SURA/Jefferson Science Associates, LLC

Comprehensive Health and Welfare Benefit Plan

As Amended and Restated Effective April 1, 2011

Originally Effective October 1, 1984

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ARTICLE 1
INTRODUCTION

1.01 Establishment and Restatement of Plan.

Effective October 1, 1984, Southeastern Universities Research Association, Inc established a comprehensive health and welfare benefit plan entitled Southeastern Universities Research Association, Inc./Jefferson Lab Comprehensive Health and Welfare Benefit Plan (the "Prior Plan"). The Prior Plan was subsequently amended and restated, most recently, effective June 1, 2006 and renamed the Prior Plan the "SURA/Jefferson Science Associates, LLC Comprehensive Health and Welfare Benefit Plan" (the "Plan"). Now, in an effort to comply with recent legislative changes, Southeastern Universities Research Association amends and restates the Plan, as set forth in the following pages, attached Appendices, and documents that are incorporated herein by reference, effective April 1, 2011.

1.02 Purpose of Plan.

This Plan is established as an employee welfare benefit plan within the meaning of Section 3(1) of ERISA. The purpose of this Plan is to provide eligible Employees of an Employer with welfare benefits under certain terms and conditions. The benefits offered under this plan are fully insured.

The Employer also intends that, for purposes of the annual report requirement (Form 5500), this document is considered a "wrap" plan and the terms of the underlying plans for which Participants are making contributions through this Plan are hereby incorporated by reference. This document is not intended to give any substantive rights to benefits that are not already provided by the attached group health insurance contract.

1.03 Adoption of Plan by Multiple Employers.

Effective June 1, 2006, Southeastern Universities Research Association, Inc. permitted Jefferson Science Associates, LLC to adopt this Plan. However, Jefferson Science Associates, LLC is not a member of the same controlled group of employers, as defined under Sections 414(b) or (c) or the Internal Revenue Code of 1986, as amended. As such, Southeastern Universities Research Association, Inc. approved the adoption of the Plan by Jefferson Science Associates, LLC and acknowledges that the Plan will be considered a "multiple employer welfare arrangement."

ARTICLE 2
DEFINITIONS

Each following word, term and phrase shall have the following meanings whenever such word, term or phrase is capitalized and used in any Article of this Plan unless the context clearly indicates otherwise:

2.01 **"Administrator"** means the individual(s) or corporation appointed by the Employer to carry out the administration of the Plan. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan. In the event the Administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the Administrator.

2.02 **"Affiliated Company"** shall mean the Company and any business unit that (a) is or is part of a member of a controlled group of corporations within the meaning of Code section 414(b), that includes the Company; (b) is under common control, within the meaning of Code section 414 (c), with the Company; or (c) is a member of an affiliated service group, within the meaning of Code section 414(m), that includes the Company.

2.03 **"Board"** shall mean the board of directors of the Company.

2.04 **"Code"** shall mean the Internal Revenue Code of 1986, as amended, supplemented, or replaced, from time to time. Where appropriate, reference to any section or subsection of the Code includes reference to any corresponding or succeeding provisions of any legislation which amends, supplements, or replaces such section or subsection.

2.05 **"Company"** shall mean Southeastern Universities Research Association, Inc., with respect to its Eligible Employees, and any Affiliated Companies or other Participating Employers that are approved by Southeastern Universities Research Association, Inc. to participate in this Plan, with respect to their Eligible Employees; provided, however, that for purposes of Sections 5.01, the right to amend or terminate the Plan, to determine whether another employer may be a Participating Employer, or to perform other settlor-type functions, "Company" means solely Southeastern Universities Research Association, Inc.

2.06 **"Coverage Documents"** shall mean the applicable Insurance Contracts or other written document related to the underlying Welfare Benefit components listed in Appendix A hereof.

2.07 **"Dependent"** shall mean any individual who qualifies as a Dependent under the respective Coverage Document for purposes of that Welfare Benefit to the extent permitted by law. In addition, any child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609 shall be considered a Dependent under this Plan.

Effective April 1, 2010, the requirement that a dependent child have full-time student status in order to extend coverage past a stated age will generally not apply if the child's failure to maintain full-time status is due to a medically necessary leave of absence or other change in enrollment (such as reduction of hours). If the child's treating physician certifies in writing that the child is suffering from a serious illness or injury, and that the leave of absence or other change in enrollment is medically necessary, coverage may continue for up to a year after the date the medically necessary leave of absence or other change in enrollment begins. To be eligible for the

extension, the child must be enrolled in the Plan as a full-time student immediately before the first day of the medically necessary leave of absence. This extension of coverage continues to apply if the manner of providing coverage under the Plan changes (such as from self-funded to fully insured) if the changed coverage continues to provide coverage for dependent children. However, this extension does not extend coverage beyond the date that a child fails to meet the Dependent eligibility requirements other than the requirement to be a full-time student.

Notwithstanding the foregoing, effective April 1, 2011, for purposes of any Program that is a "group health plan" under reg. §54.9815-2714T, any person who is a child of a Participant is a "Dependent" until his twenty-sixth (26th) birthday even if that person is not a Dependent under IRC §152.

