SOUTHERN TIER ENVIRONMENTS FOR LIVING, INC.

HEALTH REIMBURSEMENT ARRANGEMENT PLAN

PURPOSE

The Southern Tier Environments for Living, Inc. Health Reimbursement Arrangement Plan (the "Plan") is adopted by Southern Tier Environments for Living, Inc. effective 12/1/2013. The purpose of the Plan is to allow Employees of Southern Tier Environments for Living, Inc. and other Participating Employers, to obtain reimbursement of Deductible Medical Care Expenses on a nontaxable basis from the HRA account. Southern Tier Environments for Living, Inc. intends that the Plan qualify as an employer-provided medical reimbursement plan under Code Sections 105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Deductible Medical Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from the Participant's income for Federal Income Tax purposes under Section 105(b) of the Internal Revenue Code.

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Section 1

DEFINITIONS

The words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context, and pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural.

"Administrator" means Southern Tier Environments for Living, Inc., who has been appointed by the Employer with full authority, discretion, and responsibility to manage and direct the operation and administration of the Plan.

"Beneficiary" means the person, persons or trust designated by written revocable designation filed with the Plan Administrator by the Participant to receive payments under this Plan, including the Participant and any dependents of a Participant.

"Benefits" means the reimbursement benefits for Deductible Medical Care Expenses described under Section 4.

"Board" means the Board of Directors or other governing body of the Employer (the Board). The Board, upon adoption of this Plan, appoints the Plan Administrator to act on the Employer's behalf in all matters regarding the Plan.

"Change in Status" means any of the events described in the SPD, as well as any other events that the Plan Administrator in its sole discretion decides to recognize on a uniform and consistent basis as a reason to change the enrollment mid-year.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986 as amended.

"**Compensation"** means earned income, salaries, wages, fees, commissions, and all other earnings paid to the Employee by the Employer.

"Dependent" means any individual who is a tax dependent of the Participant as defined in Code Section 152(a), with the following exceptions: any child to whom Code Section 152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents. Notwithstanding the foregoing, the HRA Account will provide benefits in accordance with the applicable requirements of a QMCSO, even if the child does not meet the definition of "Dependent."

"Effective Date" is defined in the Purpose of the Plan as 12/1/2013.

"Eligible Employee" means any Employee who is eligible to participate in the Plan as provided in Section 2.1.

"Eligible Deductible Medical Expense" means those expenses incurred by the Participant, or the Participant's Spouse or Dependents, after the effective date of the Participant's participation in the HRA and during the Plan Year. Deductible Medical Care Expenses generally means expenses incurred by a Participants or his or her Spouse or Dependents for medical care. For purposes of this plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense.

"Employee" means any individual who is considered to be in a legal employer-employee relationship with the Employer for federal tax-withholding purposes, excluding independent contractors, temporary or casual employees, any individuals covered under a collective bargaining unit, any self-employed individual, any partner in a partnership, and any more-than 2% shareholder by virtue of the Code Section 318 ownership attribution rules. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits in accordance with Section 4.7.

"Employer" means Southern Tier Environments for Living, Inc. and any other Related Employer that adopts this Plan with the approval of Southern Tier Environments for Living, Inc. Related Employers if any, which have adopted this Plan are listed in Schedule C of this Plan.

"Employment Commencement Date" means the first regularly-scheduled working day on which the employee first performs an hour of service for the Employer for compensation.

"Enrollment Form" means the form provided by the Administrator for the purpose of allowing an eligible Employee to participate in this Plan.

"Enrollment Period" means the calendar month preceding the beginning of any Plan Year.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Health FSA" means a Health Flexible Spending Arrangement.

"Health Insurance Plan" means the plan(s) that the Employer maintains for its Employees and their Spouses and Dependents that may be eligible under the terms of such plan, providing major medical type benefits through a group insurance policy or group health plan.

"Highly Compensated Employee" means any Employee defined as such in Section 414(q) of the Code.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"HRA" means a health reimbursement arrangement as defined in IRS Notice 2002-45.

"HRA Account" means the HRA Account described in Section 5.4.

"Key Employee" means any Employee defined as such in Section 416(I) of the Code.

"Participant" means any Eligible Employee who has met the conditions for participation set forth in Section 1.11 above and, in Section 2.

"Participating Employer" means Southern Tier Environments for Living, Inc. and any Related Employer that adopts this Plan with the consent of the Board.

"Plan" means the Southern Tier Environments for Living, Inc. Health Reimbursement Arrangement as described herein and in any applicable Adoption Agreement, and which is intended for the exclusive benefit of Eligible Employees, and as may be amended from time to time.

"Plan Number" or **"PN"** assigned by the Plan Sponsor is #503.

"Plan Sponsor" means Southern Tier Environments for Living, Inc.

"Plan Year" means the twelve-month period commencing each 12/1 and ending on the subsequent 11/30, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

"QMCSO" means a qualified medical child support order, as defined in ERISA Section 609(a).

"Related Employer" means any employer affiliated with Southern Tier Environments for Living, Inc. that, under Code Section 414(B) (c), or (m), is treated as a single employer with Southern Tier Environments for Living, Inc. for purposes of Code Section 105.

