COMMUNITY ACTION OF ORLEANS AND GENESEE, INC.

FLEXIBLE SPENDING ACCOUNT PLAN
(With Pre-Tax Insurance Premiums)

SUMMARY PLAN DESCRIPTION

DISCLAIMER

EBS-RMSCO, Inc. is providing this form summary plan description to assist the sponsoring employer with its obligations under the Employee Retirement Income Security Act of 1974 ("ERISA"), including its disclosure obligations to plan participants. This form summary plan description was completed using information provided by the sponsoring employer. EBS-RMSCO, Inc. is not a law firm, has not reviewed that information for legal sufficiency, and does not give legal or tax advice. The sponsoring employer should have this form summary plan description reviewed by its own legal counsel for compliance with ERISA, tax requirements, and other applicable laws and regulations.

The sponsoring employer, as the plan sponsor and plan administrator, is also responsible for the accuracy of the summary plan description, its distribution to participants, and the overall operation of the plan. The sponsoring employer should review this form summary plan description carefully to ensure that it accurately reflects all of the terms and provisions of the employer's plan. Please note that EBS-RMSCO, Inc. will make substantive changes to this form summary plan description, but will not make format, stylistic and other non-substantive changes.

Generally, ERISA requires that employee contributions to an employee health plan be held in a trust. The U.S. Department of Labor (DOL) has issued ERISA Technical Release 92-01, which explains the ERISA trust requirement, and states that the DOL will not enforce the requirement with respect to certain types of plans. The sponsoring employer should consult with its own legal counsel about whether a trust must be established to hold employee contributions to this plan. The sponsoring employer is solely responsible for determining whether the ERISA trust requirement applies and, if it does, complying with it.

COMMUNITY ACTION OF ORLEANS AND GENESEE, INC.

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(With Pre-Tax Insurance Premiums)

SUMMARY PLAN DESCRIPTION

Of the Provisions of the Plan
in Effect on January 1, 2012

INTRODUCTION

This Summary Plan Description ("SPD") presents a brief description of the Plan. It is not meant to interpret, extend, or change the official Plan documents. If there is any conflict between this SPD and the Plan documents, the Plan documents will govern your rights to benefits. Copies of the Plan documents are available for inspection from the Fiscal Office, Community Action of Orleans and Genesee, Inc., 409 East State Street, Albion, New York 14411, during regular business hours.

The information in this SPD may be modified by a "Summary of Material Modification" (“SMM”). Check to see if there are any SMM’s attached when you refer to this SPD.

IMPORTANT PLAN INFORMATION YOU SHOULD KNOW

Plan Name:	Community Action of Orleans and Genesee, Inc. Flexible Spending Account
Plan Number:	510
Plan Type:	Cafeteria (Section 125) Plan
Plan Year:	The Plan Year begins on January 1 and ends on December 31
Employer and Plan Sponsor:	Community Action of Orleans and Genesee, Inc. 409 East State Street Albion, New York 14411 (585) 589-5605
Employer Identification Number:	16-6059252
Plan Administrator:	Community Action of Orleans and Genesee, Inc. 409 East State Street Albion, New York 14411 (585) 589-5605
Type of Plan Administration:	The Plan is administered by the Employer through a Committee appointed by the Employer. All benefits are paid from the general assets of the Employer. The Employer is responsible for determining the types of benefits available under the Plan, deciding requirements for eligibility to participate in the Plan, and setting the amount of Employer and participant contributions. The Fiscal Office is the primary source for information about these aspects of the Plan.
Plan Agent for Service of Legal Process:	Community Action of Orleans and Genesee, Inc. 409 East State Street Albion, New York 14411 Legal process may also be served upon the Plan Administrator.

1. What is the advantage to me of the Flexible Spending Account Plan?

You can use the Plan to pay your premium on a pre-tax basis for the group coverage sponsored by your Employer and listed in Question and Answer 4. (Your cost for the group coverage listed is referred to in this SPD as your "premium" whether the coverage is provided through an insured plan or is self-insured by your Employer.) You can also make pre-tax contributions to the Plan that are credited to your plan account(s) and can be used to pay or reimburse you for expenses described in Question & Answer 5. These amounts are deducted from your pay and are not reported as taxable income on your W-2 form, so you do not pay income tax or Social Security taxes on them, if the Plan continues to satisfy certain tax requirements.

2. Who is eligible to participate in the Plan?

You are eligible to participate in the Plan if you are:

a full-time employee of the Employer who normally works 35 hours or more per week.

