Southern Tier Environments for Living, Inc.
Dental and Vision Benefits Plan

Summary Plan Description

December 1, 2007

Explanation of Dental and Vision Benefits

The following is an explanation of the STEL, Inc. Dental and Vision Benefits Plan.

Southern Tier Environments for Living, Inc. (STEL, Inc.) provides a dental and vision reimbursement plan benefit to eligible employees. Our plan pays benefits based upon actual dental expenses, not a fixed dollar amount per specific procedure. Vision coverage is paid at a set dollar amount. This is not dental/vision insurance.

The Benefit Reimbursement Amount per Benefit Year (December 1st to November 30th) is as follows:

Amount of Dental Expense (Per covered person)	Employer Share	Employee Share	Plan Benefits
First $100	100%	0%	$100
Next $500	80%	20%	$400
Next $1000	50%	50%	$500

Amount of Vision Expense (Per covered person)	Employer Share	Employee Share	Plan Benefits
First $100	$100	0	$100

Claims submitted to STEL, Inc. must be accompanied by the STEL, Inc. Dental or Vision Claim Form. Claims are to be submitted to the Administrative Assistant for processing.

If you have any questions, please contact the STEL, Inc. Human Recourses Department at 716-366-3200 ext. 212 Mark Wasiewicz or ext. 222 Sandra Maroney.

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I. Introduction

Southern Tier Environments for Living, Inc. has established the Southern Tier Environments for Living, Inc. Dental and Vision Benefits Plan in order to provide dental and vision benefits to eligible employees and their eligible family members. In this Summary, Southern Tier Environments for Living, Inc. is referred to as the "Employer" and the Southern Tier Environments for Living, Inc. Dental and Vision Benefits Plan is referred to as the "Plan."

This Summary is the "summary plan description" of the Plan, as in effect as of December 1, 2007, for purposes of the Employee Retirement Income Security Act of 1974 ("ERISA").

This Summary, together with any benefit schedules and additional documentation provided by the Employer and all amendments to this Summary, also constitute the plan document for the Plan for purposes of ERISA and the Internal Revenue Code ("Code").

The Plan is subject to all of the terms, provisions and conditions set forth in this Summary.

II. Definitions

Capitalized terms in used in this Summary have the following meanings:

1. "Administrator" means the person, committee or firm responsible for the day-to-day management and administration of the Plan. As of December 1, 2007, the name, address and phone number of the Administrator are as follows:

   Southern Tier Environments for Living, Inc.
   715 Central Avenue
   Dunkirk, New York 14048
   (716) 366-3200
   Attention: Director of Human Resources

2. "Covered Expenses" means and includes the reasonable costs of professional services or treatments provided to a Covered Person by:

   (a) a Dentist, or a person (such as an oral hygienist) working under the supervision of a Dentist, including routine checkups and cleaning ("Covered Dental Expenses"), or

   (b) a Vision Care Provider ("Covered Vision Expenses").

   However, Covered Expenses shall not include any excluded expenses listed in Section IV.3, below.

3. "Covered Person" means and includes an Eligible Employee who has completed the Waiting Period and become covered by the Plan, and such individual's covered Eligible Dependents.

4. "Dentist" means a properly licensed dentist who is rendering services and treatment within the scope of his/her licensure and training.

5. "Eligible Dependents" of an Eligible Employee include the following:

   (a) the legal spouse of an Eligible Employee;

   (b) the unmarried children of an Eligible Employee under the age of 19, and who are dependent upon the employee for support and maintenance; provided, that unmarried children of an Eligible Employee can be covered until their 23rd birthday provided they are full-time college students; and

   (c) children of an Eligible Employee who have attained the age specified in sub-paragraph (b) above who are incapable of self-sustaining employment due to a handicap or disability, and are still dependent on the Eligible Employee for support.

   No person will be considered an Eligible Dependent unless:

   - the Eligible Employee is able to claim the person as a dependent for federal income tax purposes, or

   - the person cannot be claimed as the Eligible Employee's dependent for tax purposes solely because the Eligible Employee is a dependent of another taxpayer, the person is married, the person has gross income in excess of the applicable limit under the Code, or the right to claim the person as a dependent was awarded to the Eligible Employee's ex-spouse under a divorce decree.

