STEL

SOUTHERN TIER ENVIRONMENTS FOR LIVING

September 28, 2011

RE: **Open Enrollment** – Medical Insurance/Flexible Spending/ Hospital Reimbursement Account Plans

ATTENTION: Eligible Full Time Employees

I am writing to inform you about our medical insurance programs. Once again medical insurance premiums continue to rise. This year Community Blue's premium increased over 13%. Over the last 10 years medical insurance costs in Western New York have experienced double digit rate increases. Medical insurance costs continue to rise at an alarming rate. We've taken many steps to evaluate our insurance options including:

- Biding out the insurance to different insurance companies and evaluated experienced rating
- Obtaining staff members feedback/concerns via our medical insurance survey last summer and
- Comparing various plan options

This is the second year plan offerings are based on experienced rates, meaning future premiums are partly based on our group's service utilization and costs.

This year's premium increase resulted to **$85,000** in additional costs. Unfortunately, the agency is not able to absorb this cost increase this year forcing us to modify our plan offerings and employee contribution. As always our goal is to provide high quality medical insurance to our employees and their families. We understand as costs increase employees' shoulder part of the burden. We're happy to report in the 2011/2012 plan year STEL will continue to pay **100%** of "High Deductible Single Plan" option and **90%** of the "High Deductible Family Plan option".

Effective December 1st, the following health insurance plan benefit changes will occur:

- **POS 7100 Plan will be offered as our "standard" plan**. All other premium plans will be based off this plan option. The high deductible health plan option, will allow employees to establish a Health Care Savings Plan. See attached Summary of Benefits for more information.
- **POS 128 Plan will be offered as a premium plan. Plan benefits will remain the same**
- **POS 206 Plan will continue to be offered as a premium plan. Plan benefits will remain the same.**
- **The Hospital Reimbursement account will be available for the "premium" plan participates however the reimbursement rate will change to $750/1500 (single/family).**
- **The $350 Healthcare Reimbursement account will be eliminated**.
- **If you would like to make a change from one plan to the other, you will need to complete a new enrollment form.**

Please remember to log on to www.bcbswny.com and setup your own account. You will be able to:

- Track your claims
- Order ID cards
- Access personalized prescription drug information
- Use Healthcare Advisor
- Access Health Advocate
- Locate a provider

Flexible Spending Account (Section 125) & Healthcare Savings Accounts

- High Deductible plan participants my elect to have their seed money placed in their HSA or FSA account. Remember, employees may only have account.

As always, we seek strategies to provide comprehensive high quality benefits for our employees while attempting maintain fiscal discipline. There's no doubt healthcare costs are one of the top issues facing private and public employers across the country. In future years we will continue to closely assess our medical plans and evaluate all options to meet the needs of our staff members.

Refer to your plan documents regarding all plan changes and provisions.

Please be advised your **open enrollment ends Friday, November 4th**, so please have your change forms to the Human Resources office by this date.

If you should have any questions regarding any benefit program, please feel free to contact Mark Wasiewicz at (716) 366-7792 X 212. Thank you for this opportunity to share this important information with you.

Sincerely,

Thomas J. Whitney
Executive Director

STEL, Inc.
2011-2012
Open Enrollment Kit
&
Meeting Schedule

Tuesday, October 4th at 11:00 AM
Gowanda Community Residence
14192 Taylor Hollow Rd. Gowanda, NY

Wednesday, October 5th at 1:00 PM
Perkins Hall Community Residence
14190 Taylor Hollow Rd. Gowanda, NY

Tuesday, October 11th at 1:00 PM
Dunkirk Administration Office
715 Central Ave. Dunkirk, NY

Tuesday, October 11th at 3:00 PM
Park Avenue Community Residence
815 Park Ave. Dunkirk, NY

Wednesday, October 12th at 1:00 PM
North Main Community Residence
878 N. Main St. Jamestown, NY

Wednesday, October 12th at 2:30 PM
Prendergast Community Residence
628 Prendergast Ave. Jamestown, NY

Thursday, October 13th at 1:00 PM
Jamestown Office
97 Forest Ave. Jamestown, NY

Monday, October 17th at 1:00 PM
Aldrich St. Community Residence
14712 Aldrich St. Gowanda, NY

Tuesday, October 18th at 11:00 AM
Olean Community Residence
144 South Union St. Olean, NY

