COMMUNITY SERVICES
FOR THE DEVELOPMENTALLY DISABLED

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1/3/11

December 22, 2010

Department of Health and Human Service
Office of Consumer Information and Insurance Oversight
Attn: James Mayhew; Room 737-F-04
200 Independence Ave. SW
Washington, DC 20201

RE: Annual Limit Requirements of PHS Act Section 2711 – Waiver Application

Please accept this letter as the application for waiver from the restricted annual limit requirements of PHS Act Section 2711 for the Community Services for the Developmentally Disabled Health Reimbursement Account. The Plan is a health reimbursement arrangement.

I. Terms of the Plan for which the waiver is sought: The Plan provisions that limit the annual benefit to the amount credited to the Plan participant's account, which is always below the minimum annual limit prescribed in interim regulations issued under the PHSA Act. **See the relevant Plan provisions in the attached Plan Document.**

II. There are currently Ex. 4 participants in the Plan, and Ex. 4 covered dependents for a total of Ex. 4 people covered.

III. Each Plan year, the employer credits an amount to each Plan participant's account. **See the relevant Plan provisions in the attached Plan Document.** As noted above, the annual benefit is limited to the amount credited to the Plan participant's account.

IV. By way of this application, we request that the restricted annual limit imposed under the interim final regulations (IFR) be waived for the 2011 Plan year.

V. By signing below, the Plan administrator is certifying that:
   i. That the Plan was in effect prior to September 23, 2010; and
   ii. The application of the restricted annual limit to the Plan would result in a significant decrease in access to benefits for those currently covered by the Plan. Simply stated, the employer/sponsor is financially unable to adhere to the restricted annual limits. Payment of benefits up to the minimum annual limit would be a financial impossibility and, without a waiver, the Plan will be terminated.

Thank you for your consideration. Please contact this office directly at 716-883-8888 if you have any questions.

Sincerely,

Mark R. Foley, President and CEO,
Plan Administrator

COMMUNITY SERVICES FOR THE DEVELOPMENTALLY DISABLED

HEALTH REIMBURSEMENT ACCOUNT PLAN DOCUMENT

COMMUNITY SERVICES FOR THE DEVELOPMENTALLY DISABLED

HEALTH REIMBURSEMENT ACCOUNT PLAN DOCUMENT

DISCLAIMER

This plan is not integrated with any insured group health plan sponsored by the employer (i.e., it is not designed to reimburse only deductible amounts, co-payments and/or out-of-pocket expenses under a group health insurance policy).

EBS-RMSCO, Inc. Benefit Solutions, Inc. is providing this form plan document and a 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 plan document 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 plan document 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 plan document and the overall operation of the plan. The sponsoring employer should review this form plan document 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 plan document, but will not make format, stylistic and other non-substantive changes.

Generally, ERISA requires that employee contributions to an employee health plan, including amounts paid for COBRA continuation coverage, 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 HRA. The sponsoring employer is solely responsible for determining whether the ERISA trust requirement applies and, if it does, complying with it.

SECTION 1
PRELIMINARY MATTERS

1.1 Form. The Community Services for the Developmentally Disabled Health Reimbursement Account Plan is set out in this document and any amendments hereto.

1.2 Purpose. This HRA shall be interpreted and administered in a manner consistent with the Code and ERISA. It is maintained for the exclusive benefit of Participants, and is intended to satisfy the requirements of Section 106 of the Code (such that Employer contributions made on behalf of Participants are excluded from their gross income), and the requirements of Section 105 of the Code (such that benefits paid to or on behalf of Participants are excluded from their gross income).

SECTION 2
DEFINITIONS

2.1 "Account" means an account established for a Participant under the HRA for payment or reimbursement of Eligible Expenses.

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

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

2.4 "Committee" means the person or persons appointed by the Employer as members of the Committee to administer this HRA in accordance with Section 5 hereof.

2.5 "Contributions" means amounts contributed by the Employer to the HRA on behalf of Participants.

2.6 "Dependent" means a Participant's spouse or dependent as defined for purposes of Section 105(b) of the Code, and any child to whom Section 152(e) of the Code applies shall be treated as a dependent of both parents.

2.7 "Effective Date" means the day the HRA begins as set forth under the name of the first Employer listed in Section 2.10.

2.8 "Eligible Expense" means an expense incurred by a Participant for himself, his spouse or his Dependent for "medical care," as that term is used for purposes of Section 105(b) of the Code, including the cost of non-prescription "over-the-counter" medicines and drugs, but excluding premiums for group or individual health or dental insurance coverage.

2.9 "Employee" means any person who performs services for the Employer as a common law employee and receives compensation for his services other than a pension, retirement allowance, retainer, or fee under contract. Notwithstanding the preceding sentence, the following persons are not considered Employees eligible to participate in the HRA: (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 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 an election is made under the Code for the Employer to be a Subchapter S corporation, any person who owns directly, or indirectly through attribution rules contained in Section 318 of the Code, more than 2% of the Employer.