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

"SPD" means the separate Summary Plan Description describing the terms of this Plan.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Section 2

PARTICIPATION IN THE PLAN

2.1 Commencement of Participation. An individual is eligible to participate in the Plan if the individual is an Employee and participating in the Employer's group health insurance. The Employee's coverage will commence on the first day of the next calendar month, after the employee has met the Plan's eligibility requirements and an enrollment form has been submitted to the Administrator.

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

A. the date on which the Plan terminates; or

B. the date on which the employee ceases to be an Eligible Employee; provided that eligibility may continue beyond such date for purposes of COBRA coverage, as may be permitted by the Administrator on a uniform and consistent basis under Section 4.7.

Reimbursements from the HRA Account after termination of participation will be made pursuant to Section 4.6 and 4.7 (relating to a run-out period for submitting claims incurred prior to termination and relating to COBRA). Notwithstanding the foregoing, a former Eligible Employee who is absent by

reason of sickness, disability, or other authorized leave of absence may continue as a Participant for so long as such authorized absence continues in accordance with such rules and regulations as the Participating Employer may direct.

2.3 Recommencement of Participation. A former active Participant, who is rehired within 30 days or less of the date of termination of employment, will be reinstated with the same HRA Account balance that such individual had before termination. If an Employee terminates employment and is not rehired within 30 days, or ceases to be an Eligible Employee for any other reason and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 2.1 before again becoming eligible to participate in the Plan. However, any former active Participant shall be prohibited from making any enrollment change from his prior enrollment in the Plan Year, except as provided in Section 2.4. Such family status changes must occur while the Employee is a Participant.

2.4 Modification to Benefit Enrollees. Any Participant may make a change to his or her enrollment form after the Plan Year has commenced, to be effective for the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

In general, a change in enrollment is considered if there is a change in status for the Participant's dependents. Any new enrollment form shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the enrollment form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

(1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a spouse, legal separation or annulment;

(2) Number of Dependents: Events that change a Participant's number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

(3) Dependent satisfies or ceases to satisfy the eligibility requirements due to attainment of age, change in student status, or any similar circumstance;

(4) In the event of a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires accident or health coverage for a Participant's child:

2.5 FMLA and USERRA Leaves of Absence. A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 (“FMLA Leave” applicable to groups of 50+ employees), or under the Uniformed Services Employment and Reemployment Rights Act of 1994

("USERRA Leave" applicable to any size group), may revoke his election to participate under any group health insurance benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her FMLA or USERRA Leave, the Participant may be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the FMLA or USERRA Leave, and with such other rights to make enrollment changes as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on FMLA or USERRA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the FMLA or USERRA leave commences, as other Plan Participants.

2.6 Non-FMLA and Non-USERRA Leaves of Absence. A Participant who goes on a leave of absence that is not subject to FMLA or USERRA will be treated as having terminated participation, as described in Section 2.2.

Section 3

BENEFITS and FUNDING OF THE PLAN

3.1 Provision of Benefits. When the Eligible Employee becomes a plan Participant, an HRA **a**ccount will be established for the Participant to receive Benefits in the form of reimbursements for Deductible Medical Care Expenses. Under no circumstances shall benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for eligible Deductible Medical Care Expenses. The benefits provided thereunder shall be subject further to the provisions of any plan, contract, or other arrangement setting forth the further terms and conditions of the Benefit Program, and the terms of each Participating Employer's plan, contract or other arrangement, under which benefits provided are incorporated by reference in this Plan.

3.2 Plan Enrollment. An Employee who becomes eligible to participate in the Plan will begin participation on the first day of the month after the eligibility requirements have been satisfied, provided that an Enrollment Form is submitted to the Plan Administrator before the first day of the month in which participation will commence. Once enrolled, the employee's participation will continue from month-to-month and year–to-year until the employee's participation terminates, pursuant to Section 2.2. The Spouse and any Dependents, whose Deductible Medical Expenses may be submitted to the HRA, must be identified on the Enrollment Form.

3.3 Employee Contributions. There are no employee contributions for benefits under the Plan.

3.4 Employer Contributions. The Employer funds the full amount of the HRA Accounts.

3.5 **No Funding Under a Cafeteria Plan.** The benefits cannot be funded with salary reduction contributions, employer contributions (e.g. flex credits) or otherwise under a cafeteria plan.

3.6 Funding of the Plan. All of the amounts payable under the Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or to segregate any amount for the benefit of any 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 this Plan may be made. There is no trust or other fund from which Benefits are paid.

3.7 Nondiscrimination. Contributions and benefits under the Plan shall not discriminate in favor of Highly Compensated Employees; nor shall the aggregate cost of the Benefit Programs provided to Key Employees exceed 25% of the aggregate of such cost for the Benefit Programs provided to all Employees under the Plan.

Section 4

HEALTH REIMBURSEMENT BENEFITS

4.1 Benefits. The Plan will reimburse Participants for Deductible Medical Care Expenses up to the unused amount in the Participant's HRA Account, as set forth and adjusted under Section 4.3.