Wednesday, October 19th at 1:00 PM
Wellsville Community Residence
99 Madison St. Wellsville, NY

Southern Tier Environments for Living, Inc.
September 28, 2011

BENEFIT INFORMATION SHEET

Effective 12/01/11 -11/30/12
(Rates subject to change)

MEDICAL INSURANCE

"HIGH DEDUCTIBLE OPTION" COMMUNITY BLUE POS 7100

	Actual Costs	STEL Contribution	Employee Contribution
SINGLE	$392.75		**None.**
***NO HEALTH CARE REIMBUSTMENT ACT.**		$402.32/mo. **$4,827.84/yr.**	STEL will contribute $360.00yr to a Heath Care Savings Act.
FAMILY	$1,089.25		$108.93/mo. $54.47/pay
***NO HEALTH CARE REIMBUSTMENT ACT.**		$1,004.22/mo. **$12,050.64/yr.**	STEL will contribute $532.00/yr to a Heath Care Savings Act.

"PREMIUM OPTION 1" BLUE CROSS POS 128

	Actual Costs	STEL Contribution	Employee Contribution
SINGLE	$457.23/mo.	$402.32/mo. **$4,827.84/yr.**	$54.91/mo. $27.46/pay
FAMILY	$1,268.07/mo.	$1,004.22/mo. **$12,050.64/yr.**	$263.85/mo. $131.93/pay

"PREMIUM OPTION 2" BLUE CROSS POS 206

	Actual Costs	STEL Contribution	Employee Contribution
SINGLE	$505.29/mo.	$402.32/mo. **$4,827.84/yr.**	$102.97/mo. $51.49/pay
FAMILY	$1,401.39/mo.	$1,004.22/mo. **$12,050.64/yr.**	$397.17/mo. $198.59/pay

DENTAL/VISION BENEFITS

	Actual Cost & STEL Cost	Employee Contribution
SINGLE & FAMILY	Direct Reimbursement	**NONE**

HOSPITAL REIMBURSEMENT ACCOUNT

$750 Single/$1500.00 Maximum Per Employee Account For Hospitalization Deductibles	Direct Reimbursement	**NONE**
FLEXIBLE SPENDING ACCOUNT (SEC. 125 PLAN)	**STEL Cost** $60 Administration Fee Per Account	**NONE**

NOTES:

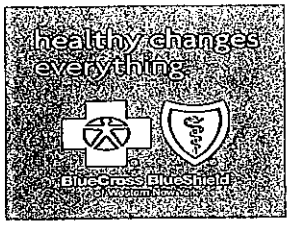
1. Regular part time employees (20 hrs. per week or more) are eligible to purchase (100% Employee Contribution) Community Blue coverage at the Actual Cost.
2. Payroll deductions incurred the first two pays per month only.
3. If your medical insurance election requires an employee contribution please consider enrollment in Sec. 125 Plan. This will allow your contribution to be taken from your gross pay (before Federal, State, and FICA deductions). Please read the Sec. 125 Summary Plan description carefully.
4. Full time employees may elect to "Opt Out" of STEL's medical insurance plan for $2000 Benefit Bonus