2.10 "Employer" means the Employer and any Affiliated Employer identified below, and their legal successors; provided, however, that as used in Section 5 (Administration) and Section 6 (Amendment and Termination), "Employer" shall mean only the first Employer listed below.

Employer: Community Services for the Developmentally Disabled

Address: 180 Oak Street
Buffalo, New York 14203

Effective Date: 03/01/2010

Affiliated Employer: N/A

Address: _____

Effective Date: _____

Affiliated Employer: N/A

Address: _____

Effective Date: _____

Affiliated Employer: N/A

Address: _____

Effective Date: _____

Affiliated Employer: N/A

Address: _____

Effective Date: _____

Affiliated Employer: N/A

Address: _____

Effective Date: _____

An Affiliated Employer may discontinue its participation in the HRA by giving advance written notice of the effective date of discontinuance to the Committee and its Participants.

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

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

2.13 "HRA" or "Plan" means the Health Reimbursement Account Plan, as set forth in this document and as amended from time to time.

2.14 "Highly Compensated Individual" means a Participant who is a highly compensated participant within the meaning of Section 105(h) of the Code.

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

2.16 "Participant" means an Employee who meets the requirements for participation specified in Section 3.

2.17 "Plan Administrator" means the Employer or other person(s) appointed by the Employer to serve as Plan Administrator in accordance with Section 5 hereof.

2.18 "Plan Year" means:

each 12-consecutive month period beginning March 1 and ending the following February 28.

However, if the Employer terminates the HRA pursuant to Section 6, the last Plan Year shall end on the effective date of termination. If an Affiliated Employer discontinues its participation in the HRA, Participants who are Employees of the

Affiliated Employer shall be treated as having participated in the HRA for a short Plan Year ending on the effective date of such discontinuation.

2.20 "Statutory Leave" means an unpaid leave of absence from employment under the FMLA or USERRA.

2.21 "USERRA" means the Uniformed Services Employment and Reemployment Rights Act.

SECTION 3
PARTICIPATION

3.1 Eligibility Requirements. An Employee shall be eligible to participate in the HRA when he satisfies the following requirements:

all employees of the Employer. Consumers of the Supported Employment Program, Relief MSC and Temporary employees are not eligible to participate in the plan.

3.2 Participation Date. An eligible Employee shall become a Participant in the HRA on March 1st following the date of hire, provided he still satisfies the eligibility requirements of Section 3.1 on that date, and has completed and filed all of the forms required for participation by the Plan Administrator or Committee. However, no Employee shall be eligible to participate in the HRA until the Effective Date or, in the case of an Employee of an Affiliated Employer, the effective date that the Affiliated Employer adopts the HRA, as indicated in Section 2.10.

3.3 Duration of Participation. Except as otherwise provided in this Plan document, an Employee shall continue as a Participant so long as he remains an Employee, satisfies the eligibility requirements of this Section 3, and continues to complete and file the forms required for participation by the Plan Administrator or Committee.

3.4 Reinstatement of Former Participant. If, within thirty (30) days after ceasing to be a Participant (pursuant to Section 3.3 above), a person is an Employee and again satisfies the eligibility requirements of Section 3.1, he will be immediately reinstated as a Participant with the Account balance he had as of the date he ceased being a Participant (but reduced by the amount of any payments or reimbursements made from the Account after he ceased being a Participant). If a

person ceases to be a Participant (pursuant to Section 3.3 above), and is not an Employee or does not otherwise again satisfy the eligibility requirements of Section 3.1 within thirty (30) days after ceasing to be a Participant, he will not become a Participant again on the later of the date he again satisfies the requirements of Sections 3.1 or the date specified in Section 3.2. However, notwithstanding any provision of this Plan to the contrary, in either case the Participant's Account balance shall be adjusted to the extent necessary to avoid duplicate crediting of Contributions to his Account.

3.5 Special Participation Rights. Notwithstanding any other provision of this Plan document, an Employee shall be entitled to commence, continue, suspend and recommence participation in the HRA in accordance with his rights under COBRA (or similar state law), HIPAA, FMLA or USERRA. The Committee or Employer will advise any Employee who is eligible for a Statutory Leave of his right to maintain coverage under the HRA during the Statutory Leave and, if coverage is discontinued during the Statutory Leave, his right to resume coverage after the Statutory Leave. The Plan Administrator or Committee shall advise each Employee who takes any other type of leave of absence from his employment of his right, if any, to maintain such coverage during the period of leave.

3.6 COBRA Coverage. The Plan Administrator or Committee shall advise each Participant and his Dependents of any rights they may have to continue coverage under the HRA pursuant to COBRA.

SECTION 4
CONTRIBUTIONS, ENROLLMENT AND BENEFITS

4.1 Enrollment. The Committee may establish an enrollment procedure whereby each person eligible to participate in the HRA must enroll in the Plan. If an enrollment procedure is established, enrollment forms (written or electronic) must be completed and filed with the Employer on or before the date specified by the Committee. If no enrollment procedure is established, each person who is eligible to participate in the HRA shall automatically become a Participant on the date he satisfies the requirements for eligibility.