6. "Eligible Employee" means a regular full-time employee of the Employer. A full-time employee is an individual who works 40 hours or more per week. Persons rendering services to the Employer as independent contractors or as employees of a leasing service or other third party are not Eligible Employees even if subsequently characterized as employees for other purposes. Union employees whose employment is governed by a collective bargaining agreement are not Eligible Employees.

7. "Employer" means Southern Tier Environments for Living, Inc.

8. "Entry Date" means the date on which an Eligible Employee begins participating in a Plan, as described in Section III.1. As of December 1, 2007, the Entry Date is the first day of the first month which begins after the employee's completion of the Waiting Period.

9. "Plan" means the Southern Tier Environments for Living, Inc. Dental and Vision Care Benefits Plan, as set forth in this Summary and as exempted from time to time.

10. "Plan Year" means the annual period on which the Plan's records are kept. The Plan Year begins on December 1 and ends on November 30 of each year.

11. "Vision Care Provider" means a properly licensed physician or optometrist who is rendering services and treatment within the scope of his/her licensure and training.

12. "Waiting Period" means the period of time an employee must be employed by the Employer prior to becoming eligible for coverage under the Plan. As of December 1, 2007, the waiting period is 30 days of full time employment with the Employer, including employment with the Employer prior to the effective date of this Summary.

III. When Coverage Begins and Ends

1. When Coverage Begins

(a) Employees - Each Eligible Employee will first be a Covered Person on the first Entry Date that occurs after such Employee has completed the required Waiting Period. As of December 1, 2007, the Waiting Period is 30 days of full-time employment with the Employer and the Entry Date is the first day of the first month beginning after completion of the Waiting Period. For example, if an Eligible Employee is hired on June 15, 2008 and works full-time for at least 30 days, her Entry Date would be August 1, 2008. The Entry Date and Waiting Period may be changed by the Employer at any time.

(b) Family Members - All persons who are then Eligible Dependents of an Eligible employee will become Covered Persons on that employee's Entry Date. If an Eligible Employee acquires new Eligible Dependents after becoming a Covered Person (for example, by reason of marriage or the birth or adoption of a child), coverage of the new Eligible Dependent will be retroactive to the date the person became an Eligible Dependent if the Eligible Employee notifies the Administrator in writing within 30 days; otherwise coverage will not begin until the Administrator is notified in writing.

The Administrator may require reasonable documentation from the Eligible employee with respect to any Eligible Dependent (including but not limited to a marriage or birth certificate, as applicable) as a condition to coverage of such dependent.

2. When Coverage Ends

(a) Employees: Generally, an Eligible Employee's coverage under the Plan will terminate on the earliest of the following dates:

(i) the date the employee dies;

(ii) the date which the employee's employment with the Employer terminates;

(iii) the date as of which the employee is no longer an "Eligible Employee" as defined in Section 11.6; or

(iv) the date on which the Plan is terminated.

(b) Spouses: Generally, the spouse of an Eligible Employee will cease to be covered under the Plan on the earliest of the following:

(i) the date on which the employee and the spouse are legally divorced, or the marriage is annulled;

(ii) the date on which the employee's coverage under the Plan terminates; or

(iii) the date on which the Plan is terminated.

(c) Dependent Children: Generally, a dependent child of an Eligible Employee will cease to be covered under the Plan on the earliest of the following:

(i) the earliest date on which the child no longer to qualifies as an "Eligible Dependent" under Section 11.5 (for example, upon reaching age 19 if not a full-time college student);

(ii) the date on which the employee's coverage under the Plan terminates; or

(iii) the date on which the Plan is terminated.

IV. Plan Benefits

1. General. After the Employee submits a paid receipt or itemized statement, along with a completed claim form as proof that a Covered Person has incurred Covered Expenses for care or treatment by a Dentist or Vision Care Provider, the Plan will pay up to the Maximum Reimbursement specified below for the service(s) provided.

2. Coordination of Benefits. The amount payable by the Plan is subject to coordination of benefits as described in Section VIII, below, if applicable.

3. Excluded Expenses. The Plan does not cover:

(a) Expenses covered under Worker's Compensation or employer liability laws.

(b) Expenses covered by any governmental agency or under any governmental program or law, except as to charges, which the person is legally obligated to pay.

(c) Expenses incurred prior to the date the person became covered under this Plan, or after the date the person ceases to be covered.