4.2 Eligible Deductible Medical Care Expenses. Under the HRA Account, a Participant may receive reimbursement for eligible Deductible Medical Care Expenses incurred during a Period of Coverage.

An eligible Deductible Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Deductible Medical Care Expenses incurred before a Participant first becomes covered by the Plan are not eligible. However, a Deductible Medical Care Expense incurred during one Period of Coverage may be paid during a later Period of Coverage provided that the Participant was a Participant in the Plan during both Periods of Coverage.

Deductible Medical Care Expenses generally means expenses incurred by a Participant or his or her Spouse or Dependents for medical care. Reimbursements due for Deductible Medical Care Expenses incurred by the Participant or the Participant's Spouse or Dependents shall be charged against the Participant's HRA Account.

Deductible Medical Care Expenses can only be reimbursed to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Health Insurance Plan, other insurance, or any other accident or health plan, (see section 4.10 if the other health plan is a Health FSA). If only a portion of a Deductible Medical Care Expense has been reimbursed elsewhere (due to health insurance plan co-payment or deductible limitations), the HRA

account can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this plan.

4.3 Maximum Benefits. The maximum allowed benefit each year is outlined below:

Plan deductible is $5,500 single/$11,000 family. $1300/$2600 for all ees.
HRA benefit: 1st $1300/2600: HRA reimburses 100% via debit card or paper claims.
Next $1300/2600: No HRA benefit. EE responsible for this portion.
Next $2900/5800: HRA reimburses 100% via manual claims only.

For subsequent Plan Years, the maximum dollar limit may be changed by the Administrator and shall be communicated to Employees through the Enrollment Form, the SPD or another document. Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code Section 105(h), as may be determined by the Administrator in its sole discretion.

4.4 Establishment of the HRA Account. The Administrator will establish and maintain an HRA Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a records-keeping account with the purpose of keeping track of contributions and available reimbursement amounts.

A Participant's HRA Account will be credited at the beginning of each year with an amount equal to the applicable maximum dollar limit for the Period of Coverage.

A Participant's HRA Account will be debited during each Period of Coverage for any reimbursement of Deductible Medical Care Expenses incurred during the Period of Coverage.

The amount available for reimbursement of Deductible Medical Care Expenses is the amount credited to the Participant's HRA Account reduced by prior reimbursements debited.

4.5 Carryover of Accounts. If any balance remains in the Participant's HRA account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall remain the property of the Employer. However, upon termination of employment or other loss of eligibility, the Participant's coverage ceases, and expenses incurred after such time will not be reimbursed unless COBRA is elected. In addition, any HRA benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage in which the Deductible Medical Care Expense was incurred, such as uncashed benefit checks, shall remain the property of the Employer.

4.6 Substantiation of Expenses. Each Participant must submit a written Claim Form to the Plan Administrator accompanied by a written statement or bill from an independent third party stating that the expense has been incurred and the amount thereof. The forms shall contain such evidence as the Plan Administrator shall deem necessary as to substantiate the nature, the amount, and timeliness of any expenses that may be reimbursed.

4.7 Reimbursement. Within 30 days after receipt by the Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Deductible Medical

Care Expenses, if the Administrator approves the claim, or the Administrator will notify the Participant that his or her claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

A Participant who seeks benefits may apply for reimbursement by submitting an application in writing to the Administrator in such form as the Administrator may prescribe, within 90 days, following the close of the Plan Year in which the Deductible Medical Care Expense was incurred. The application must include the person or persons on whose behalf the Deductible Medical Care Expense was incurred, the nature and date of the Expense incurred, the amount of the requested reimbursement, and a statement that such Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such expense has been exhausted.

The application shall be accompanied by a Substantiation of Expense along with any additional documentation that the Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least $10.00.

4.8 Reimbursements after Termination and COBRA. When a Participant ceases to be a Participant under Section 2.2, the Participant will not be able to receive reimbursements for Deductible Medical Care Expenses incurred after his or her participation terminates. The Participant, or the Participant's estate, may claim reimbursement for any Deductible Medical Care Expenses incurred during the Period of Coverage prior to termination of participation, provided that the Participant or the Participant's estate, files a claim within 90 days, following the close of the Plan Year in which the Deductible Medical Care Expense was incurred.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, the Participant and his or her Spouse and Dependents (Qualified Beneficiaries), whose coverage terminates under the HRA account because of a COBRA qualifying event, shall be given the opportunity to continue on a self-pay basis, the same coverage that he or she had under the HRA account the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). However, in the event that such coverage is modified for all similarly situated non-COBRA Participants prior to the date continuation coverage is elected, Qualified Beneficiaries shall be eligible to continue the same coverage that is provided to similarly situated non-COBRA participants. At the beginning of each month in the Plan Year, Qualified Beneficiaries shall be credited with the monthly reimbursement accrual (the maximum annual reimbursement amount, divided by the number of months in

that Plan Year) that is made available to similarly situated non-COBRA beneficiaries and any unused reimbursement amounts from the previous Coverage Period shall be carried over (provided that the applicable premium is paid). A premium for continuation coverage shall be charged to Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Plan Administrator and are permitted by COBRA.