2.08 **"Employee"** means any person who is employed by the Employer as a common-law employee and who is compensated from the Employer's payroll. Provided, however, unless specifically included under the documentation with respect to an underlying component Welfare Benefit provided under the Plan set forth in Appendix A, "Employee" does not include any of the following:

(a) Temporary or seasonal workers classified as such on the Employer's payroll records;

(b) Persons classified by the Employer as project employees. A Project Employee is an individual employed by Southeastern Universities Research Association, Inc. on a temporary basis to work on a specific, named project, for a limited, defined duration of time.

(c) Persons classified and treated by the Employer as independent contractors, contract workers, or any other individual who is not designated as of the initial date of the relationship as a common law employee of the Employer; if someone so classified and treated is subsequently determined by the Employer or any governmental agency or court to be a common law employee of the Employer, such person shall not be considered an Employee until the day after the final determination that such person is a common law employee of the Employer;

(d) Individuals characterized as leased employees (as defined by Code Section 414(n)) or any individuals who would be leased employees but for the fact they are common law employees of the Employer;

(e) Individuals included in a unit covered by a collective bargaining agreement if Welfare Benefits were the subject of good faith bargaining; and

(f) Nonresident aliens who receive no United States source income from the Employer.

In the event a person listed in one or more of the subsections (a) through (f) above is specifically included as an "Employee" under the Coverage Document with respect to an underlying component Welfare Benefit provided under the Plan set forth in Appendix A, he shall be considered an Employee under this Plan only with respect to that specific underlying component Welfare Benefit, and not with respect to any other benefits provided under this Plan.

2.09 **"Employer"** shall mean the Company and any Affiliated Company or Participating Employer which shall ratify and adopt this Plan in a manner satisfactory to the Board pursuant to Article 7 hereof. Participating Employers are set forth in Appendix B hereof. The term, Employer, shall

include any legal entity, unincorporated business organization or corporation into which the Employer may be merged or consolidated or by which it may be succeeded.

2.10 **"ERISA"** shall mean the Employee Retirement Income Security Act of 1974, as amended, supplemented, or replaced from time to time. Where appropriate, reference to any section or subsection of ERISA includes reference to any corresponding or succeeding provisions of any legislation which amends, supplements, or replaces such section or subsection.

2.11 **"HIPAA"** shall mean the Health Insurance Portability & Accountability Act of 1996.

2.12 **"Insurance Company or Insurance Companies"** shall mean an insurance company(ies) which is qualified to do business in the State and which validly issues an Insurance Contract.

2.13 **"Insurance Contract"** shall mean a group or individual insurance contract or policy issued to the Employer by an Insurance Company licensed to do business in the State to provide certain welfare benefits under the Plan to Employees of the Employer pursuant to Section 5.02 of the Plan.

2.14 **"Participating Employer"** shall mean an Employer that participates in this Plan for the benefit of its Eligible Employees, pursuant to approval of such participation by Southeastern Universities Research Association, Inc. Any Participating Employers are listed in Appendix B.

2.15 **"Plan"** shall mean the SURA/Jefferson Science Associates, LLC Comprehensive Health and Welfare Benefit Plan as consolidated herein, together with any and all Coverage Documents and any and all amendments and supplements to any of such Coverage Documents.

2.16 **"Plan Number"** shall mean for purposes of the Plan's annual Form 5500 filing requirements, 501.

2.17 **"Plan Year"** shall mean the twelve (12) consecutive month period beginning on each April 1 and ending on each following March 31 thereafter.

2.18 **"Reviewing Fiduciary"** shall mean the applicable Insurance Company which has issued the applicable Insurance Contract or other applicable organization described in Section 2560.503-1(g)(2) of the Department of Labor regulations regarding Pension and Welfare Benefit Programs, as amended from time to time.

2.19 **"Spouse"** shall means "spouse" as defined in an Insurance Contract for purposes of that Contract or the legally married husband or wife of a Participant, unless legally separated by court decree.

ARTICLE 3
ELIGIBILITY

3.01 Eligibility and Participation.

(a) An individual who is eligible with respect to the Plan will be an Employee (or Dependent thereof) who is eligible to participate in and receive benefits under one or more of the component Welfare Benefits provided under the Plan. The specific terms and conditions regarding eligibility and participation under the Plan with respect to any given component Welfare Benefit provided under the Plan, including any applicable enrollment procedures and when such coverage commences, are set forth in the Coverage Documents with respect to such Welfare Benefit referenced in Appendix A.

(b) Notwithstanding anything to the contrary, any Employee (or Dependent thereof) is eligible for coverage with respect to a given component Welfare Benefit provided under the Plan only if any contributions required by Participants, in accordance with Section 4.01, with respect to such coverage have been made for the period for which coverage is claimed.

(c) To the extent permitted by the Coverage Documents with respect to certain component Welfare Benefits referenced in Appendix A, an Employee may enroll his or her same sex domestic partner (and the otherwise eligible Dependents of their same sex domestic partner) for certain component Welfare Benefits provided under the Plan. The term "same sex domestic partner" shall be defined by the Coverage Document with respect to that component Welfare Benefit.