(d) Procedures covered under the Employer's medical plan, whether or not the Covered Person is enrolled in the medical plan.

(e) Orthodontia treatments and services.

(f) Cosmetic procedures.

(g) Purchases of toothbrushes, toothpaste, floss, or other personal care items, including nonprescription drugs.

(h) Vision examinations, frames, or lenses, which are not prescribed by a licensed physician or optometrist.

(i) Replacement of lost, stolen, broken or damaged lenses, contact lenses or frames.

(j) Industrial safety glasses, goggles or sunglasses.

(k) Vision examinations, frames or lenses required by your employment.

(l) Vision examinations rendered, or lenses or frames ordered before Plan coverage becomes effective, or after Plan coverage has terminated.

(m) Any other expenses which are determined by the Administrator to be excluded and communicated to Eligible Employees.

V. Summary of Dental Benefits

The following dental benefits are available to Covered Persons under the Plan:

1. Maximum Annual Benefit. The annual maximum reimbursement for Covered Dental Expenses per Plan Year (per Covered Person) is One Thousand Dollars (**$1000.00**).

2. Copayment Levels for Covered Dental Expenses

For each Covered Person, the Plan will pay a percentage of that person's Covered Dental Expenses incurred in a Plan Year, as show in the following table:

Amount of Dental Expense	*Employer Share*	*Employee Share*	*Plan Benefits*
First $100.00	100%	0%	$100.00
Next $500.00	80%	20%	$400.00
Next $1000.00	50%	50%	$500.00

Example:

For example, if you have $250 of Covered Dental Expenses in a Plan Year, the Plan would pay the first $100 in full, and 80% of the next $150 ($120), for a total of $220. You would pay just $30.

VI. Summary of Vision Benefits

The Plan will pay up to **$100** per Plan Year to each Covered Person for Covered Vision Expenses. The Covered Person does not have to pay any portion of the first $100 of such expenses, but must pay any vision expenses in excess of $100.

Example:

For example, if you have $120 of Covered Vision Expenses during a Plan Year, the Plan would pay $100 and you would pay just $20.

VII. Benefit Claims.

1. Claiming Plan Benefits. To claim Plan benefits, you must submit a paid receipt or itemized statement, and a completed claim form to the Administrator at the following address: Southern Tier Environments for Living, Inc., 715 Central Avenue, Dunkirk, New York 14048, Attention: Director of Human Resources. Claims must be submitted within ninety (90) days of the date on which charges were incurred. Claim forms are available from the Administrator.

2. If Your Claim is Denied.

   (a) If your claim is denied in whole or in part, you will receive written notification from the Administrator within 30 days of the date you filed the claim. The 30-day period may be extended by up to an additional 15 days if necessary and you will be notified of any such extension. A claim work sheet will be provided showing the calculation of the total amount payable, charges not payable, the reasons for denial of any portion of your claim, and the steps you may take to have the claim reviewed.

   (b) If additional information is needed for payment of a claim, the Administrator will notify you within the initial 30-day period, and you will have 45 days to submit the additional information.

   (c) If your claim is denied, you may request a review by filing a written application with the Administrator. *Requests for review must be filed within 180 days after you receive notice of denial.* The denial of your claim will then be reviewed by an officer or committee appointed by the Employer for this purpose who will not be the same person who originally denied your claim (or a subordinate of such person). The person reviewing the claim will conduct a full review, without deferring to the initial denial, and if the denial is based upon a medical judgment, will consult with an independent health care professional. You may submit your opinion of the issues and your comments in writing.

   (d) A decision will be made within 60 days and will be delivered to you in writing setting forth specific reasons for the decision and specific references to the pertinent Plan provisions upon which the decision is based. The decision will be final, except as provided in the following sentence. If you still disagree with the denial of your claim following the review, you have the right to file a lawsuit under ERISA. *However, by participating in the Plan*

you agree not to sue unless you have filed your claim in a timely manner and appealed the initial denial of your claim within 180 days as described above. In addition, you agree not to sue more than 180 days after your appeal is denied. For more information on your right to sue for benefits, see "ERISA Rights", Section XI, below.