4.2 Annual Contributions. Subject to Section 4.3, each Plan Year the Employer may credit a Contribution to each Participant's Account. For the 2010/2011Plan Year the Contribution for each Participant shall be Ex. 4 -for Relief employees; Ex. 4 - Part-time employees; Ex. 4 - Full-time employees. Prior to the beginning of each subsequent Plan Year, the Employer shall provide written notice to Participants of the amount of the Contribution, if any, to be credited to their Accounts for that Plan Year.

The annual Contribution for a Plan Year shall be credited to the Participant's Account as of the later of the first day of the Plan Year or the date he becomes a Participant.

4.3 Unused Contributions. Any Contributions credited to a Participant's Account as of the date he ceases to be a Participant (after payment of claims for Eligible Expenses incurred before he ceased to be a Participant) shall be forfeited.

Any Contributions that remain credited to a Participant's Account as of the end of a Plan Year (after payment of all claims for Eligible Expenses incurred during the Plan Year) shall be carried over and be available for payment or reimbursement of the Participant's Eligible Expenses incurred in subsequent Plan Years; provided, however, that no more than $[redacted] may ever be credited to the Participant's Account. If the sum of the Contributions to be credited to a Participant's Account for a Plan Year and any Contributions carried over from prior Plan Years exceeds this maximum dollar limit, then the amount credited to the Participant's Account shall be adjusted to avoid such excess by reducing the Contributions for the Plan Year and/or forfeiting unused Contributions as of the end of the prior Plan Year.

4.4 Benefits. Subject to Section 5.10, a Participant shall be entitled to payment or reimbursement of his Eligible Expenses from his Account; provided, however, no Participant shall be entitled to payment or reimbursement of an Eligible Expense unless: (a) the Eligible Expense is incurred on or after the date he becomes a Participant and before the date he ceases to be a Participant; (b) the Eligible Expense has not been reimbursed, and is not reimbursable, from any other source; and (c) the Participant properly completed and filed any claim forms, and provided any information, required by the Plan Administrator or Committee to substantiate the nature and amount of the expense and the timeliness of the claim. For purposes of the HRA, an expense is incurred when the medical care or service giving rise to the expense is furnished, or the drug, supply, equipment or other item giving rise to the expense is purchased. Furthermore, no Participant shall be entitled to payment or reimbursement of Eligible Expenses for which a claim is required unless he submits the claim within 120 days after the end of the Plan Year in which the expense was incurred, or any earlier date specified herein.

Each claim must be substantiated with the following information: (i) the person or persons on whose behalf the Eligible Expense was incurred; (ii) the nature of the medical care, service, drug, supply, equipment or other item giving rise to the expense; (iii) the amount of the expense and the requested payment or reimbursement; and (iv) the date or dates the expense was incurred. Claims shall be accompanied by a copy of the bill supporting the expense and shall contain the Participant's certified statement that the Eligible Expense has not been reimbursed, and is not reimbursable, from any other source. The Plan Administrator or

Committee shall provide claim forms for payment or reimbursement of Eligible Expenses.

Notwithstanding the above, the Employer may make arrangements for automatic payment or reimbursement for Eligible Expenses.

Payments or reimbursements made from a Participant's Account shall reduce the amount in the Account. The maximum amount available for payment or reimbursement from a Participant's Account at any time shall equal the amount then credited to his Account.

If a Participant is also a participant in a cafeteria plan (as defined in Section 125 of the Code) maintained by the Employer and an Eligible Expense is payable or reimbursable under both this HRA and the cafeteria plan, the Eligible Expense shall be paid first from the cafeteria plan, up to the amount available in the Participant's cafeteria plan account.

4.5 Frequency of Payments and Reimbursements. If the HRA covers premiums for group health insurance maintained by the Employer for Participants, payment of such premiums shall be made automatically. Payment or reimbursement of other Eligible Expenses shall be made at least monthly, provided the Participant files a written form for payment or reimbursement at least five business days before a scheduled payment/reimbursement date.

4.6 Right of Recovery and Subrogation. If an expense is paid under the HRA that is not an Eligible Expense, the HRA has the right to recover the amount paid from the person who received the payment, the person for whom the payment was made, or from any insurance company or other party that owes payment for the expense. The HRA also has the right to decrease future benefits otherwise payable under the HRA to the Participant who benefited from such payment. Whenever an expense is paid under the HRA, the HRA is subrogated to the Participant's or his Dependent's right of recovery against any third party that caused injury or sickness for which the expense was incurred. The Participant or Dependent may not act to prejudice this right of subrogation, and must execute and deliver documents and do whatever else is necessary to secure the Plan's right of subrogation (including the right to sue the third party in the name of the Participant or Dependent). The Plan Administrator or Committee may require the Participant or Dependent to sign an agreement acknowledging these HRA rights as a condition to receiving payment from the HRA. However, failure to require such an agreement will not affect the Plan's subrogation rights.

4.7 Nondiscrimination Requirements. The Committee may, in its sole and absolute discretion, take any actions that it deems appropriate to assure compliance with all

applicable nondiscrimination requirements and all applicable limitations on payments and reimbursements to Highly Compensated Individuals, including reducing pro rata or terminating Contributions credited to Highly Compensated Individuals, as necessary, to satisfy such requirements.