3.02 Enrollment.

Eligible Employees must complete an application form (available through the Plan Administrator) to enroll themselves and/or their eligible Spouses and Dependents. New Employees must enroll within certain time periods after being hired, as discussed in the Coverage Documents for the applicable underlying component Welfare Benefit. Otherwise, enrollment generally is limited to the annual open enrollment period that occurs before April 1 of each year.

3.03 Special Enrollment Rights.

In certain circumstances, enrollment may occur outside the open enrollment period. The Plan's certificate of insurance booklet and "Special Enrollment Notice" contain information about the special enrollment rights.

(a) The Plan shall comply with the special enrollment provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and Article 10 herein, with respect to those underlying component Welfare Benefits provided under the Plan that are subject to HIPAA.

(b) Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to

Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

3.04 Termination of Participation.

A Participant's benefits (and the benefits of his or her eligible family members) will terminate on the day the Participant no longer meets the eligibility requirements proscribed in Section 3.01 herein unless the respective Coverage Document for that particular benefit provides otherwise.

3.05 Reinstatement.

A person who formerly participated hereunder with respect to benefits under an applicable Coverage Document may participate with respect to such benefits again if and when he meets the requirements of Section 3.01 hereof.

3.06 Continuation Coverage.

If coverage for a Participant, his or her eligible Spouse, or any eligible Dependent ceases because of certain "qualifying events" specified in the Consolidated Omnibus Budget Reconciliation Act of 1985 and Article 9 hereof, then the Participant, his or her eligible Spouse, or any eligible Dependents may have the right to purchase continuing coverage under the Plan for a limited period of time, unless the Coverage Document for a particular Welfare Benefit referenced in Appendix A otherwise specifically provides for continuation coverage with respect to such Welfare Benefit in a legally sufficient manner.

3.07 Qualified Medical Child Support Orders.

With respect to any component Welfare Benefits that are group health plans, the Plan shall provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA Section 609(a). The provisions of Appendix C herein set forth the procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain a copy of such procedures, without charge, from the Plan Administrator.

ARTICLE 4
FUNDING AND BENEFITS

4.01 Contributions and Funding Policy.

With respect to each underlying component Welfare Benefit provided under the Plan, Participants shall make contributions with respect to each Welfare Benefit, if any, in the amounts specified and adjusted from time to time by the Employer for particular groups of Participants. Such contributions shall be made on a pre-tax or after-tax basis as permitted by the Employer. At least annually, the Employer shall provide to individuals eligible to participate in the Plan with respect to a given Welfare Benefit a schedule of the required contributions, if any, for such Welfare Benefit.

Unless the Coverage Document related to the underlying Welfare Benefit component referenced in Appendix A expressly provides to the contrary or is otherwise impermissible under applicable law, each Participant required to make contributions under this Section 4.01 who is an Employee of the Employer shall authorize payment of his contributions by payroll deduction pursuant to the terms of the cafeteria plan within the meaning of Code Section 125 maintained by his Employer.

The Employer shall provide funds that, when combined with the contributions made by Participants, are at least sufficient (as determined in the Employer's sole discretion) to provide for the underlying component Welfare Benefits provided under this Plan. Participant contributions toward the cost of a particular Welfare Benefit will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit.

Any Insured Welfare Benefit provided under the Plan shall be funded by the corresponding Policies; provided, however, any dividends credited to the Employer under any such Policy are reserved by, and to the benefit of, the Employer to the extent that the total of such dividends does not exceed the total of Employer contributions under the policy or contract for such premium year and to such extent such dividends shall not constitute an asset of the Plan. Nothing herein shall be construed to require the Employer to maintain any fund or segregate any amount for the benefit of any particular Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of the Employer from which any payment under the Plan may be made.

4.02 Benefits.

The Coverage Documents related to underlying Welfare Benefit components are identified in Appendix A and attached hereto, may be amended from time to time by an authorized officer of the Company or by executing a new Appendix A. Any such amended Appendix A shall be attached hereto. Such Coverage Documents, as now constituted or as hereafter amended or revised, are hereby incorporated by reference into and made a part of this Plan as if fully copied herein verbatim. The conditions of payment, benefits, manner, and time of payment and other provisions are set forth in each applicable Coverage Document herein by reference.

Notwithstanding any other provision of this Plan, in the event that the full insurance benefit is not received by or on behalf of the Plan participant or his beneficiaries, then the Employer shall have no legal obligation whatsoever. The Plan participant may be free to settle, compromise, or refuse to pursue the claim as he, in his sole discretion, sees fit. For purposes of clarification and

notwithstanding any other provision of this Plan or any Coverage Document, no approval, consent, or acceptance by any Insurance Company or other administrative entity which may issue any Insurance Contract or Coverage Document for the purposes of this Plan shall be required to modify, alter, amend, or terminate this Plan; rather, the Company shall have the right to modify, alter, amend or terminate this Plan as provided in Article 6 hereof.

4.03 Preexisting Conditions and Other Exclusions.

Eligible Plan participants and beneficiaries may be entitled to a reduction or an elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if they have credible coverage from another plan. Without evidence of creditable coverage, participants and beneficiaries may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after their enrollment date, to the extent permitted by law.