High Deductible Option

STEL

Traditional Blue POS 7100

DEDUCTIBLES/MAXIMUMS	
In network deductible - Combined with out of network deductible	$1,250/$2,500
In network coinsurance	n/a
In network out of pocket maximum	$5,000/$10,000
Out of network deductible - Combined with in network deductible	$1,250/$2,500
Out of network coinsurance	20% Coinsurance after deductible
Out of network out of pocket maximum	$10,000/$20,000
Annual maximum	Unlimited
Lifetime maximum	Unlimited
Benefit administration	Plan year benefits
Dependent Age	26
Student Age	26
Dependent/Student coverage ends	Coverage ends at birth date
Domestic partner	No Coverage for domestic partner
PRESCRIPTION DRUG	
Prescription Copay	$15/$50/$75 After deductible
Mail order copay per 90 day supply	2.5 copays per 90 day supply
Mandatory mail order applies	n/a
Prescription deductible	n/a
Generic Oral Contraceptive coverage	$0 Copay for generic contraceptives (after deductible)
PHYSICIAN SERVICES - Office	
PCP Copay	$15 After deductible
Specialist Copay	$15 After deductible
Pediatric visits for children up to age 19	$15 After deductible
Well child visits and immunizations for children up to age 19	Covered in Full
Allergy immunotherapy	$15 After deductible
Chiropractic	$15 After deductible
Laboratory services	$15 After deductible
Radiology (x-ray, MRI, CT & other high tech imaging)	$15 After deductible
Pre & post natal care	Covered in full after deductible and initial PCP copay
PHYSICIAN SERVICES - Routine/Preventive	
Abdominal aortic aneurysm screening	Covered in Full
Adult immunizations (Flu vaccinations covered in full)	Covered in Full
Bone mineral density screening	Covered in Full
Routine Colorectal Cancer Screening	Covered in Full
Routine Mammogram	Covered in Full
Routine OB/GYN	Covered in Full
Routine Pap smear	Covered in Full
Routine Physical exam	Covered in Full
PSA test	Covered in Full
Routine eye exam	Covered in Full
HOSPITAL	
Inpatient hospital stay	$250 Per Admission, after deductible
Inpatient maternity stay	$250 Per Admission, after deductible
Outpatient surgery	$75 after deductible
EMERGENCY HOSPITAL CARE	
Emergency room (copay waived if admitted to hospital)	$50 after deductible
Ambulance - ground ambulance	$50 after deductible
Ambulance - air ambulance	$50 after deductible
Urgent care centers	$35 after deductible
MENTAL HEALTH & SUBSTANCE ABUSE	
Mental Health (inpatient)	$250 Per Admission, after deductible
Mental Health (outpatient)	$15 After deductible
Alcohol & Substance Abuse (inpatient detox)	$250 Per Admission, after deductible
Alcohol & Substance Abuse (inpatient rehab)	$250 Per Admission, after deductible
Alcohol & substance abuse (outpatient)	$15 After deductible



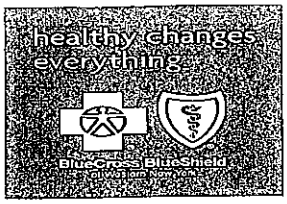
	STEL
	Traditional Blue POS 7100
DIABETIC SUPPLIES & SERVICES	
Diabetic equipment & supplies (test strips, syringes, etc.)	$15 After deductible
OTHER SERVICES	
Cardiac rehabilitation (24 visits within 12 weeks of acute episode)	$15 After deductible
Chemotherapy	$15 After deductible
Dialysis	$15 After deductible
Durable medical equipment	50% After deductible
Home care	40 Visits, Specialist copay after deductible
Hospice	$15 After deductible
Physical, speech & occupational therapy	$15 After deductible
Post-mastectomy prosthetics	Covered in full after deductible
Prosthetic and orthotic appliances	50% After deductible
Radiation therapy	$15 After deductible
Skilled nursing facility	60 Days, Inpatient copay after deductible
Rate Structure	
Funding	Prospective
Tier Structure	2-Tier

Premium Option 1

STEL

Traditional Blue POS 128

DEDUCTIBLES/MAXIMUMS	
In network deductible	N/A
In network co-insurance	N/A
In network out of pocket maximum	N/A
Out of network deductible	$1,000/$2,000
Out of network coinsurance	25%
Out of network out of pocket maximum	$5,000/$10,000
Annual maximum	Unlimited
Lifetime maximum	Unlimited
Benefit administration	Plan year benefits
Dependent Age	26
Student Age	26
Dependent/Student coverage ends	Coverage ends at birth date
Domestic partner	No Coverage for domestic partner
PRESCRIPTION DRUG	
Prescription Copay	$10/$50/$100
Mail order copay per 90 day supply	2.5 Copays
Mandatory mail order applies	N/A
Prescription deductible	N/A
Generic Oral Contraceptive coverage	Yes, $0 copay for generic contraceptives
PHYSICIAN SERVICES - Office	
PCP Copay	$30
Specialist Copay	$50
Pediatric visits for children up to age 19	Covered in Full
Well child visits and immunizations for children up to age 19	Covered in Full
Allergy immunotherapy	$50
Chiropractic	$50
Laboratory services	Covered in Full
Radiology (x-ray, MRI, CT & other high tech imaging)	$50
Pre & post natal care	Covered in full after initial PCP copay
PHYSICIAN SERVICES - Routine/Preventive	
Abdominal aortic aneurysm screening	Covered in Full
Adult immunizations (Flu vaccinations covered in full)	Covered in Full
Bone mineral density screening	Covered in Full
Routine Colorectal Cancer Screening	Covered in Full
Routine Mammogram	Covered in Full
Routine OB/GYN	Covered in Full
Routine Pap smear	Covered in Full
Routine Physical exam	Covered in Full
PSA test	Covered in Full
Routine eye exam	Covered in Full
HOSPITAL	
Inpatient hospital stay	$1,000/$2,000
Inpatient maternity stay	Covered in Full
Outpatient surgery	$150
EMERGENCY HOSPITAL CARE	
Emergency room (copay waived if admitted to hospital)	$100
Ambulance - ground ambulance	$100
Ambulance - air ambulance	$100
Urgent care centers	$35
MENTAL HEALTH & SUBSTANCE ABUSE	
Mental Health (inpatient)	$1,000/$2,000
Mental Health (outpatient)	$50
Alcohol & Substance Abuse (inpatient detox)	$1,000/$2,000
Alcohol & Substance Abuse (inpatient rehab)	$1,000/$2,000
Alcohol & substance abuse (outpatient)	$50