SECTION 5
ADMINISTRATION

5.1 Committee. The Employer may appoint one or more persons to serve as members of the Committee to control and manage the operation and administration of the HRA, and may remove any member of the Committee at any time. Any such appointment or removal shall be in writing. If no appointment is made, the Plan Administrator shall be the Committee.

5.2 Powers. The Committee has full authority and responsibility to control and manage the operation and administration of the HRA. The Committee shall have the exclusive right to interpret the HRA (but not to modify or amend the HRA) and to decide any and all questions arising in the administration, interpretation, and application of the HRA. The Committee shall establish whatever rules it finds necessary for the operation and administration of the HRA and shall endeavor to apply such rules in its decisions so as not to discriminate in favor of any person. The decisions of the Committee or its action with respect to the HRA shall be conclusive and binding upon the Employer and all persons having or claiming to have any right or interest in or under the HRA.

5.3 Delegation of Responsibilities. The members of the Committee may elect from their number a chairman, who need not be an Employee, and may appoint a secretary, who need not be an Employee or a member of the Committee. They may appoint from their number such subcommittees with such powers as they shall determine. They may allocate responsibility among themselves or delegate any of their duties or responsibilities to other persons, including the Employer or any of its officers or employees. Any such allocation or delegation of responsibilities shall be by an instrument in writing, setting forth specifically the delegated duties, signed by or on behalf of the Committee and the delegated person and shall be exercised in a reasonable manner taking into account the discretionary or ministerial nature of the responsibility allocated or delegated and the capabilities of such person or persons to whom the responsibility is allocated or delegated. A member of the Committee may resign at any time by delivering a written resignation to the Employer.

5.4 Agents and Contractors. The Committee or any person or persons to whom the Committee has delegated responsibilities may employ, with the approval of the Committee, one or more accountants, legal counsel or other persons as shall be

deemed necessary for the effective control and management of the operation and administration of the HRA. The members of the Committee, the Employer and its officers and directors, and any person to whom any duty or responsibility has been delegated by the Committee, shall be entitled to rely upon all tables, certificates, opinions and reports furnished by any duly appointed accountant, legal counsel or other person and shall be fully protected in respect of any action taken or permitted by them in good faith in reliance upon any such tables, certificates, opinions or reports.

5.5 Meetings. The Committee may hold meetings upon such notice, at such place or places, and at such time or times as it may determine. A majority of the members of the Committee shall constitute a quorum for the transaction of business. All resolutions or other actions taken by the Committee shall be by vote of a majority of those present at a meeting of the Committee at which a quorum shall be present or, if they act without a meeting, in writing by all the members of the Committee.

5.6 Expenses. Neither the Plan Administrator nor any Committee member shall receive any compensation for his services, but the Employer may reimburse the Plan Administrator or a Committee member for any necessary expenses incurred in connection with his duties under the HRA. All reasonable expense incurred in administering the HRA, including, but not limited to, administrative fees and expenses owing to any accountant, attorney, consultant, or other service provider that may be employed by the Employer, Plan Administrator or Committee, in connection with the administration of the HRA, shall be paid by the Employer or, at the Employer's discretion, paid from Participants' Accounts.

5.7 Records. The Committee shall maintain records showing the fiscal transactions of the HRA.

5.8 Plan Administrator. The Employer may appoint one or more persons to act as Plan Administrator within the meaning of Section 3(16)(A) of ERISA and may remove the Plan Administrator from office at any time. Any such appointment or removal shall be in writing signed by the Plan Administrator and acknowledging the appointment. If no appointment is made, the Employer shall be the Plan Administrator. The Plan Administrator shall file such documents and shall have such duties as are required by applicable law, and as may be delegated in the instrument of appointment.

5.9 Indemnification. Each person who is or has been a member of the Committee or the Plan Administrator shall be indemnified by the Employer against expenses (including amounts paid in settlement with the approval of the Employer) reasonably incurred by him in connection with any action, suit, or proceeding to which he may be a party or with which he shall be threatened by reason of his

being, or having been, a member of the Committee or the Plan Administrator, except in relation to matters as to which he shall be adjudged in such action, suit, or proceeding to be liable for a breach of any fiduciary responsibility under ERISA. The foregoing right of indemnification shall be in addition to any other rights to which any member of the Committee or Plan Administrator may be entitled as a matter of law.

5.10 Claims Procedures. Eligible Expenses shall be paid in accordance with the terms of the HRA. A Participant who disagrees with a decision concerning his right to participate in the HRA or wishes to make a claim for payment or reimbursement of an Eligible Expense may file a claim in writing with the Committee. Any such claim must be filed no later than 120 days following the end of the Plan Year in which the Eligible Expenses was incurred, or if earlier 90 days after he ceases participation in the HRA. The Employer or the Committee shall establish and maintain claims procedures in accordance with ERISA, which shall include: (i) a procedure for advising claimants on how to make claims for benefits; (ii) a procedure for the review of such claims and giving timely written notice to the claimant concerning the determination made on the claim; and (iii) a procedure for requesting a review of any claim that is denied in whole or part and giving timely written notice to the claimant concerning the decision on review.