4.9 Named Fiduciary. Southern Tier Environments for Living, Inc. is the named fiduciary for the Plan for purposes of ERISA section 402(a).

4.10 Compliance with ERISA, COBRA, HIPAA, etc. Benefits shall be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, and other group health plan laws to the extent required by such laws.

4.11 Coordination of Benefits; Health FSA to Reimburse First - Benefits under this plan are intended to pay benefits solely for Deductible Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Deductible Medical Care Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from this Plan. Without limiting the foregoing, if the Participant's Deductible Medical Care Expenses are covered by both this Plan and by a Health FSA, then this Plan is not available for reimbursement of such Deductible Medical Care Expense until after amounts available for reimbursement under the Health FSA have been exhausted.

Section 5

APPEALS PROCEDURE

5.1 Procedure If Benefits Are Denied Under This Plan. If a claim for reimbursement under this Plan is wholly or partially denied, claims shall be administered in accordance with the claims procedure set forth in the SPD. The Committee acts on behalf of the Administrator with respect to appeals.

Section 6

PLAN ADMINISTRATION

6.1 Administrator. The administration of this Plan shall be under the supervision of the Administrator. It is the principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

6.2 Powers of the Administrator. The Administrator shall have the duties and powers it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Administrator with respect to any

matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following discretionary authority:

(A) to construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan, and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan.

(B) to prescribe procedures to be followed and the forms to be used by Employees and Participants to enroll in and submit claims pursuant to this Plan;

(C) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Administrator determines to be appropriate;

(D) to request and receive from all Employees and Participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(E) to furnish each Employee and Participant with reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate;

(F) to receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Administrator determines from time to time to be necessary and proper;

(G) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(H) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(I) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(J) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

The Plan Administrator shall adopt such rules for administration of the Plan as it considers desirable, provided they do not conflict with the Plan; and may construe the Plan, correct defects, supply omissions and reconcile inconsistencies to the extent necessary to effectuate the Plan, and such action shall be conclusive. Records of administration of the Plan shall be kept by the Plan Administrator, and Participants and their Beneficiaries may examine records pertaining directly to themselves.

6.3 Provision for Third-Party Plan Service Providers. The Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

6.4 Fiduciary Liability. To the extent permitted by law, the Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

6.5 Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards. In order that the Plan Administrator may receive and use Protected Health Information (PHI) for Plan Administration purposes, the Plan Administrator agrees to:

a. Not use or further disclose PHI other than is permitted or required by the Plan Documents or as required by law (as defined in the Privacy Standards);

b. Ensure that any agent, including a subcontractor, to whom the Plan Administrator provides PHI, agrees to the same restrictions and conditions that apply to the Plan Administrator with respect to PHI;

c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Administrator becomes aware;

e. Make available PHI in accordance with Section 164.524 of the Privacy Standards;

f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards;

g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards;

h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to any officer or employee of the U.S. Department of Health and Human Services to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards;

i. If feasible, return or destroy all PHI received from the Plan that the Plan Administrator or employer still maintains in any form, and retain no copies of such PHI 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 disclosure to those purposes that make the return or destruction of the PHI infeasible; and

j. Ensure that adequate separation between the Plan and the Plan Administrator or employer, as required in Section 164.505(f)(2)(iii) of the Privacy Standards is established as follows:

i. The following employees, or classes of employees, or other person under control of the Plan Administrator, shall be given access to the PHI to be disclosed:

Human Resources Manager

Staff designated by Human Resources Manager

Chief Financial Officer

Plan Auditor

ii. The access to and use of PHI by individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Administrator or employer performs for the Plan.

iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator or employer shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Plan Administration activities are limited to activities that would meet the definition of claims processing, payment, quality assurance, auditing, monitoring and management of the plan.

6.7 Compensation of the Plan Administrator. Unless otherwise determined by the employer and permitted by law, any Administrator who is also an employee of the employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the employer.

6.8 Inability to Locate Payee. If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date that any such payment first became due.

6.9 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Administrator shall, to the extent that it deems

administratively possible and otherwise permissible under code Section 105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerate, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the HRA Account or distributions to which he or she is properly entitled under the Plan.

Section 7

MISCELLANEOUS PROVISIONS

7.1 Expenses. All reasonable expenses incurred in administering the Plan are currently paid by the Employer.

7.2 Not an Employment Contract. Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with any Employer.

7.3 Amendment and Termination. The Employer reserves the right to amend or terminate all or any part of this Plan at any time for any reason, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan. Any such amendment or termination shall be effective as of such date as the Employer shall determine.

7.4 Headings and Captions. The headings and captions set forth in the Plan are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

7.5 Applicable Laws. This Plan shall be construed, administered and enforced according to the applicable federal law and the laws of the state of the principal place of business of the Employer to the extent not preempted.

7.6 Code and ERISA Compliance. It is intended that this Plan meet all applicable requirements of the IRS Code and ERISA, and of all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

7.7 Tax Consequences. Neither the Employer nor the Plan Administrator makes any warranty or guarantee that any amounts paid to or for the benefit of any Participant under this Plan will be treated as excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the responsibility of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable. Under

no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employee as a result thereof.