Notwithstanding the foregoing, exclusions of pre-existing conditions shall not apply to participants under age 19 as required by the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act.

The Coverage Documents relating to an underlying Welfare Benefit component reference in Appendix A contain information about the exclusions due to preexisting conditions and other exclusions with regard to that Welfare Benefit.

4.04 Subrogation and Reimbursement

The Coverage Documents relating to an underlying Welfare Benefit component reference in Appendix A contain information abut the Plan’s right to subrogation or reimbursement of benefits with regard to that Welfare Benefit.

ARTICLE 5
ADMINISTRATION OF PLAN

5.01 Powers, Duties and Responsibilities of the Plan Administrator.

The Plan is administered by the Company, the Plan Administrator and the Named Fiduciary for all purposes except deciding benefit claims. With regard to the insured benefits provided under the Plan, the Company and the Insurance Company share responsibility for administering the Plan, as discussed below:

5.02 Power and Authority of Insurance Companies.

Benefits are provided under a group insurance contract entered into between the Company and the Insurance Companies. Claims for benefits are sent to the Insurance Company. The Insurance Companies, not the Company, is responsible for paying claims.

The Insurance Company is the Named Fiduciary for benefit claims and is responsible for:

- determining eligibility for and the amount of any benefits payable under the Plan; and
- providing the claims procedures to be followed and the claims forms to be used by eligible individuals pursuant to the Plan.

The Insurance Company also has the authority to require eligible individuals to furnish it with such information as it determines is necessary for the proper administration of the Plan.

5.03 Records and Reports.

The Plan Administrator shall keep a record of all actions taken and shall keep all other books of account, records and other data that may be necessary for proper administration of the Plan and shall be responsible for supplying all information and reports to governmental agencies or departments, Employees, eligible Dependents, beneficiaries, and others as required by law. The Plan Administrator shall make available to each Employee such of his records under the Plan as pertain to him, for examination at reasonable times during normal business hours. The fiscal records of the Plan shall be maintained on the basis of the Plan Year, provided that the policy years of Coverage Documents may be different than the Plan Year.

5.04 Reliance on Tables, Etc.

In administering the Plan, the Plan Administrator shall be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions, and reports which are furnished by, or in accordance with the instructions of, the Insurance Company or by legal counsel, accountants, actuaries, consultants, experts, specialists, advisers, or other persons employed or engaged by the Plan Administrator.

5.05 Nondiscriminatory Exercise of Authority.

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

(a) The Plan Administrator shall not take any action or direct any action with respect to any of the benefits provided hereunder that would be impermissibly discriminatory in favor of Employees who are officers or highly compensated Employees of the Employer, or that would result in benefiting one Participant or group of Participants at the expense of another, or in the application of different rules to substantially similar sets of facts.

(b) The Plan shall comply with all applicable nondiscrimination rules under the Code. Should the Plan be subject to nondiscrimination testing under the Code or any other applicable law, the Plan Administrator may make any decisions or elections, whether voluntary or required by law, necessary to facilitate such testing. Any elections required to be in writing shall be stated from time to time in Plan documentation with respect to the applicable underlying component Welfare Benefit referenced in Appendix A.

5.06 Indemnification of Plan Administrator.

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

5.07 Expenses of Administration.

All expenses incurred prior to the termination of the Plan that shall arise in connection with the administration of the Plan, including but not limited to administrative expenses and compensation and other expenses and charges of any legal counsel, accountants, actuaries, consultants, experts, specialists, advisers, or other persons employed or engaged by the Plan Administrator in connection with the administration of the Plan, shall be paid by the Employer.

ARTICLE 6
AMENDMENT AND TERMINATION OF PLAN

6.01 Amendment of Plan.

The Board shall have the right at any time, and from time to time, to modify, alter or amend the Plan in whole or in part effective as of a specified date. Any amendment to the Plan shall be effective and documented in writing. No amendment shall have the effect of denying to any Employee benefits which would provide coverage for periods prior to such amendment or denying benefits for events that occurred prior to such amendment.

6.02 Termination of Plan.

Although the Company expects the Plan to be continued indefinitely, the Board shall have the right to terminate the Plan in whole or in part any time, effective as of such date as the Board may determine. However, no such termination shall have the effect of denying to any Employee or benefits which would provide coverage for periods prior to such termination or denying benefits for events that occurred prior to such termination.

6.03 No Vested Right to Benefits.

Notwithstanding anything in this Plan or in any Coverage Document to the contrary, no Employee shall have any vested right to continued benefits under the Plan and any benefits or coverage may be altered or terminated at any time for periods after the amendment or termination of the Plan pursuant to Section 6.01 or 6.02.

ARTICLE 7
ADOPTION OF PLAN BY AFFILIATED COMPANIES

7.01 In General.

The Plan may be adopted by any Affiliated Company or Participating Employer authorized by the Board to adopt the Plan. Any such adoption shall be accomplished and evidenced in a manner satisfactory to the Board. Employers that have adopted the Plan are listed in Appendix B attached hereto.