SECTION 6
AMENDMENT AND TERMINATION

6.1 Amendment. The Employer may amend the HRA at any time or from time to time by an instrument in writing executed with the same formality as this instrument. However, no amendment shall affect the rights of Participants to payment or reimbursement of Eligible Expenses incurred prior to the effective date of the amendment.

6.2 Termination. The HRA is intended by the Employer to be a permanent program for the provision of health care benefits. The Employer nevertheless reserves the right to terminate the HRA at any time and for any reason. Such termination shall be effected by a written instrument executed by the Employer with the same formality as this instrument. Termination of the HRA shall not affect the rights of Participants under the HRA with respect to the payment or reimbursement of Eligible Expenses incurred prior to the effective date of the termination.

SECTION 7
HIPAA PRIVACY RULES

7.1 Definitions. For purposes of this Section:

A) "Authorization" means a valid written authorization to disclose Protected Health Information by the person to whom such Protected Health Information pertains and which is made in accordance with Section 164.508 of the Privacy Rules.

B) "Electronic Protected Health Information" means Protected Health Information that is transmitted by or maintained in electronic media.

C) "Plan Administration Functions" means the administration functions performed by the Plan Sponsor on behalf of this Plan. It excludes functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.

D) "Privacy Rules" means the health privacy regulations promulgated by the United States Department of Health and Human Services, found at 45 CFR, Parts 160-164.

E) "Protected Health Information" means individually identifiable health information as described at Section 160.103 of the Privacy Rules.

F) "Summary Health Information" means information that may be individually identifiable health information, which:

(i) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Plan; and

(ii) from which identifying information described in Section 164.514 of the Privacy Rules (such as name, address, age, telephone number, fax number, electronic mail address, social security number, medical records number, health plan beneficiary number, photograph, etc.) has been deleted, except that addresses may be aggregated to the level of a five-digit zip code.

7.2 Disclosure of Summary Health, Enrollment and Disenrollment Information. The Plan may disclose, or allow a Plan health insurance issuer or HMO to disclose, the following information to the Plan Sponsor:

A) Summary Health Information, provided the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan, or for the purpose of modifying, amending or terminating the Plan.

B) Information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from the health insurance issuer or HMO offered by the Plan.

7.3 Disclosure of Protected Health Information. The Plan may disclose, or allow a Plan health insurance issuer or HMO to disclose, Protected Health Information only:

A) for the purposes and in accordance with the requirements of Section 164.512 of the Privacy Rules (such as disclosures required by law, and disclosures for public health activities or law enforcement purposes); or

B) directly to the individual to whom the Protected Health Information pertains; or

C) pursuant to a valid Authorization signed by the individual to whom the Protected Health Information pertains; or

D) without the Authorization of the individual to whom the Protected Health Information pertains, provided such individual is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the disclosure in accordance with the requirements of Section 164.510 of the Privacy Rules; or

E) to the Plan Sponsor for purpose of Plan Administration Functions only, but only: (i) if any notice of privacy practices required to be given by the Plan under Section 164.520 of the Privacy Rules contains a separate statement that the Plan, or a Plan health insurance issuer or HMO, may disclose Protected Health Information to the Plan Sponsor; and (ii) after the Plan Sponsor certifies in writing that the Plan has been amended to incorporate this Section and agrees to:

i) not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law;

ii) ensure that any agent, including any subcontractor to whom the Plan Sponsor provides Protected Health Information received from the

Plan, agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to the Protected Health Information;

iii) not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless pursuant to an Authorization from the individual to whom the Protected Health Information pertains;

iv) report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for, whenever it becomes aware of such use or disclosure;

v) make available Protected Health Information to the individual to whom it pertains in accordance with the access provisions of Section 164.524 of the Privacy Rules;

vi) make available Protected Health Information for amendment, and incorporate any amendments to Protected Health Information, in accordance with the amendment provisions of Section 164.526 of the Privacy Rules;

vii) make available Protected Health Information as required to provide an accounting of disclosures in accordance with the accounting provisions of Section 164.528 of the Privacy Rules;

viii) make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the United States Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rules;

ix) if feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such information, when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor will limit further use and disclosure to those purposes that make the return or destruction of the information infeasible;

x) ensure that adequate separation occurs between the Plan and the Plan Sponsor, as described below;

xi) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan;

xii) ensure that the adequate separation between the Plan and the Plan Sponsor is supported by reasonable and appropriate security measures for any Electronic Protected Health Information;

xiii) ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures;

xiv) report to the Plan any security incident of which it becomes aware; and

xv) make its policies, procedures and documentation relating to safeguards for Electronic Protected Health Information available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance.

7.4 Plan Sponsor's Use of Protected Health Information. The Plan Sponsor shall use or disclose Protected Health Information only if it has properly received the Protected Health Information from the Plan, or a Plan health insurance issuer or HMO, and such use and disclosure complies with the requirements of the Privacy Rules and this Section. The Plan Sponsor will notify the Plan of any misuses or impermissible disclosures of Protected Health Information of which it becomes aware.