7.8 Indemnification of the Employer. If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

7.9 Non-Assignability of Rights. The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

7.10 Plan Provision Controlling. In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument are in any construction interpreted as being in conflict with the provisions of the Plans as set forth in this document, the provisions of this Plan shall be controlling.

7.11 Severability. Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder thereof shall be given effect to the maximum extent possible.

Executed December 1, 2013

ATTEST: **Southern Tier Environments for Living, Inc.**

_____ _____

Witness Authorized Officer

SOUTHERN TIER ENVIRONMENTS FOR LIVING, INC.
HEALTH REIMBURSEMENT ARRANGEMENT
SUMMARY PLAN DESCRIPTION
Effective Date: 12/1/2013

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As used in this Summary Plan Description (SPD), "Your" means an active Employee as described under "Who is Eligible."

PLAN PURPOSE

The purpose of the Southern Tier Environments for Living, Inc. Health Reimbursement Arrangement Plan ("Plan") is to provide you with additional health coverage benefits. The benefits available under this Plan and other important information concerning the Plan, such as rules that must be satisfied before you become eligible and laws that protect your rights are outlined in this summary plan description.

WHO IS ELIGIBLE

With respect to the HRA, if you are eligible to participate in and enrolled in the Southern Tier Environments for Living, Inc. group Health Insurance Plan, or any affiliate of the Employer, which adopts the Plan ("Participating Employer"), you are eligible to participate in the HRA Plan.

There are certain employees who are not eligible to participate in the Plan. They are Employees who are not eligible to receive medical benefits under Southern Tier Environments for Living, Inc. group Health Insurance Plan.

WHEN YOU MAY PARTICIPATE

You are eligible to participate in the Plan on the first day you become eligible to participate in the Southern Tier Environments for Living, Inc. group Health Insurance Plan.

SCHEDULE OF BENEFITS

The Health Reimbursement Account (HRA) benefits allow you to be reimbursed for certain out-of-pocket deductible medical benefits which are incurred by you and your dependents. The expenses that qualify are those covered under your Major Medical Plan. Please refer to your Major Medical Plan Document for a complete listing of covered expenses.

The maximum allowed benefit each year is outlined below:

Plan deductible is $5,500 single/$11,000 family. $1300/$2600 for all ees.
HRA benefit: 1st $1300/2600: HRA reimburses 100% via debit card or paper claims.
Next $1300/2600: No HRA benefit. EE responsible for this portion.
Next $2900/5800: HRA reimburses 100% via manual claims only.

Expenses are considered "incurred" when the service is performed, not necessarily when it is reimbursed. Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage.

HOW HEALTH REIMBURSEMENT ACCOUNTS (HRAs) WORK

Your employer has set aside a specific amount of funds each Plan Year from which you may be reimbursed for eligible Deductible Medical Expenses that you have incurred during your Period of Coverage. Normally, you would pay for these expenses out of pocket, with your own after-tax income. Your employer is funding the account, and as such, there should be no tax liability to you.

To receive reimbursement, you must complete a claim form and submit it along with your paid bills or other substantiation of expenses, to the Plan Administrator. The Plan Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the Plan Administrator proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If your request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement check soon thereafter up the amount available in your HRA account.

You may submit expenses that you incur each "Coverage Period". A new "Coverage Period" begins each calendar year.

FUTURE OF THE HEALTH REIMBURSEMENT ARRANGEMENT

The Plan is based on the Employer's understanding of the current provisions of the Internal Revenue Code. The Employer reserves the right to amend or discontinue the Plan if regulations or changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you were entitled before the date of the amendment or termination.

COBRA CONTINUATION COVERAGE *(Generally applicable to groups of 20+ employees)*

If you terminate employment, under Federal law, you, your spouse, and/or your covered dependents lose coverage under this Plan. You, your spouse, and/or your covered dependents may be entitled to continuation of health care coverage. The Administrator will inform you of these rights if you lose coverage for any reason other than divorce, legal separation or a covered dependent ceasing to be a dependent. Generally, if your employer (and any related companies) employed twenty (20) or more employees "on a typical business day" in the preceding calendar year, health plan continuation must be made available for a period not to exceed eighteen (18) months if a loss of benefits occurs because of your termination of employment or reduction of hours, or for a period not to exceed three (3) years for any of the other reasons given in (b) and (c) below. Under certain circumstances, persons who are disabled at the time of termination of employment or reduction in hours and/or within the first 60 days of COBRA coverage may be eligible for continuation of coverage for a total of 29 months (rather than 18). You should check with the Administrator for more details regarding this extended coverage. However, in certain circumstances, this continuation coverage may be terminated for reasons such as failure to pay continuation coverage cost, coverage under another employer's plan (whether as an employee or otherwise, provided the other employer's health plan does not contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary unless the pre-existing condition limit does not apply to, or is satisfied by, the qualified beneficiary by reason of the group health plan portability, access and renewability requirements of the Health Insurance Portability and Accountability Act, ERISA or the Public Health Services Act), termination of the health plan, a "for cause" termination of coverage for reasons such as fraud, or you (or the person entitled to continued coverage) become enrolled in Medicare. However, if you become enrolled in Medicare, your covered dependents may still qualify for continuation coverage. The cost of continuation coverage must be paid by the individual choosing such coverage; however, the cost may not exceed 102% of the cost of the same coverage for a "similarly situated" employee or family member. When the continuation coverage for a disabled person is extended from 18 months to 29 months, the disabled person may be charged 150% (rather than 102%) of the cost of the coverage after expiration of the initial 18-month period.

