, the provisions of the Plan are highly technical in nature. If any conflict should arise between this Summary Plan Description (SPD) and the provisions of the Plan, or if, after the best efforts of all involved in writing this summary, any provision is not covered or only partially covered, the terms of the actual Plan document (which will be available to you for review at the offices of the Company) will govern in all cases. Consequently, you are urged to review the Plan document itself whenever a matter or issue of importance arises for you. Plan provisions change from time to time. Those changes occur because the law changes or because the Company changes the Plan. Changes made to the Plan are effective on certain dates specified in the Plan amendments.