7.5 Adequate Separation Between Plan and Plan Sponsor. The following classes of employees, or other persons under the control of the Plan Sponsor, shall have access to Protected Health Information solely for the purposes specified below, and only for Plan Administration Functions. No other employees of the Plan Sponsor, or other persons under the control of the Plan Sponsor, shall have access to Protected Health Information.

Third party administrators, and their employees, retained by the Plan Sponsor to assist with Plan Administration Functions, such as processing claims, keeping Plan records, and preparing Plan reports, will have access to Protected Health Information.

Employees who work in the Plan Sponsor's Benefits or Human Resources Department will have access to Protected Health Information:

A) to the extent necessary to assist Plan participants and their family members with getting benefit claims resolved;

B) that is the result of pre-employment physicals requested or required by the Plan Sponsor before hiring prospective employees;

C) to the extent necessary to fulfill any responsibility they may have to review and determine claims and appeals of denied claims under this Plan;

D) to the extent necessary to monitor and enforce the subrogation provisions of the Plan, and work with the Plan Sponsor's subrogation entity to help the Plan obtain reimbursement when appropriate;

E) to the extent necessary to correspond with other group health plans on coordination of benefits issues.

Employees who work in the Plan Sponsor's Legal Department will have access to Protected Health Information to the extent necessary to: (i) enforce the provisions of the Plan; and (ii) respond to, defend against, and provide necessary information to outside counsel for responding to and defending against, lawsuits against the Plan, Plan Sponsor or Plan fiduciaries, or other lawsuits that require benefits information or Protected Health Information.

Employees who work in the Plan Sponsor's Finance Department will have access to Protected Health Information to the extent necessary to conduct an internal audit of the Plan's expenses and payments of claims.

7.6 Non-Compliance. A Plan participant who believes the Plan has unlawfully used or disclosed his or her Protected Health Information may file a complaint with Sharon Chmielnicki, Community Services for the Developmentally Disabled, 180 Oak Street, Buffalo, New York, 14203.

If any employee or other individual under the control of the Plan or the Plan Sponsor fails to comply with the provisions of this Section regarding use or disclosure of Protected Health Information, the Plan or Plan Sponsor, as the case may be, shall impose reasonable sanctions on such individual as necessary, in its discretion, to end such non-compliance. If appropriate, such sanctions shall be imposed progressively (for example, an oral warning, written warning, transfer to another department, and termination); or, in the discretion of the Plan or Plan

Sponsor, the employment or other relationship between the Plan or Plan Sponsor and such individual could be immediately terminated.

7.7 Individuals' Rights With Respect to Protected Health Information. An individual may request restrictions on certain uses and disclosures of his or her Protected Health Information, as provided in Section 164.522(a) of the Privacy Rules (although the Plan is not required to agree to a requested restriction). An individual has the right to receive confidential communications of Protected Health Information, as provided in Section 164.522(b) of the Privacy Rules, if the individual believes the Plan's usual method of communicating Protected Health Information could endanger him or her. An individual also has the right to inspect and copy his or her Protected Health Information, as provided in Section 164.524 of the Privacy Rules.

The Plan will track disclosures of Protected Health Information for a period of six years (but not prior to April 14, 2003), and will provide to an individual upon request an accounting of disclosures of his or her Protected Health Information, to the extent required and in accordance with Sections 164.528 and 164.530 of the Privacy Rules. An individual has the right to amend his or her Protected Health Information maintained by the Plan in accordance with Section 164.526 of the Privacy Rules.

SECTION 8
MISCELLANEOUS

8.1 No Employment Rights Conferred. The adoption and maintenance of the HRA shall not be deemed to constitute a contract between the Employer and any Participant or to be a consideration for, or an inducement to or condition of, the employment of any person. Nothing herein contained shall be deemed to: (i) give to any Participant the right to be retained in the employment of the Employer; (ii) interfere with the right of the Employer to discharge any Participant at any time; (iii) give to the Employer the right to require any Participant to remain in its employment; or (iv) interfere with any Participant's right to terminate his employment with the Employer at any time.

8.2 No Compensation for Other Purposes. Payment or reimbursement of Eligible Expenses shall not be treated as additional compensation to the Participant for purposes of determining Contributions or benefits under any qualified retirement plan maintained by the Employer or for purposes of any other benefit obligations of the Employer.

8.3 General Assets. Payment or reimbursements of Eligible Expenses shall be made out of the assets of the Employer generally available for payment of its obligations. There shall be no trust fund for such payment or reimbursement.

8.4 Nonalienation of benefits. Except as provided in a qualified medical child support order (within the meaning of Section 609 of ERISA), and except to the extent that this provision may be contrary to other law, benefits payable from the HRA shall not be subject to assignment or transfer or otherwise alienable, either by voluntary or involuntary act of a Participant or by operation of law, nor subject to attachment, execution, garnishment, or other seizure under any legal or equitable process.