(a) If you would otherwise lose your health plan coverage under this Plan because of a termination of

employment or a reduction in hours, you may continue the health plan coverage provided under this Plan.

(b) Your spouse may choose continuation coverage for himself or herself if he or she loses group health coverage for any of the following reasons: (1) your death; (2) your divorce or legal separation; or (3) you become enrolled in Medicare.

(c) Your dependent children, including a child born to or placed for adoption with the Participant during the period of COBRA coverage, may choose continuation coverage for themselves if they lose group health coverage for any of the following reasons: (1) death of a parent; (2) your divorce or legal separation; (3) you become enrolled in Medicare; or (4) your dependent ceases to be a dependent child under the Plan.

It is your responsibility to notify the Plan Administrator of a divorce, legal separation or other change in marital status, change in a spouse's address, or a child losing dependent status under the plan, within sixty (60) days of the event. It is your Employer's responsibility to notify the Plan Administrator of your death, termination of employment or reduction in hours, the Employer's bankruptcy, or Medicare eligibility.

For purposes of this section the words "Dependent" and "Medicare" shall have the following meanings:

- "Dependent" means an individual who meets the definition of dependent under the Participating Employer health plan covering the Qualified Beneficiary. No person shall be considered a dependent of more than one Employee. If you and your spouse are employed by the Employer, dependent children may be covered by you or your spouse, but not by both.
- "Medicare" means the Health Insurance For the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

FAMILY AND MEDICAL LEAVE *(Applicable to groups of 50+ employees)*

As an employee of Southern Tier Environments for Living, Inc. you may be entitled under the federal Family and Medical Leave Act (FMLA) to up to 12 work weeks of unpaid, job-protected leave in any 12-month period. You may be eligible if you have worked for Southern Tier Environments for Living, Inc. for at least one year, and for 1,250 hours during the previous 12 months. Such leave may be available for the birth and care of a newborn child, placement of a child for adoption or foster care, a serious health condition of a family member (child, spouse or parent) or a personal serious health condition.

As a participant in the Health Reimbursement Arrangement, you have while on leave under the FMLA the option to continue your health benefits on the same terms and conditions as immediately prior to your taking FMLA leave. You and your eligible dependents shall remain covered under this plan while you are on FMLA leave as if you still were at work. Your coverage will be maintained until you return to work or, if earlier, you notify Southern Tier Environments for Living, Inc. that you will not return to work. If you choose not to

remain covered under the plan while on FMLA leave, and subsequently return to work before, or at the end of FMLA leave, you and your eligible dependents shall immediately become covered under the health plan without proof of insurability and without regard to pre-existing conditions that arise while on FMLA leave. You and your eligible dependents may also be reinstated in the HRA Plan, on the same terms that applied to the Participant prior to his or her taking the FMLA. More details on your FMLA rights and benefits while on FMLA leave should be found in your employer's employee handbook.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

(Applicable to any size group) A Participant who takes an unpaid leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA Leave"), may revoke his election to participate under any group health insurance benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her USERRA Leave, the Participant may be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the USERRA Leave, and with such other rights to make enrollment changes as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on USERRA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the USERRA leave commences, as other Plan Participants.

NON-FMLA AND NON-USERRA LEAVES OF ABSENCE

A Participant who goes on a leave of absence that is not subject to FMLA or USERRA will be treated as having terminated participation.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Generally, your Plan benefits may not be assigned or alienated however, an exception applies in the case of a "qualified medical child support order." Basically, a qualified medical child support order is a court–ordered judgement, decree, order or property settlement agreement in connections with state domestic relations law which either creates or extends the rights of an "alternate recipient: to participate in a group health plan, including this Plan, or enforces certain laws relating to medical child support. An "alternate recipient" is any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a Participant's group health plan.

A medical child support order satisfies certain specific conditions to be qualified. You will be notified by the Plan Administrator, if it receives a medical child support order that applies to you, and the Plan's procedures for determining whether the medical child support order is qualified.

ADMINISTRATIVE FACTS

Plan Sponsor and Administrator

The Plan is sponsored by Southern Tier Environments for Living, Inc., 715 Central Avenue, Dunkirk, New York 14048, 716-366-7792. The Southern Tier Environments for Living, Inc. Federal Tax ID Number is 22-2360739. Southern Tier Environments for Living, Inc. also acts as Plan Administrator. The Plan Administrator manages the overall operations of the Plan and decides all questions that come to it on a fair and equitable basis for participants and their Beneficiaries. If an Employee covered under the Plan has any questions about the Plan, the Employee should contact the Plan Administrator.