ARTICLE 8
CLAIM AND REVIEW PROCEDURES

8.01 In General.

The applicable Insurance Company which has issued the applicable Insurance Contract or other applicable organization described in Section 2560.503-1(g)(2) of the Department of Labor Regulations regarding Pension and Welfare Benefit Programs, as amended from time to time "(Section 2560"), shall review claims under Section 8.02 hereof as "the appropriate named fiduciary" pursuant to Section 503 of ERISA and Section 2560.

8.02 Claims Procedures.

For purposes of determination of the amount of, and entitlement to, benefits of the component benefit programs provided under insurance or contracts, the respective Insurance Company is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance.

To obtain benefits from the respective Insurance Company of a component benefit program, the participant must follow the claims procedures under the applicable insurance contract, which may require the participant to complete, sign and submit a written claim on the Insurance Company's form.

The Insurance Company will decide a participant's claim in accordance with its reasonable claim procedures, as required by ERISA. The Insurance Company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide a claim. If the Insurance Company denies a claim in whole or in part then the participant will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the participant may appeal to the Insurance Company for a review of the denied claim. The Insurance Company will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA. If the participant does not appeal on time, then he or she will lose his or her right to file suit in a state or federal court, as he or she will not have exhausted his or her internal administrative appeal rights.

ARTICLE 9
CONTINUATION COVERAGE

9.01 Applicability and Scope.

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, related regulations, and this Article 9. If during the Plan Year, the Employer employs fewer than twenty (20) employees on a typical business day, this Article 9 shall not apply.

9.02 Definitions.

For purposes of this Article 9, the following definitions shall apply:

(a) "Covered Employee" means an Employee or former Employee enrolled in the Plan as of the day before a Qualifying Event.

(b) "COBRA Continuation Coverage" means the continuation of group health care coverage pursuant to Code Section 4980B and ERISA Sections 601 and 609.

(c) "Entitled" means, with respect to Medicare coverage, notification by the Social Security Administration that Medicare Part A coverage is in effect.

(d) "Qualified Beneficiary" means any person who, as of the day before a Qualifying Event, is (i) a Covered Employee, (ii) a Dependent of the Covered Employee, including the Spouse of the Covered Employee, (iii) a child is born to, adopted, or placed for adoption with a Qualified Beneficiary any time while COBRA Continuation Coverage is in effect. Provided, however, a Covered Employee can be a Qualified Beneficiary only in the event of the Qualifying Event described in Section 9.02(e)(1) below. Provided, further that, in the event of a Qualifying Event described in Section 9.02(e)(6), a Covered Employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such Qualifying Event, is a beneficiary under the Plan as the Spouse, surviving Spouse, or dependent child of the Covered Employee shall be considered a Qualified Beneficiary. A person who fails to elect COBRA Continuation Coverage within the applicable election period shall not be considered a Qualified Beneficiary.

(e) "Qualifying Event" means, any of the following events which, but for COBRA Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary:

(1) the termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of the Covered Employee;

(2) the death of the Covered Employee;

(3) the divorce or legal separation of the Covered Employee from the Covered Employee's Spouse;

(4) the Covered Employee becoming Entitled to Medicare benefits under Title XVII of the Social Security Act;

(5) a dependent child ceasing to be a dependent child under the generally applicable requirements of the Plan; or

(6) a bankruptcy proceeding under Title 11 of the United States Code with respect to the Employer from whose employment an Employee retired.

9.03 COBRA Continuation Coverage Benefits

(a) Upon a Qualifying Event, each Qualified Beneficiary may elect to continue the level of benefits coverage in effect under the Plan for such Qualified Beneficiary on the day before the Qualifying Event; provided, however, each Qualified Beneficiary may change the level of benefits coverage during any open and/or annual enrollment period to the same extent that a Participant to whom a Qualifying Event has not occurred may under the terms of the Plan. In addition, if a Qualified Beneficiary of another group health plan maintained by the Employer is prevented from receiving the previous level of benefits due to a change in plan benefits or termination of such other Employer-sponsored group health plan, such individual shall be entitled to elect any level of coverage available under this Plan.

(b) Coverage may continue for a period of thirty-six (36) months from the date of any Qualifying Event described in Sections 9.02(e)(2) through (e)(6). Coverage may continue for a period of 18 months from the date of the Qualifying Events described in Section 9.02(e)(1); provided, however, if the Qualified Beneficiary is determined to be disabled under Title II or Title XVI of the Social Security Act, coverage may continue (with respect to all Qualified Beneficiaries) for a period of twenty-nine (29) months from the date of the Qualifying Event. To qualify for such 29-month coverage, however, the Qualified Beneficiary must (i) be determined under the Social Security Act to have been disabled at any time before or within the first sixty (60) days of COBRA continuation coverage, and (ii) must notify the Plan Administrator of such determination within eighteen (18) months from the Qualifying Event and in accordance with the terms of Section 9.04(e).

(c) If a Qualifying Event (other than the Qualifying Event described in Section 9.02(e)(6)) occurs during the eighteen (18) months after the date of the Qualifying Event described in Section 9.02(e)(1), then coverage may continue for up to thirty-six (36) months after the date of the Qualifying Event described in Section 9.02(e)(1).