8.5 Impossibility of Performance. In the event that it becomes impossible for the Employer to perform any act under the HRA, that act shall be performed which in the judgment of the Employer shall most nearly carry out the intent and purposes of the HRA.

8.6 Death or Mental or Physical Incompetence of Participant. Any HRA benefit otherwise payable to a deceased Participant shall be paid to his spouse or, if there is no surviving spouse, to his estate. If the Committee determines that a Participant entitled to payment for an Eligible Expense is incompetent by reason of physical or mental disability, the Committee may cause such payment to be made to any other person for his benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section shall completely discharge the Employer, Plan Administrator, the Committee and the HRA with respect to the amount so paid.

8.7 Inability to Locate Payee. If the Committee is unable to pay an HRA benefit to a Participant or other person to whom such payment is due under the HRA because the Committee cannot ascertain the identity or whereabouts of such person, such benefit otherwise due such persons shall be forfeited 36 months after the date such payment first became due.

8.8 Tax Effects. Neither the Employer, Plan Administrator nor the Committee makes any warranty or other representations as to whether any payments from a Participant's Account will be excluded from the Participant's gross income for federal or state tax purposes.

8.9 Gender. For purposes of the HRA, unless the context requires otherwise, whenever the masculine gender is used, it shall also be deemed to include the feminine gender.

8.10 Headings. Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

8.11 Governing Law. All legal questions pertaining to the HRA shall be determined in accordance with the laws of the State of New York except when those laws are preempted by the laws of the United States.

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

By signing this instrument, the Employer(s) approves and adopts the terms of this Health Reimbursement Account Plan as stated herein.

Community Services for the Developmentally Disabled
(Employer Name)

By: [signature]

Title: President & CEO

Date: 5.7.10

N/A
(Affiliated Employer Name)

By: _____

Title: _____

Date: _____

N/A
(Affiliated Employer Name)

By: _____

Title: _____

Date: _____

EBS-RMSCO, Inc.
Employee Benefit Solutions

EBS-RMSCO, Inc.
Service Agreement

Appendix A – Fees and Charges

The conditions stated in this Appendix A – Fees and Charges shall be applied in conjunction with the EBS-RMSCO, Inc. Service Agreement. The "Employer" is Community Services for the Developmentally Disabled, which has an office at 180 Oak Street, Buffalo, New York 14203. The effective date of the EBS-RMSCO Service Agreement and this Appendix A – Fees and Charges is the 1 day of March, 2010.

This Service Agreement applies to the following Plan(s) (check all that apply):

- X Flexible Spending Account Plan (FSA)
- ☐ Limited Purpose Flexible Spending Account Plan (LPFSA)
- X Health Reimbursement Account Plan (HRA)
- ☐ Qualified Transit Benefit Plan (QTB)

The Employer shall pay the following fees and charges:

a) $[redacted] or [redacted] per participant per month or $[redacted] per month, whichever is greater, for administration of the Plan. For this purpose, "participant" means any employee enrolled in the Plan and any other person (i.e., former employee, or the spouse or dependent of an employee or former employee) with an account balance to his credit under the Plan. The monthly administration fee shall be based on the number of participants on the last day of each month. Billing for terminated participants will continue through the terminated participant run-out date as defined in the Plan Document. EBS-RMSCO shall bill the administration fee monthly, and payment shall be due within 30 days of the date billed. *Note: EBS-RMSCO may adjust the monthly administration fee if it will incur increased expenses as a result of changes to the Plan. Such adjustment shall be effective as of the date such Plan changes take effect.*

b) The administration fee for the run-out period following the end of a Plan Year shall be covered in the administration fees for the following Plan Year unless the Plan or this Agreement is terminated, in which case the administration fees for the run-out period shall be billed and due at the beginning of the run-out period. The number of run-out period days is defined in the Plan Document.

c) EBS-RMSCO reserves the right to assess an additional administrative charge if the Employer transmits data in a format other than EBS-RMSCO's EDI format.

d) EBS-RMSCO will provide a reasonable number of hard copy Enrollment Kits, but reserves the right to charge for additional or excessive copies.

e) [redacted] for each on-site employee enrollment presentation, plus EBS-RMSCO's travel costs for travel outside of Western New York.

f) Ex. 4 for each Automated Clearinghouse Transaction (ACH) that fails due to insufficient funds.

g) If the Employer selects the EBS Flex Card option, two initial EBS Flex Cards will be issued to each participant free of charge. A fee of Ex. 4 will apply for each additional set of EBS Flex Cards issued regardless of the reason (there are two Cards per set). The fee will automatically be deducted from the participant's account.

h) Unless due to or necessitated by EBS-RMSCO's error, the Employer shall pay Ex. 4 per occurrence for: (i) any claim reimbursement payment made outside the reimbursement schedule specified in the Agreement; (ii) any re-issuance of a claim reimbursement payment; (iii) any stop payment requested by the Employer or a participant, (iv) any reimbursement for a claim filed after the run-out period.

i) The Plan(s) associated with this Agreement will enforce a Ex. 4 minimum of claim reimbursement payments.