VIII. Coordination of Benefits

1. The purpose of the Plan is to help you meet the cost of needed dental and vision care or treatment. It is not intended that anyone receive benefits greater than the actual expenses incurred. Benefits payable by this Plan and any other group dental or medical plan be coordinated so that the total benefits allowed will not exceed the amount which would have been allowed if no other plan were involved. All benefits provided hereunder are subject to this provision. In addition, if you are entitled to receive compensation or reimbursement from any person with regard to any Covered Expenses that are reimbursed under this Plan, the Plan will be subrogated to you, which means that the Plan is entitled to enforce your right to recoup the compensation or reimbursement in your name.

2. When a Covered Person is entitled to receive benefits under another group health plan, the two plans will coordinate benefit payments in order to avoid duplicate or overpayment of claims. One plan (the primary plan) will pay its full benefits. The other plan (secondary plan) will pay any expenses in excess of the primary plan benefits, up to the maximum amount that it would pay if the Coordination of Benefits provision were not in force.

3. The Plan is primary for the Eligible Employee. If an Eligible Employee is covered by more than one plan as a result of current employment, the plan that has covered the Eligible Employee for the longest time is primary. If the Eligible Employee's spouse is covered by a plan of the spouse's current or former employer, that plan will be primary with respect to all expenses incurred by the spouse.

4. When an Eligible Dependent child is entitled to receive benefits under another group health plan, under which the Eligible Employee's spouse is a covered employee, the plan of the parent whose birthday falls first in the calendar year is primary for the Eligible Dependent child. This is called the "Birthday Rule." If both parents have the same birthday, the plan that has covered the parent longer will be primary.

IX. Plan Administration

1. The Plan is administered by the Employer, and the Employer is the "plan administrator" of the Plan, as defined in ERISA. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments and gathering information necessary for administering the Plan.

2. The Administrator may delegate any of these administrative duties to or among one or more persons or entities, including any officer or employee of the Employer,

any committee composed in whole or in part of officers or employees, or a third party administrator.

3. The fiscal records of the Plan are maintained on the basis of a "Plan Year" which ends on the last day of November of each year.

4. The Administrator has full discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits. All determinations made by the Administrator are final, conclusive and binding on all parties.

5. The Plan is a legal entity. Legal notification may be filed with, and legal process served upon the Administrator at the address stated in the "General Plan Information" at the end of this Summary.

X. Plan Amendment or Termination

1. The Plan may be amended or terminated by the Employer at any time. Any amendment or termination may be approved by either the Board of Directors or, unless the Board of Directors otherwise determines, the Chief Executive Officer of the Employer.

2. In the event of Plan termination, the Employer will have no obligation under the Plan beyond paying the difference between the claims incurred (even though later filed) and expenses of the Plan due up to the date of termination. Such claims and expenses shall be paid as normal expenses of the Plan.

XI. ERISA Rights

As a participant in ERISA plans, you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled under each of the Plans to:

Receive Information About the Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports.

- Obtain copies of the Plan documents and other Plan information upon written request to the Administrator (the Administrator may make a reasonable charge for the copies).

- Receive a summary of the Plan's annual financial report, if any (the Administrator is required by law to furnish each participant with a copy of this summary annual report).

Prudent Actions By Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the program, have a duty to operate the program prudently and in the interest of you and

other program participants. fiduciaries who violate ERISA may be removed and may be required to make good any losses they have caused the program. No one, including the Company or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

Continue Plan Coverage

Continue Plan Coverage for the Employee and his or her spouse and Eligible Dependents if there is a loss of coverage as a result of a qualifying event. You or your Eligible Dependents may have to pay for such coverage. Review Section XII of this Summary, below, on the rules governing your COBRA continuation coverage rights.

Enforce Your Rights

If your claim for a benefit is denied in whole or in part, then you must receive a written explanation of the reason for the denial. You have a right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps that you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, then you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan 's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim to be frivolous), the court may order you to pay these costs and fees.

Assistance With Your Questions

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

XII. Continuation of Coverage under COBRA

1. Introduction

The federal law requirements of the Consolidated Omnibus Reconciliation Act of 1985 (commonly known as "COBRA"), as amended from time to time, apply to the Plan. The following is intended to inform you and your Eligible Dependent(s) in summary fashion of your rights and obligations under COBRA. You and your spouse (if any) should take the time to read this summary. This summary

generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

COBRA coverage can become available to you when you would otherwise lose your Plan coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their coverage.