(d) The Qualified Beneficiary must elect coverage on or prior to the later of:

(1) sixty (60) days after the date on which coverage terminates under the Plan by reason of a Qualifying Event, or

(2) sixty (60) days after the Qualifying Beneficiary is notified by the Plan Administrator of the Qualifying Beneficiary's right to elect continuation coverage pursuant to the terms of Section 9.04(d).

(e) Notwithstanding the maximum continuation periods set forth in Sections 9.03(b) and (c), COBRA Continuation Coverage will automatically cease after any of the following:

(1) thirty (30) days after the date on which any premium for COBRA continuation coverage was due and not paid;

(2) the date on which Qualified Beneficiary first becoming Entitled, after the date of his or her election of COBRA continuation coverage, to Medicare benefits under Title XVIII of the Social Security Act;

(3) the date on which Qualified Beneficiary first becoming covered, after the date of his or her election of COBRA continuation coverage, under another group health care plan that contains no exclusion or limitation based on a preexisting condition, or that has a limitation based on a preexisting condition that is satisfied or rendered inoperative by virtue of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

(4) the date on which the Employer terminates this Plan and all other group health care plans maintained by the Employer; or

(5) in the case of a disabled Qualified Beneficiary who has elected extended COBRA continuation coverage, the month that begins more than thirty (30) days after the date of the final determination under Title II or Title XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.

9.04 Notice Requirements.

(a) When an Employee becomes covered under this Plan, the Plan Administrator shall inform the Participant (and any Dependent of the Participant who also becomes covered under the Plan) in writing, of the rights to continuation coverage under this Section 9.04.

(b) The Employer shall give the Plan Administrator written notice of a Qualifying Event described in Sections 9.02(e)(1), (e)(2), (e)(4), and (e)(6) within thirty (30) days of the occurrence of such event.

(c) In the case of a Qualified Event described in Sections 9.02(e)(3) or (e)(5), a Covered Employee or a Qualified Beneficiary who is a Spouse or Dependent of such Employee must notify the Plan Administrator within sixty (60) days of the occurrence of such event.

(d) Within fourteen (14) days of the Plan Administrator's receipt of the notice provided for in Section 9.04(b) or Section 9.04(c), the Plan Administrator shall furnish each Qualified Beneficiary with written notification of the termination of regular coverage under the Plan, as well a recital of the rights of any such Qualified Beneficiary to elect continuation coverage under this Article 9.

(e) Each Qualified Beneficiary who is determined to be disabled, consistent with the terms of Section 9.03(b), must notify the Plan Administrator of such determination within sixty (60) days after the latest of: (i) the date of the Social Security disability determination; (ii) the date of the Qualifying Event; and (iii) the date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event.

(f) Each Qualified Beneficiary who has been determined to be disabled, consistent with the terms of Section 9.03(b), must notify the Plan Administrator within thirty (30) days of the

date of any final determination by the Social Security Administration that the Qualified Beneficiary is no longer disabled.

(g) The Plan Administrator should notify each Qualified Beneficiary if their respective COBRA continuation coverage terminates before its maximum coverage period.

Notwithstanding any of the foregoing, notification to a Qualified Beneficiary who is a Spouse of a Covered Employee is treated as notification to all other Qualified Beneficiaries residing with that person at the time notification is made.

9.05 Premium Requirements.

(a) A Qualified Beneficiary who has elected continuation coverage under this Article 9 must pay a premium designated by the Employer of up to 102% of the applicable premium for the period of coverage otherwise charged to similarly situated Participants (or Dependents) with respect to whom a Qualifying Event has not occurred for the same type of coverage. In the case of an individual who is determined to have been disabled, consistent with the terms of Section 9.03(b), the premium for continuation coverage shall not exceed 150% of the applicable premium for any month after the eighteenth (18th) month of continuation coverage as described in Section 9.03(b).

(b) The required premium for continuation coverage under this Article 9, if any, may, at the Qualified Beneficiary's election, be paid in monthly installments. As noted in Section 9.03(e)(1), there is a thirty (30) day grace period following the due date of any required premium before such premium payment is considered untimely.

(c) Provided, however, no later than forty-five (45) days after the day on which the Qualified Beneficiary makes the initial election for continuation coverage hereunder, the Qualified Beneficiary must make the premium payment for the initial period of continuation coverage retroactively back to date that coverage otherwise would have been lost.

9.06 Special Continuation Coverage for Uniformed Services Leaves.

Notwithstanding any other Plan provision regarding termination of coverage, an Employee who is absent from work due to "uniformed service duty" as defined under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA), shall be considered to have experienced a Qualifying Event as of the first day of such individual's absence for such duty. Such an individual (and any of that individual's Dependents covered under the Plan) shall be treated as any other Qualified Beneficiaries for all purposes concerning continuation coverage provided under this Article 9; provided, however, the maximum period of coverage available to such an individual is the lesser of (i) 18 months (24 months for coverage elected on or after December 10, 2004) beginning on the date the individual's uniformed service duty begins, or (ii) the day after the date on which the individual fails to apply for or return to active employment with the Employer. Provided, further, coverage will continue only as long as any required Participant contributions for continuation coverage as set forth in this Article 9 are timely made, except that any individual who performs uniformed services for less than thirty-one (31) days will not be required to pay more than any required Participant contribution applicable for active Employees for the comparable level of coverage.