Notwithstanding the above, the following persons are not eligible to participate in the Plan: (i) any person providing services to the Employer through a temporary agency, leasing organization, or independent contractor arrangement, even though he subsequently may be classified as an employee for employment tax, unemployment insurance, or other purposes by a government agency or a court; (ii) if the Employer is not incorporated, any person who is the sole owner, or a co-owner or joint owner, of the Employer; (iii) if the Employer is a limited liability corporation ("LLC"), any member of the LLC; (iv) if the Employer is a Subchapter S corporation, and any person who owns directly or indirectly more than 2% of the Employer.

3. When can I begin participating in the Plan?

If you meet the eligibility requirements listed above, you may begin participating in the Plan on:

the 1st of the month following 90 days of full-time continuous employment.

Once you are eligible to participate, your premiums will automatically be paid through the Plan unless you elect otherwise in writing signed by you and filed with the Committee. If you file this election you will not be able to pay your premiums through the Plan until the next Plan Year, unless a change in status occurs that

allows you to change this election (see Question & Answer 7). To make contributions to the Plan for other expenses you must complete the enrollment process. Failure to complete enrollment by the date specified by the Committee will be considered an election not to make contributions for the Plan Year for other expenses. In that case, you will not be able to make contributions for other expenses until the next Plan Year, unless a change in status occurs that allows you to change your election (see Question & Answer 7).

Your premiums and contributions to the Plan are deducted from your pay throughout the Plan Year.

For the Plan Year, see IMPORTANT PLAN INFORMATION YOU SHOULD KNOW.

4. What premiums can I pay through the Plan?

You can pay your premiums for the following types of group coverage sponsored by your Employer:

- dental coverage
- medical coverage

5. What other expenses can be paid under the Plan?

You can also make contributions to the Plan that can be used to pay or reimburse you for the following types of expenses, provided they are not payable or reimbursable from any other source:

- dependent care expenses that would otherwise qualify for a dependent care credit on your federal income tax return if they were not paid or reimbursed under the Plan. You must designate the amount you wish to contribute for dependent care expenses. These contributions will be credited to an account that can be used only for dependent care expenses.

- health care expenses (other than insurance premiums and expenses for long-term care services) that would otherwise be deductible on your federal income tax return if they were not paid or reimbursed under the Plan (but without regard to any minimum amount of health care expenses required to take a deduction), incurred for you, your spouse, any person who qualifies as your dependent for federal income tax purposes, or your child even if he or she does not qualify as your dependent for federal income tax purposes but only through the end of the calendar year in which the child reaches age 26. Health care

expenses also include the cost of over-the-counter medicines and drugs (such as antacid, allergy medicine, pain reliever and cold medicine) provided, the over-the-counter medicine or drug is either insulin or is prescribed (without regard to whether such medicine or drug is available without a prescription). Whether a medicine or drug is a prescribed medicine or drug is determined in accordance with regulations and other guidance issued by the Internal Revenue Service. Health care expenses do not include toiletries, cosmetics, sundry items, dietary supplements, vitamins and other items that are merely beneficial to a person's general health. You must designate the amount you wish to contribute for health care expenses. These contributions will be credited to an account that can be used only for health care expenses.

6. How much can I contribute for these other expenses?

Before you can first participate in the Plan, and at the beginning of each Plan Year, you will be notified of the minimum and maximum amount you can contribute for that Plan Year. (However, under federal tax law, a participant's contribution for health care expenses for any calendar year beginning on or after January 1, 2013 cannot exceed $2,500.)

7. When can I change the amount I contribute to the Plan?

You can change your elections before the beginning of each new Plan Year. Once the Plan Year has started, federal tax laws permit you to change your elections only when one of the following "changes in status" occurs:

- You exercise special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the special enrollment or disenrollment rights under a state Children's Health Insurance Program (CHIP). (This applies only to elections for group health coverage premiums.)

- You, your spouse or dependent becomes eligible for continued health coverage under federal law (COBRA) or similar state law under a group health plan of your Employer.

- A court issues a judgment, decree or order, resulting from a divorce, legal separation, annulment or change in legal custody, requiring you to provide health coverage for a child or foster child, or requiring someone else to provide the coverage.

- You, your spouse or dependent becomes entitled to or loses Medicare or Medicaid coverage (other than only the program for distribution of pediatric vaccines).