General Information

Southern Tier Environments for Living, Inc. Health Reimbursement Arrangement is the name of the Plan.

Your Employer has assigned Plan Number 503 to this Plan.

The provisions of your Plan became effective on 12/1/2013.

Service of Legal Process

The Employer is the Plan's agent for service of legal process.

Classification and Funding

This employee benefit is a Health Reimbursement Arrangement as defined by Section 105 of the Internal Revenue Code. This Health Reimbursement Arrangement is funded solely by the Employer.

Not a Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and Southern Tier Environments for Living, Inc. or a Participating Employer. Southern Tier Environments for Living, Inc.'s rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

Your Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), defines **Protected Health Information (PHI)** as information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present or future payment of the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the

participant. Protected health information includes information of persons living or deceased.

The HIPAA definition of PHI applies to this plan and it restricts a Plan Administrator's use and disclosure of PHI. The Plan Administrator shall have access to PHI from the Plan only as permitted under this plan or as otherwise required or permitted by HIPAA, subject to the conditions of permitted disclosure and after obtaining written certification. The Plan may disclose PHI to the Plan Administrator, provide that the Plan Administrator uses or discloses the PHI for Plan administration purposes only. Plan Administration Purposes include administrative functions performed by the Plan Administrator on behalf of the Plan, such as, claims processing, auditing, and monitoring.

The Plan may disclose to the Plan Administrator information on whether the individual is participating in the plan, or is enrolled in or has disenrolled from the Plan.

With respect to PHI disclosed by The Plan to the Plan Administrator, the Plan Administrator shall:

1. Not use or disclose the PHI other than is permitted or required by the Plan or by law.
2. Not use or disclose the PHI for employment-related actions and decisions.
3. Ensure that any agents, or subcontractors to whom PHI is provided, agrees to the same privacy restrictions and conditions that apply to the employer and the Plan Administrator.
4. Report to The Plan any use or disclosure of PHI that is any violation of the HIPAA Privacy Rule.
5. Make available PHI to comply with the HIPAA right to access in accordance with the law.
6. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.
7. Return or destroy all PHI received from the Plan that the employer or Plan Administrator still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, if feasible.
8. Satisfy the requirement of adequate separation between the Plan and the employer.

The employer shall allow a designated person and no other persons, access to PHI. These specified employees or classes of employees shall only have access to and use PHI to the extent necessary to perform the Health Reimbursement Arrangement Plan administration functions that the Plan Administrator performs for the Plan. Any of these specified employees who do not comply with the provisions of this Section shall be subject to disciplinary action by the employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

ERISA Rights Statement

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted to help assure that all employer-sponsored group benefit programs conform to standards set by Congress. An employee, who is a Participant in the Plan is entitled to certain rights and protections under ERISA, which provides that all Participants will be entitled to: (1) examine, without charge, at the Plan Administrator's office and at other appropriate locations, all Plan documents and copies of documents filed with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions; (2) obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator, subject to a reasonable charge for the copies; and (3) receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report. Plan records are kept on a Plan year basis.

In addition to creating rights for plan Participants, ERISA imposes duties upon those responsible for the operation of the Plan who are called "fiduciaries" and who have a duty to operate the Plan prudently and in the interest of Participants and Beneficiaries. If a claim for a benefit is denied in whole or in part, the claimant must receive a written explanation of the reason for the denial. The claimant has the right to have the claim reviewed and reconsidered.

Under ERISA, there are steps the Employee covered under the Plan can take to enforce the above rights. For instance, if the person request materials and does not receive them within 30 days, the person may file suit in a federal court. In such a case, the court may require the company to provide the materials and pay the person up to $110 a day until the person receives the materials, unless the materials were not sent because of reasons beyond the Employer's control.

If a person has a claim for benefits which is denied or ignored, in whole or in part, the person may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if the Employee covered under the Plan is discriminated against for asserting his or her rights, the person may seek assistance from the U.S. Department of Labor, or may file suit in federal court. The court will decide who should pay court costs and legal fees. If the claimant loses, the court may order the claimant to pay these costs and fees, for example, if it finds the claims to be frivolous.

If you have any questions about your Plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration (PWBA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

The rights reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan.

Special Note: This is a Summary Plan Description only. Your specific rights to benefits under the Plan are governed solely, and in every respect by Southern Tier Environments for Living, Inc. Health Reimbursement Arrangement Plan document, a copy of which is available from the company upon your request (see Statement of ERISA Rights). If there is any discrepancy between the description of the Plan as contained in this material and the official Plan document, the language of the Plan document shall govern.

SOUTHERN TIER ENVIRONMENTS FOR LIVING, INC.
HEALTH REIMBURSEMENT ARRANGEMENT PLAN
QUESTIONS AND ANSWERS

INTRODUCTION

As a part of our efforts to keep your medical benefit costs as affordable as possible Southern Tier Environments for Living, Inc. (referred to in these questions as answers as the "Company"), is pleased to sponsor the Southern Tier Environments for Living, Inc. Health Reimbursement Arrangement.

The Plan provides each eligible employee with the opportunity to receive from the Company reimbursement for specific Deductible Medical Expenses.