9.07 Special Continuation for FMLA.

Notwithstanding any other Plan provision regarding termination of coverage, in the event participation in a health benefit offered through this Plan would terminate due to a Participant taking a leave of absence pursuant to the terms of the Family and Medical Leave Act of 1993, as amended (FMLA), such benefits shall be continued for the lesser of: the period of such leave, or 12 weeks. Provided, however, coverage will continue only as long as any required Participant contributions are timely made. Employees on leave must make the same contribution as is required for active Participants. Coverage under other Welfare Benefits (other than health benefits) provided under the Plan shall continue or terminate during a period of a FMLA leave to the same extent as such benefits continue or terminate during periods of leave under similar circumstances (i.e., paid or unpaid leave, as the case may be) that is not a FMLA leave.

9.08 Special Rules for Certain Assistance Eligible Individuals.

Notwithstanding any other Plan provision to the contrary set forth above, this Plan shall comply, to the extent applicable, with the requirements of the American Recovery and Reinvestment Act of 2009 (ARRA), as amended, with respect to (i) giving certain "assistance eligible individuals" the right to pay reduced COBRA premiums for certain periods of coverage beginning on or after February 17, 2009, and (ii) providing certain additional election rights to such individuals.

For specific information regarding the Plan's administration of these COBRA rights provided under the ARRA, as amended, see the notices distributed to all affected Employees.

ARTICLE 10
SPECIAL RULES RELATED TO HIPAA

10.01 Applicability and Scope.

This Article shall apply only with respect to any group health benefits that are provided to individuals participating under the Plan ("Health Plan Participants") that are subject to the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA").

10.02 Compliance with HIPAA Privacy Standards.

(a) In the event any benefit under this Plan subject to the subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

(b) The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth 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 and including any genetic information as defined by the Genetic Information Nondiscrimination Act (GINA).

(c) Protected Health Information disclosed to members of the Employer'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 to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care.

(d) The Plan shall disclose Protected Health Information only to members of the Employer's workforce who 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. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer'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.

(2) In the event that any member of the Employer'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:

(i) 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;

(ii) 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;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

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

(e) The Employer must provide certification to the Plan that it agrees to:

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

(2) 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 Employer with respect to such information;

(3) 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 Employer;

(4) 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;

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

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

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

(8) 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;

(9) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer 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

(10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

10.03 Compliance with HIPAA Electronic Security Standards.

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

(a) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(b) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(c) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 10.05.

ARTICLE 11
GENERAL PROVISIONS

11.01 No Contract of Employment.

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between any individual and the Company to the effect that the individual will be employed for any specific period of time.

11.02 Insurance Contract Controls.

Benefits hereunder are provided solely pursuant to an insurance contract between the Plan Sponsor and the Insurance Company. If the terms of this document conflict with the terms of the insurance contact, the terms of the insurance contract will control, unless superseded by applicable law.

11.03 Limitation of Rights.

Neither the establishment of this Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Employee or other person any legal or equitable right against the Employer, except as provided herein. Neither the establishment of this Plan nor any amendment thereof, nor the payment of benefits, nor any action taken with respect to this Plan shall confer upon any person the right to be continued in the employment of the Employer.

11.04 Headings.

The headings and subheadings of articles and sections are included solely for convenience of reference, and if there be any conflict between such headings and the text of the Plan, then the text of the Plan shall control.

11.05 Gender and Number.

Whenever any words are used herein in the masculine, feminine, or neutral gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

11.06 Severability of Provisions.

The provisions of this Plan are severable, and should any provision be ruled illegal, unenforceable, or void, all other provisions not so ruled shall remain in full force and effect.

11.07 Entire Plan.

This Plan instrument, including Appendix A attached hereto and the Coverage Documents identified in Appendix A, constitute the entire employee welfare benefit plan for the eligible Employees described herein. No modifications or alterations to this Plan shall be enforceable unless properly and validly made pursuant to the provisions of Article 5 or Article 6 hereof.

11.08 Compliance With State and Federal Mandates.

To the extent applicable, the Plan will provide benefits in accordance with the requirements of all applicable laws and as described in the certificate of insurance booklet, including the Employee Retirement Income Security Act of 1974 (ERISA), the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Genetic Information Nondiscrimination Act (GINA), the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), and the Women's Health and Cancer Rights Act of 1998 (WHCRA), and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act ("PPACA").

IN WITNESS WHEREOF, the Company has caused this Plan to be duly executed for and on behalf of the Company by its duly authorized officer on this the 20th day of April, 2011.

SOUTHEASTERN UNIVERSITIES
RESEARCH ASSOCIATION, INC.