- Your premium increases significantly. (However, if there is an ordinary increase or decrease in premiums, your contributions will automatically be adjusted to reflect the change.) Note, a significant increase in premiums allows you to change the amount of those premiums you pay through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

- There is a significant curtailment in, or cessation of, your group coverage. (In the case of group health coverage, there must be reduced coverage for employees generally.) Note, that a significant curtailment in, or cessation of, your group coverage allows you to change the amount of the premiums you pay for that coverage through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

- A new group coverage option is added or a group coverage option you have selected is eliminated. Note that the addition or elimination of a coverage option allows you to change the amount of the premiums you pay for that coverage through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

- Your legal marital status changes (including a change resulting from marriage, divorce, death of a spouse, legal separation, or annulment).

- The number of your dependents changes (including a change resulting from a birth, death, adoption or placement for adoption of a child).

- There is a change in your employment status, or in the employment status of your spouse or dependent, resulting from termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite, or other change that causes you, your spouse or dependent to become or cease to be eligible for coverage under the Plan or other employer plan providing the same type of benefits. However, if your employment terminates and resumes in the same Plan Year within a period of 30 days or less, your elections in effect before the termination will automatically be reinstated upon resumption of your employment, unless some other intervening event has occurred that would permit a change in your elections.

- A change in your place of residence, or the place of residence of your spouse or dependent, that makes you, your spouse or dependent ineligible for group coverage at the new place of residence. Note, a change in residence allows you to change the amount of the premiums you pay through the Plan for the group coverage for which you, your spouse or dependent is no longer eligible, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

- Your dependent's eligibility for health coverage changes due to the dependent's age, student status or marital status or similar circumstance.

- There is a change in your dependent care provider or a change in the cost of services provided by a dependent care provider who is not a relative.

- A person's status as a dependent for purposes of your dependent care election changes.

- Your spouse, former spouse or dependent makes a change under another plan which is either (i) consistent with one of the events described above, or (ii) for the normal election period under the other plan and that election period is different from the Plan Year of this Plan.

- You, your spouse or dependent loses group health coverage sponsored by a governmental or educational institution, including a State children's health insurance program under Title XXI of the Social Security Act, a medical care program of an Indian Tribal government (as defined in section 7701(a)(40)), the Indian Health Service, a tribal organization, a State health benefits risk pool, or a foreign government group health plan. Note loss of such coverage allows you to change the amount of premiums you pay through the Plan for medical coverage, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

Note that any election change must be made within 30 days of an event described above, and must conform to and be consistent with that event.

Also, even if you are allowed to change your health care expense reimbursement election, you may not reduce the annual contribution elected to less than the amount of health care expenses already reimbursed to you for the Plan Year.

8. How do I receive my benefits from the Plan?

Amounts are deducted directly from your pay and used to pay your premiums. Your employer may make arrangements for automatic payment or reimbursement of other expenses covered under the Plan. Otherwise, these expenses will be paid/reimbursed at least monthly, provided you file a written claim for payment or reimbursement at least five business days before a scheduled payment/reimbursement date.

The Committee will inform participants of the scheduled payment/reimbursement dates. Claims for payment or reimbursement must be made on forms provided by the Committee. You may request forms from the Fiscal Office, Community Action of Orleans and Genesee, Inc., 409 East State Street, Albion, New York 14411.

The Employer may also make arrangements for expenses to be paid and processed using a pre-paid "debit" card. Expenses paid or reimbursed in this manner must be substantiated as an expense qualifying for payment or reimbursement under the Plan in accordance with federal tax law. If an expense cannot be substantiated, the Employer will take action consistent with tax regulations to require the participant to repay the unsubstantiated amount, including: (i) denying the participant access to a pre-paid card (and requiring him to submit written forms for future claims) until the unsubstantiated amount is recovered; (ii) demanding that the participant repay the unsubstantiated amount; (iii) deducting the unsubstantiated amount from the participant's wages; and (iv) offsetting payment of other claims for expenses incurred in the same Plan Year by the unsubstantiated amount. If these efforts are unsuccessful, the participant will remain indebted to the Employer for the unsubstantiated amount. The Employer or Plan Administrator may adopt other rules for the use of pre-paid cards, such as suspending or terminating participation in the Plan for misuse of a pre-paid card, canceling a person's pre-paid card when he ceases participation in the Plan, establishing transaction limits or restrictions on the pre-paid card, and charging fees for the use of pre-paid cards.