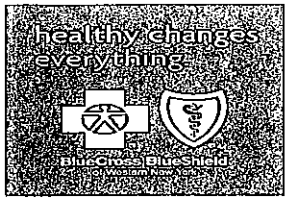
	STEL Traditional Blue POS 128
DIABETIC SUPPLIES & SERVICES	
Diabetic equipment & supplies (test strips, syringes, etc.)	$30
OTHER SERVICES	
Cardiac rehabilitation (24 visits within 12 weeks of acute episode)	$50
Chemotherapy	$50
Dialysis	Covered in Full
Durable medical equipment	50% Copay
Home care	$50
Hospice	Covered in Full
Physical, speech & occupational therapy	30 Visits, Specialist copay
Post-mastectomy prosthetics	Covered in Full
Prosthetic and orthotic appliances	50% Copay
Radiation therapy	$50
Skilled nursing facility	50 Days, Inpatient copay
Rate Structure	
Funding	Prospective
Tier Structure	2-Tier

Premium Option 2

STEL

Traditional Blue POS 206

DEDUCTIBLES/MAXIMUMS	
In network deductible	N/A
In network co-insurance	N/A
In network out of pocket maximum	N/A
Out of network deductible	$500/$1,000
Out of network coinsurance	25%
Out of network out of pocket maximum	$5,000/$10,000
Annual maximum	Unlimited
Lifetime maximum	Unlimited
Benefit administration	Plan year benefits
Dependent Age	26
Student Age	26
Dependent/Student coverage ends	Coverage ends at birth date
Domestic partner	No Coverage for domestic partner
PRESCRIPTION DRUG	
Prescription Copay	$10/$30/$50
Mail order copay per 90 day supply	2.5 Copays
Mandatory mail order applies	N/A
Prescription deductible	N/A
Generic Oral Contraceptive coverage	Yes, $0 copay for generic contraceptives
PHYSICIAN SERVICES - Office	
PCP Copay	$25
Specialist Copay	$25
Pediatric visits for children up to age 19	Covered in Full
Well child visits and immunizations for children up to age 19	Covered in Full
Allergy immunotherapy	$25
Chiropractic	$25
Laboratory services	Covered in Full
Radiology (x-ray, MRI, CT & other high tech imaging)	$25
Pre & post natal care	Covered in full after initial PCP copay
PHYSICIAN SERVICES - Routine/Preventive	
Abdominal aortic aneurysm screening	Covered in Full
Adult immunizations (Flu vaccinations covered in full)	Covered in Full
Bone mineral density screening	Covered in Full
Routine Colorectal Cancer Screening	Covered in Full
Routine Mammogram	Covered in Full
Routine OB/GYN	Covered in Full
Routine Pap smear	Covered in Full
Routine Physical exam	Covered in Full
PSA test	Covered in Full
Routine eye exam	Covered in Full
HOSPITAL	
Inpatient hospital stay	$500/$1,000
Inpatient maternity stay	Covered in Full
Outpatient surgery	$75
EMERGENCY HOSPITAL CARE	
Emergency room (copay waived if admitted to hospital)	$100
Ambulance - ground ambulance	$100
Ambulance - air ambulance	$100
Urgent care centers	PCP Copay
MENTAL HEALTH & SUBSTANCE ABUSE	
Mental Health (inpatient)	$500/$1,000
Mental Health (outpatient)	$25
Alcohol & Substance Abuse (inpatient detox)	$500/$1,000
Alcohol & Substance Abuse (inpatient rehab)	$500/$1,000
Alcohol & substance abuse (outpatient)	$25