2. What is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA coverage must pay for COBRA coverage.

3. Who Is Entitled to Elect COBRA Coverage?

If you are an employee, you will become a qualified beneficiary if you lose your Plan coverage because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your Plan coverage because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was previously reduced or eliminated.

Your dependent children will become qualified beneficiaries if they lose Plan coverage because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

4. When is COBRA Coverage Available?

When the qualifying event is the termination of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the Employer of any of these qualifying events.

5. You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the Employer in writing within 60 days after the later of: (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

In providing this notice, you must follow the Notification Procedures at the end of this summary. If these procedures are not followed or if the notice is not provided to the Employer during the 60-day notice period, THEN ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.

6. Electing COBRA

Each qualified beneficiary will have an independent right to elect COBRA coverage. Covered employees and spouses (if the spouse is a "qualified beneficiary") may elect COBRA coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA coverage on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60 day election period WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

7. How Long Does COBRA Coverage Last?

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility under the Plan as a dependent child, COBRA coverage can last for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries other than the employee who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare

entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost Plan coverage as a result of the termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Note: this COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination of employment or reduction of hours.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

Note: The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods for several reasons, which are described below.

There are two ways (described in the following paragraphs) in which this 18-month period of COBRA coverage can be extended:

Disability extension of 18-month period of continuation coverage

If a qualified beneficiary (which may include you or a family member covered under the Plan) is determined by the Social Security Administration to be disabled and you notify the Company in a timely fashion, all if the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only to qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the employee's termination of employment or reduction of hours, and must last at least until the end of the 18-month period of COBRA coverage.

The disability extension is available only if you notify the Employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of covered employee's termination of employment or reduction of hours; or
- The date on which the qualified beneficiary loses (or would lose) Plan coverage as a result of the covered employee's termination of employer or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must follow the Notification Procedures at the end of this Notice. If these procedures are not followed or if the notice is not provided to the Employer during the 60-day notice period and within

18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

Second qualifying event extension of COBRA coverage

If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours of employment, the spouse and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

This extension is available only if you notify the Employer in writing of the second qualifying event within 60 days after the date of the second qualifying event. In providing this notice, you must follow the Notification Procedures at the end of this Notice. If these procedures are not followed or if the notice is not provided to the Company during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO THE SECOND QUALIFYING EVENT.

If You Have Questions

Questions concerning your Plan or your COBRA coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Employer informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Employer.

COBRA Notification Procedures

Warning: If your notice is late or if you do not follow these notification procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).

Notices Must Be Written and Submitted on Plan Forms: Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.

How, When and Where to Send Notices: You must mail or hand deliver your notice to:

Southern Tier Environments for Living, Inc.
715 Central Ave.
Dunkirk, NY 14048
Attention: Human Resources Director

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "You Must Give Notice of Some Qualifying Events", "Disability extension of COBRA coverage", and "Second qualifying event extension of COBRA coverage")

Information Required for All Notices: Any notice you provide must include (1) the name of the Plan (Southern Tier Environments for Living, Inc. Dental and Vision Benefits Plan); (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event: If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the Company that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the Company that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional Information Required for Notice of Disability: Any notice of disability that you provide must include: (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration's determination; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required for Notice of Second Qualifying Event: Any notice of a second qualifying event that you provide must include: (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

Who May Provide Notices: The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

General Plan Information

Plan Name	Southern Tier Environments for Living, Inc. Dental and Vision Benefits Plan
Plan Number	502
Employer Address	Southern Tier Environments for Living, Inc. 715 Central Ave. Dunkirk, NY 14048
Employer Identification Number	22-2360739
Type of Plan	The Plan is a welfare benefit plan that provides self-insured dental and vision care benefits. All Plan benefits are paid from the general assets of the Employer.
Plan Administrator	Southern Tier Environments for Living, Inc. 715 Central Ave. Dunkirk, NY 14048 Attention: Director of Human Resources (716) 366-3200
Type of Administration	The Plan is administered by the employer. Benefit claims and coverage decisions are made by the Employer as Plan Administrator.
Agent for Service of Legal Process	The Plan Administrator (see above)
Contributions	As of December 1, 2007, the cost of Plan benefits is paid entirely by the Employer.
Plan Year	The fiscal records of the Plan are kept on the basis of the Plan Year, which begins on December 1 and ends on November 30 of each year.