If a participant attempts to have an expense paid through a pre-paid card but, for any reason, it is not successfully processed, he should submit a written claim for the expense. A claim for the expense is not considered denied until he submits a written claim and the written claim is denied in accordance with the claims procedures described in the Answer to Question 15.

Note:

- The amount of dependent care expenses paid or reimbursed cannot exceed the contributions you have made to the Plan for dependent care expenses, less the amount of such expenses already paid or reimbursed from the Plan for the Plan Year.

- The amount of health care expenses paid or reimbursed cannot exceed the amount of your health care expense contribution election for the Plan Year, less the amount of such expenses already paid or reimbursed from the Plan for the Plan Year.

- Only expenses incurred on or after the date you begin participating in the Plan and before the date you stop participating in the Plan are covered under the Plan. Generally, you stop participating in the Plan when you are no longer an eligible employee of the Employer. (See Question and Answer 2.)

In addition, except when the grace period discussed below applies (see Question and Answer 9), any expenses incurred after you stop making Plan contributions for those expenses are not covered.

- If you are employed through the end of the Plan Year, you have until 120 days after the end of each Plan Year to submit a claim for payment or reimbursement for expenses that you incurred during the Plan Year or during the "grace period" for the Plan Year. (Question & Answer 9 discusses the grace period and Question & Answer 10 explains rules that apply when you terminate employment before the end of a Plan Year.)

By January 31st of each year, you will receive a W-2 Wage and Tax Statement showing the amount of your contributions to the Dependent Care portion of the Plan for the previous calendar year.

9. What happens if I am employed by the Employer through the end of a Plan Year but my contributions for expenses (other than premiums) are greater than my actual expenses during the Plan Year?

If the amount you contribute exceeds the expenses you actually incur during the Plan Year, plus the expenses you incur during the "grace period" for the Plan Year, you will forfeit the excess contributions. The grace period for a Plan Year is the 2-1/2 month period following the end of a Plan Year.

Expenses incurred during the grace period may be paid or reimbursed from a participant's account with contributions made for that Plan Year (to the extent those contributions have not already been used or are not required to pay expenses actually incurred during the Plan Year) only if: (i) the claims for expenses incurred during the grace period are submitted no later than 120 days following the end of the Plan Year; and (ii) all other requirements and conditions for payment or reimbursement of the expenses are satisfied. If contributions for a Plan Year are greater than the amount paid for expenses incurred during that Plan Year (including expenses incurred during the grace period), the excess contributions are forfeited.

Therefore, you should be careful to contribute only the amount you think will be needed to cover your anticipated expenses for the Plan Year.

Note that the grace period does not affect the rules regarding when expenses must be incurred, and when claims for expenses must be submitted, if a participant's employment with the Employer terminates before the end of a Plan Year.

10. What happens if my employment terminates before the end of a Plan Year?

You may claim payment or reimbursement for expenses incurred before your termination, provided you submit your claim for payment or reimbursement no later than 90 days after your termination. You may also have a right to COBRA continuation coverage. (See "COBRA Continuation Coverage" in Question and Answer 16.)

11. What happens if I take a leave of absence during the Plan Year?

A paid leave of absence is not itself a change in family status, so your elections will stay in place unless you have another reason to change them. However, a leave under the Family and Medical Leave Act or the Uniform Services Employment and Reemployment Rights Act is a change in status, so you may change your elections as explained in Question & Answer 7. Also, see Question & Answer 16 for special rules applicable to a leave under the Family and Medical Leave Act and the Uniform Services Employment and Reemployment Rights Act.

12. Can the Employer amend or terminate the Plan?

The Employer can amend or terminate the Plan at any time, but will notify you in advance. Amendment or termination of the Plan will not affect your right to payment or reimbursement for expenses incurred before the date of the change. The Employer may also take action to assure compliance with nondiscrimination requirements and limitations that apply to the Plan under federal tax law, including

reducing contributions made by certain highly compensated individuals and/or key employees in order to satisfy those requirements and limitations.

13. Can a person's coverage under the Plan ever be rescinded?

A person's coverage under the Plan may be rescinded (i.e., retroactively cancelled or discontinued) if the person (or a person who sought coverage for the covered person) performed an act, practice, or omission that constitutes fraud, or made an intentional misrepresentation of fact, to get the Plan coverage. Any person whose coverage is rescinded will receive at least 30 days advance written notice before his coverage is rescinded. Rescission of a person's coverage is considered an adverse benefit determination for purposes of the Plan's claims procedures described in the Answer to Question 15.