	STEL Traditional Blue POS 206
DIABETIC SUPPLIES & SERVICES	
Diabetic equipment & supplies (test strips, syringes, etc.)	$25
OTHER SERVICES	
Cardiac rehabilitation (24 visits within 12 weeks of acute episode)	$25
Chemotherapy	$25
Dialysis	Covered in Full
Durable medical equipment	50% Copay
Home care	$25
Hospice	Covered in Full
Physical, speech & occupational therapy	20 Visits, Specialist copay
Post-mastectomy prosthetics	Covered in Full
Prosthetic and orthotic appliances	50% Copay
Radiation therapy	$25
Skilled nursing facility	50 Days, Inpatient copay
Rate Structure	
Funding	Prospective
Tier Structure	2-Tier

Southern Tier Environments for Living, Inc.

Benefits Election Form 2011-2012

Instructions: Please review your staff member information and note any changes on this form.

This form must be returned to the Human Resources Office by Friday, November 4, 2011.

Staff Member Information:

Name: _____ Department: _____

Address: _____ Position: _____

_____

**** Please check the health insurance contract you elect ****

MEDICAL INSURANCE ELECTION OPTIONS:

"HIGH DEDUCTABLE OPTION"

_____ Blue Cross POS 7100 _____ Family Coverage** _____ Single Coverage

"PREMIUM OPTION 1"

_____ Blue Cross POS 128 _____ Family Coverage** _____ Single Coverage

"PREMIUM OPTION 2"

_____ Blue Cross POS 206 _____ Family Coverage** _____ Single Coverage**

** Please refer to Medical Insurance Rate sheet.

"OPT OUT"

_____ I elect to "opt out" of STEL's Health Plan in lieu of $2000.00 Benefit Bonus Prorated Basis in Pay Check*.

*Staff members who choose the "opt out" must be covered by another comprehensive health insurance contract. Proof of insurance must be provided with this form. Acceptable forms of proof include a letter from the employer who sponsors the insurance program or the insurance company itself certifying coverage or a copy of a health insurance ID card issued by the insurance company. **THIS VERIFICATION IS REQUIRED ANNUALLY.**

FLEXIBLE SPENDING ACCOUNTS

_____ Yes, I choose to **participate** in the Flexible Spending Account Plan.

_____ No, I choose **not to participate** in the Flexible Spending Account Plan.

_____

Staff Member's Signature Date

Other Information: I would like the following Benefit Information sent to me at: _____ Office _____ Home

_____ Flexible Spending Account
_____ First Unum Enhanced Short Term Disability Insurance
_____ Vanguard 403b(7) Account
_____ Federal and State Tax Withholding Forms
_____ Employee Assistance Program
_____ Other (Specify): _____

To: Southern Tier Environments for Living, Inc.

From: _____

Date: _____

Re: Premium Only Plan Salary Reduction Election Form

INSTRUCTIONS

Staff members who elect a medical insurance option requiring an employee contribution may choose to have the insurance cost deducted from their paycheck on a pre-tax basis. Complete the form below and make your election. If you have any questions, please call Mark Wasiewicz, Human Resources Director at 716-366-7792 x212.

Plan Year
From **12/1/11 to 11/30/12**

My social security number is: _____

Check One:

_____ I elect to have my cost for employer-sponsored insurance deducted from my pay on a pre-tax basis.

_____ I **do not** wish to have my cost for employer-sponsored insurance deducted from my pay on a pre-tax basis.

AUTHORIZATION

I hereby elect the benefits indicated above. I understand that this election is binding and cannot be revoked or modified until the next plan year, except under the limited circumstances that are described in detail in the SPD that I have received from my employer (i.e. marriage, divorces, birth, and adoption).

SIGNATURE OF PARTICIPANT **DATE**