By: Elizabeth L. Lawson

Title: Chief Governance Officer / Principal
JSA/JLab Liaison and Corporate Secretary

APPENDIX A

WELFARE BENEFITS PROVIDED UNDER THE PLAN

Effective as of April 1, 2011

This Appendix A is attached to, forms a part of, and is incorporated by reference into the SURA/Jefferson Science Associates, LLC Comprehensive Health and Welfare Benefit Plan (the "Plan"). The words, terms and phrases used herein shall have the same meaning as those defined in and used in the Plan. As of the date of execution of the Plan, including this Appendix A, by the Company, the Coverage Documents under or pursuant to which premiums or contributions are paid and/or benefits are provided under the Plan are as follows:

A. Group Comprehensive Medical Benefits

Benefits provided under an insured arrangement with:

Anthem Blue Cross & Blue Shield
PO Box 27401
Richmond, VA 23279
(804) 354-7000

HealthKeepers
2220 Edward Holland Drive
Richmond, VA 23230
(804) 354-7000

Sentara Optima Health Plan
4417 Corporation Lane
Virginia Beach, VA 23462
(800) 736-8272

B. Group Dental Benefits

Benefits provided under an insured arrangement with:

Delta Dental Plan of Virginia
4818 Starkey Road
SW Roanoke, VA 24014
(540) 989-8000

C. Group Long-Term Disability Benefits

Benefits provided under an insured arrangement with:

Metropolitan Life Insurance Company (MetLife)
200 Park Avenue
New York, New York 10166
(800) 300-4296

D. Group Short-Term Disability Benefits

Benefits provided under an insured arrangement with:

Metropolitan Life Insurance Company (MetLife)
200 Park Avenue
New York, New York 10166
(800) 300-4296

E. Group Term Life Insurance Benefits

Benefits provided under an insured arrangement with:

Metropolitan Life Insurance Company (MetLife)
200 Park Avenue
New York, New York 10166
(800) 275-4638

F. Group Accidental Death and Dismemberment Benefits

Benefits provided under an insured arrangement with:

Metropolitan Life Insurance Company (MetLife)
200 Park Avenue
New York, New York 10166
(800) 275-4638

APPENDIX B

PARTICIPATING AFFILIATED OR RELATED EMPLOYERS

Effective as of April 1, 2011

Jefferson Science Associates, LLC
628 Hofstadter Road, Suite 2
Newport News, VA 23606-3060
EIN: 20-3974952

APPENDIX C

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROCEDURES

Effective as of April 1, 2011

1.1 In General.

In the case of any medical child support order ("Order") that is received with respect to the Plan, its status under ERISA shall be determined in accordance with the provisions set forth in this Plan.

1.2 Notification of Receipt.

Promptly upon receipt of an Order, the Plan Administrator will notify in writing each person named therein, at the address specified in the Order (if applicable), of the receipt by the Plan of the Order and forward to them notification of the procedures set forth in this Plan. If the Plan Administrator is able to determine whether an Order is qualified promptly upon receipt of such Order, the Plan Administrator may send one notice which informs each person named therein both of the receipt of the Order and of the Plan Administrator's determination, as provided in Sections 1.5 and 1.6.

1.3 Review of Order.

The Plan Administrator will ascertain, with the assistance of legal counsel, as appropriate, whether:

(1) The Order is a judgment, decree, or order (including approval of a property settlement agreement) issued either by a court of competent jurisdiction, or through an administrative process established under state law that has the force and effect of law under applicable state law, which:

(A) provides for child support with respect to a child of a Participant under a group health plan or provides for health benefit coverage to such a child under this Plan, made pursuant to a state domestic relations law (including a community property law), or

(B) enforces a state medical child support law enacted under the Social Security Act with respect to a group health plan;

(2) The Order specifies the name and the last known full mailing address (if any) of the Participant and each alternate recipient covered by the Order, or if not, that the information is available from the records of the Plan or Employer;

(3) The Order clearly identifies the Plan or plan(s) to which it applies;

(4) The Order clearly specifies a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined;

(5) The Order does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirement of a law relating to medical child support under Social Security Act; and

(6) The Order clearly specifies the period to which it applies.

Provided, however, any appropriately completed National Child Support Notice, issued pursuant to the Child Support Performance and Incentive Act of 1998, shall be deemed satisfy the requirements to be a “qualified medical support order.”

1.4 Suspension of Claims.

Claims for a proposed alternate recipient shall be suspended until the Plan Administrator has determined whether the order in question is qualified.

1.5 Notification of Status.

When the Plan Administrator determines whether the Order satisfies the requirements to be a "qualified medical child support order," the Plan Administrator shall notify in writing all persons named in the Order and any representatives designated in writing by such persons ("Interested Parties") of the determination as soon as practicable following such determination.

(1) If no Interested Party disputes this determination within thirty (30) days of receipt of such notice or if all Interested Parties agree in writing not to dispute the Plan Administrator’s determination, then the Plan Administrator shall proceed with implementing the Order as a "qualified medical child support order."

(2) If any Interested Party disputes this determination within thirty (30) days of receipt of such notice, then the suspension of claims provided in Section 1.4 shall continue and the Interested Party disputing the determination may request a review of the determination in accordance with the claims procedures set forth in the Plan.

1.6 Notification of Non-Qualified Status.

If the Plan Administrator determines that the Order is not a "qualified medical child support order," the Plan Administrator shall notify in writing all Interested Parties of its determination, and such notice will state the reasons for such determination. Following such a determination, any Interested Parties may re-submit a revised Order to the Plan Administrator.