14. Who controls the operation of the Plan?

A Committee appointed by the Employer controls and manages the operation of the Plan. The Committee decides all questions arising in the interpretation and application of the Plan, and may establish rules for the operation of the Plan.

15. What if I have questions about coverage or benefits, or want to make a claim for benefits?

You should contact the Fiscal Office, Community Action of Orleans and Genesee, Inc., 409 East State Street, Albion, New York 14411 if you have questions about any group coverage sponsored by the Employer. Claims for group coverage benefits should be filed in accordance with the procedures applicable to that coverage. See the Fiscal Office, Community Action of Orleans and Genesee, Inc., 409 East State Street, Albion, New York 14411 if you need information on how to file a claim for a group coverage benefit.

You should contact the Fiscal Office, Community Action of Orleans and Genesee, Inc., 409 East State Street, Albion, New York 14411 if you have questions about the operation of this Plan.

If you disagree with a decision concerning your right to participate in the Plan or wish to make a claim for a benefit, you may file a claim in writing with the Committee. If you wish, you may appoint someone to file the claim and act on your behalf, provided you give the Committee signed written notification of the appointment. The claim procedure is different depending on whether the claim is related to a health care expense or is any other type of claim. If any part of the claim is denied, the Committee will provide you with a written notice, within 30

days after the receipt of a health claim or 90 days after the receipt of any other type of claim. However, if an extension is necessary due to reasons beyond the Committee's control, the time to make the determination may be extended for up to another 15 days for a health claim or 90 days for any other type of claim. (If an extension for a health claim is necessary because additional information is needed from you, then you will be given 45 days from the date you receive the notice to provide the information.) In any case, you will receive written notice of the reasons for the extension, any additional information required for the Committee to make the determination, and the date the determination is expected.

If a claim is denied in whole or in part, you will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (iv) a description of the Plan's review procedures and time limits; and (v) a statement that you have a right to sue under the Employee Retirement Income Security Act following an adverse determination upon review. In the case of a health claim, the notice will also state the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the determination. If the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination on a health claim, the notice shall also contain the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request. If the determination on a health claim is based upon a medical necessity, experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances), or a statement that such explanation will be provided free of charge upon request.

If a claim is denied and you want a review, you must notify the Committee in writing within 180 days after you receive the written notice of denial of health claim, or 60 days after you receive the written notice of denial of any other type of claim. You may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. You will be notified of the determination on review within 60 days after the Committee receives the request for review. A notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a statement that, upon request, you are entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; (iv) a statement that you have a right to sue under the Employee Retirement Income Security Act; and (v) the following

statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency." If the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination on a health claim, the notice shall also contain the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request.

If the determination on a health claim is based upon a medical necessity, experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances), or a statement that such explanation will be provided free of charge upon request.

16. What additional rights do I have as a participant?

Federal law gives you rights with regard to coverage and certain specific benefits. The following is a summary of those rights.

COBRA Continuation Coverage

You may have a right under "COBRA" to continue to participate in the health care expense portion of the Plan only after you would otherwise lose coverage under the Plan by continuing to make payments to the Plan, plus an administrative charge, on after-tax instead of a pre-tax basis. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family when they would otherwise lose your group health coverage. Below is a summary of COBRA continuation coverage, when it may become available, and what you need to do to protect the right to receive it.

What is COBRA Continuation Coverage?

COBRA continuation 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 below. After a qualifying event, COBRA continuation 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 continuation coverage must pay for COBRA continuation coverage.

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

(1) Your hours of employment are reduced; or
(2) 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 coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
(5) You become divorced or legally separated from your spouse.

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

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
(5) The parents become divorced or legally separated; or
(6) The child stops being eligible for coverage under the plan as a “dependent child.”

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

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), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Fiscal Office, Community Action of Orleans and Genesee, Inc., 409 East State Street, Albion, New York 14411. The notice must be in writing, and must contain your name and address, the name and address of any affected dependents, a description of the qualifying event, and the date of the qualifying event. You may be asked to provide additional documentation or information after you have submitted the notice.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage, which lasts no longer than the last day of the Plan Year in which the qualifying event occurs. Furthermore, COBRA continuation coverage is not available to a qualified beneficiary even for that Plan Year unless the qualified beneficiary could become entitled to payment or reimbursement for health care expenses incurred during the remainder of that Plan Year which exceeds the amount that he or she could be required to pay for COBRA continuation coverage under this Plan for the remainder of that Plan Year.