Following are commonly asked questions and answers describing the basic features of the Plan and how it operates. Please review these questions and answers carefully, and do not hesitate to ask questions. This is your benefit and it is important that you understand how it works and how it can help you. However, you should note that the questions and answers address only the key parts of the Plan. Consult the Plan document or summary plan description for more details.

QUESTIONS AND ANSWERS

1. What is the purpose of the Plan?

The purpose of the Plan is to permit eligible employees to receive reimbursement for specific Deductible Medical Expenses, from the Company.

2. What benefits are offered through the Plan?

A Health Reimbursement Arrangement (HRA), which is explained in more detail below.

3. Who may participate in the Plan?

With respect to the HRA, if you are eligible to participate in the Southern Tier Environments for Living, Inc. group Health Insurance Plan, you are eligible to participate in the HRA Plan.

4. How does the HRA benefit help me?

It is likely that you will have some Deductible Medical Expenses that you will have to pay for in the coming year. For example, you or your dependents will have Deductible Medical Expenses that are subject to deductible or copayment limits under a health plan. You may incur expenses that are not reimbursed at all. Normally, you would pay for these expenses with out of pocket, after-tax income. And, because taxes reduce the value of a dollar, you would have to earn much more than $100 to pay for $100 of expenses.

The HRA under the Plan permits your employer to contribute to a health reimbursement arrangement account on your behalf. The HRA will reimburse you for specific Deductible Medical Expenses from funds contributed by your employer.

5. How much will my employer contribute to my HRA account?

Your employer will contribute a maximum amount outlined below:

Plan deductible is $5,500 single/$11,000 family. $1300/$2600 for all ees.
HRA benefit: 1st $1300/2600: HRA reimburses 100% via debit card or paper claims.
Next $1300/2600: No HRA benefit. EE responsible for this portion.
Next $2900/5800: HRA reimburses 100% via manual claims only.

6. How much will I be able to contribute to my HRA account?

Employees are not permitted to contribute to their HRA accounts. The accounts must be completely employer funded. You may however, contribute to a Flexible Spending Account (FSA) if your employer offers such benefits.

7. What is an "eligible expense" under the HRA?

An "eligible expense" means any item covered under the Code Section 213 of the IRS for which you have not otherwise been reimbursed from insurance or some other source, or any items that have been excluded by the employer.

8. How do I receive Deductible Medical Expense reimbursements under the Plan?

To receive a reimbursement for an eligible expense, you must complete a claim form and attach any other information or substantiation that the Plan Administrator requires. The Plan Administrator will instruct you as to how to file the form. When the claim is approved, you will be reimbursed on your eligible Deductible Medical Expense, up to the amount of funds available in your HRA account.

9. What happens to the money in my HRA account if I terminate?

You may submit claims on expenses incurred before the date of your termination, up until three months after you leave, unless your employer provides otherwise. If you elect continuation coverage through COBRA, you may continue to use your HRA account while you are an actively participating in COBRA.

10. What happens to the unused funds in my HRA account at the end of the Plan year?

The Plan does not allow carryover of unused portions to the next Plan Year.

11. How long do I have after the Plan Year ends to submit my claims?

You will have three months after the Plan Year ends to submit claims on expenses incurred in that Plan Year, unless you terminate your employment from Southern Tier Environments for Living, Inc. A terminated employee has three months from their date of termination to submit claims incurred in that Plan Year.

12. Are my Plan benefits taxable?

Under current law, the benefits you receive under the Plan are not currently taxable to you, nor are the benefits subject to federal income tax withholding and Social Security withholding taxes.

13. Can I change my covered dependents during the Plan Year?

Yes, you may make changes under your HRA account during the Coverage Period.

14. Who holds the funds I have set aside under the Plan?

Amounts your employer contributes to your HRA will be retained by the Company. Separate bookkeeping entries will be maintained to keep track of your HRA benefits.

15. When will my participation in the plan cease?

Your participation will continue until you separate from service with the Company or if the Plan is terminated by your employer. If your employment status changes so that you are no longer eligible to participate in the group health insurance, your participation in the Plan will cease. However, you may be eligible for continuation coverage under this Plan.

16. What is continuation coverage?

If you terminate employment, under Federal law, you, your spouse, and/or your covered dependents lose coverage under this Plan. You, your spouse, and/or your covered dependents may be entitled to continuation of health care coverage. See the Summary Plan Description or Plan Document for more details about COBRA.

17. Will I have any administrative costs under the Plan?

No, the Company will pay the entire cost of administering the Plan.

18. How long will the Plan remain in effect?

The Company has the right to modify or terminate the program at any time, or to elect not to continue sponsorship of the Plan.

19. What happens if my claim for benefits is denied?

If you or your beneficiaries claim benefits under the Plan or the Company's health care program offered in conjunction with this Plan, and the claim for benefits is denied, an appeal process will be provided under the terms and conditions of the health care plan.

20. Will the claims information I submit to my plan administrator be kept private?

Yes, the new HIPAA Privacy Rules require that all Protected Health Information (PHI) given to the plan administrator be kept completely confidential.