If You Have Questions

Questions concerning your Plan or your COBRA continuation 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 Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Information about the Plan and COBRA continuation coverage can be obtained from the Fiscal Office, Community Action of Orleans and Genesee, Inc., 409 East State Street, Albion, New York 14411.

Uniformed Services Employment and Reemployment Rights Act Continuation Coverage

The Uniformed Services Employment and Reemployment Rights Act ("USERRA") also gives an employee who is absent from work due to service in the uniformed services (including active or reserve duty, whether voluntary or involuntary, and time off for training or instruction) the right to continue to participate in the health care expense portion of the Plan if the employee is covered under the Plan when the period of military service begins, and certain other requirements are satisfied. However, USERRA continuation coverage will terminate if the employee's military service ends because of: (i) separation from service with a dishonorable or bad-conduct discharge; (ii) separation from service under certain less-than-honorable conditions; or (iii) for a commissioned officer, dismissal in connection with a court-martial or, in time of war, by the President, or dropping of the commissioned officer from the rolls as a result of an unauthorized absence for at least three months or as a result of a sentence imposed after a court-martial or a conviction in another court. USERRA continuation coverage will also terminate if the employee fails to report back to work or apply for reemployment within the time period required under USERRA after completion of military leave.

The procedures, rules and deadlines for USERRA continuation coverage under the Plan are the same as the COBRA continuation coverage rules and deadlines described in the SPD, except to the extent any of those procedures, rules or deadlines conflict with USERRA regulations (e.g., if compliance with any particular procedure, rule or deadline is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

An employee also has the right to reinstatement in the Plan, without any exclusions or waiting periods due to the military leave, when he/she timely returns to work after a military leave, assuming he/she is otherwise eligible for Plan coverage. If the

employee timely returns to work after a military leave before the maximum USERRA continuation coverage period but the employee is not reinstated in the Plan because he/she is not eligible for coverage at that time (for reasons unrelated to the military leave), then the employee has a right to continuation coverage for the entire 24 month USERRA continuation coverage period (or, if sooner, the date he/she is reinstated).

Health Insurance Portability and Accountability Act of 1996 and Uniformed Services Employment and Reemployment Rights Act

You may be entitled to commence, continue, suspend and recommence participation in this Plan in accordance with your rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Information concerning your HIPAA and USERRA rights is available from Diane Bechteler, Community Action of Orleans and Genesee, Inc., 409 East State Street, Albion, New York, 14411, phone (585) 589-5605, fax (585) 589-9015.

Family and Medical Leave Act

If you are eligible for and take a leave of absence under the Family and Medical Leave Act ("FMLA Leave"), you may continue your contributions during the FMLA Leave, provided you would have been continuously employed during the entire FMLA Leave. Coverage will continue as if you were actively employed by the Employer until the earlier of the date (1) the FMLA Leave ends, or (2) you notify the Employer that you will not return to work. If you choose not to continue coverage during an FMLA Leave, you may resume Plan contributions when the FMLA Leave expires, provided you are still an employee eligible to participate in the Plan (see Question and Answer 2).

Information concerning your right to and obligations during a leave is available from the Fiscal Office, Community Action of Orleans and Genesee, Inc., 409 East State Street, Albion, New York 14411.

HIPAA Privacy Rights

The Plan has responsibilities under Health Insurance Portability and Accountability Act ("HIPAA") regarding the use and disclosure of your protected health information ("PHI"). Your PHI is any information that: (i) identifies you or may reasonably be used to identify you; (ii) is created or received by a health care provider, health plan, employer or health care clearinghouse; and (iii) relates to your

past, present or future physical or mental health or condition, or the provision of or payment for health care.

The Plan is required to maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Plan's privacy notice or more information about the Plan's privacy practices, or you want to file a privacy violation complaint, please contact Diane Bechteler, Community Action of Orleans and Genesee, Inc., 409 East State Street, Albion, New York, 14411, phone (585) 589-5605, fax (585) 589-9015.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is an order by a court for a parent to provide a child or children with health coverage. If the Plan receives a QMCSO for your child or children, you will be contacted about the procedure for the QMCSO. Copies of the Plan's QMCSO procedures are available, without charge, from the Fiscal Office, Community Action of Orleans and Genesee, Inc., 409 East State Street, Albion, New York 14411.

Your Rights Under ERISA

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

<u>Receive Information About Your Plan and Benefits</u>

This includes the ability to:

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

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of 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, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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