j) A one-time implementation fee of $Ex. 4
   (i) For FSA, LPFSA and HRA Plans, this fee includes assistance with the preparation of a Plan Document and Summary Plan Description.
   (ii) For FSA and LPFSA Plans, this fee also includes an Administrator's Guide containing a Plan overview, summary of services, guidelines for implementation, definitions, requirements, and answers to commonly asked questions.

k) For FSA, LPFSA and HRA Plans only: Ex. 4 for assistance with the preparation of each Plan amendment or restatement, and if required, a corresponding summary of material modification.

l) For FSA and LPFSA Plans only: an annual compliance service fee of Ex. 4 for non-discrimination testing as required under Federal tax law, and, if required, assistance with the completion of an IRS Form 5500. This fee may be increased or decreased if there is a change in the number of participants.

m) For HRA Plans only: an annual compliance service fee of Ex. 4 for dedicated HRA account servicing to answer routine Employer questions and to consult with the Employer about changes to the Plan Document and Summary Plan Description. Non-routine Employer specific questions that may require research or the use of our outside legal counsel will be billed additionally, pursuant to section (o) below.

n) For HRA Plans only: Please make separate elections for each of these two optional services:
   (i) an annual fee of Ex. 4 for assistance with completion of the IRS Form 5500 required for Plans with more 100 or more participants at the beginning of the Plan year ☒ **Yes or** ☐ **No**; and
   (ii) an annual fee to assist with testing compliance with the non-discrimination eligibility requirements of Section 105(h) IRC. Since testing requirements vary, the associated fee will be determined during the testing period. ☐ **Yes or** ☒**No.**

o) Requests for services that are not of a routine nature including, but not limited to, requests for special reports, requests for copies of Plan specific claims, correction due to late or erroneous Employer data, Employer audit assistance, research to answer Employer specific questions, and communicating and consulting with the Employer's representatives (including but not limited to the Employer's broker, consultant, or

attorney) will be provided at the rate of Ex. 4 per hour, with a minimum charge of one hour. For any significant services, as mutually agreed to between EBS-RMSCO and the Employer, EBS-RMSCO will provide the Employer with an advance estimate of the cost and timeline for the service. (Requests for copies of Plan specific claims must be accompanied by an electronic file containing the Social Security numbers of the participant(s) who filed the claim(s) (or other mutually agreed upon participant identifiers), and all copies of Plan specific claims will be provided only in electronic format).

p) If this Agreement is terminated by the Employer before the end of any Plan Year for any reason other than a material breach of the Agreement by EBS-RMSCO that is not corrected within thirty (30) days after EBS-RMSCO receives written notice of such breach, or if this Agreement is terminated by EBS-RMSCO before the end of any Plan Year due to the Employer's failure to pay the fees and charges provided herein, a termination fee equal to:

i) Ex. 4 for each participant in the Plan during the last month the Agreement is in effect or Ex. 4 whichever is greater; multiplied by

ii) The number of months less than 12 that this Agreement is in effect during the Plan Year in which it is terminated.

Such amount shall be due and payable upon the date the Agreement is terminated.

IN WITNESS WHEREOF, the parties have executed the EBS-RMSCO, Inc. Service Agreement and this Appendix A – Fees and Charges effective as of the date written above.

Employer:

Print: Mark R. Foley

Sign: [signature]

Title: President & CEO

Date: January 4, 2010

EBS-RMSCO:

Print: Charles G. Herendeen

Sign: [signature]

Title: Mgr. Retirement & Benefits

Date: 1/11/2010

Plan:

Signature of person authorized to sign on behalf of the Plan (i.e., Plan Administrator or member of the Administrative Committee as defined in the Plan Document).

Print: Mark R. Foley

Sign: [signature]

Title: President & CEO

Date: January 4, 2010

EBS-RMSCO, Inc.
Employee Benefit Solutions

EBS-RMSCO, Inc. Service Agreement

This Agreement shall be made effective as of the date identified in Appendix A - Fees and Charges. The Agreement shall be by and among (1) the "Employer" identified in Appendix A - Fees and Charges, (2) EBS-RMSCO, Inc. (hereinafter referred to as "EBS-RMSCO") with its principal office at 30 Perinton Hills Malls, Fairport, NY 14450, and (3) the Employer's "Plan" as identified in Appendix A - Fees and Charges, and sets forth the basis on which EBS-RMSCO agrees to provide administrative services for the Plan. Allowable Plan types associated with this Agreement are Flexible Spending Accounts (FSA), Limited Purpose Flexible Spending Accounts (LPFSA), Health Reimbursement Accounts (HRA) and Qualified Transportation Benefits (QTB).

In consideration of the mutual covenants contained herein, the Employer and EBS-RMSCO agree as follows:

I. Claims Administration

A) The Employer shall:

1) Furnish EBS-RMSCO with copies of all Plan documents and any Summary Plan Description, if applicable, in existence on the effective date of this Agreement, and shall promptly provide EBS-RMSCO with copies of any such subsequent Plan amendments and changes to the Summary Plan Description, other than any document which is identical to a document EBS-RMSCO helped prepare.

2) Operate the Plan consistent with the Plan Documents, this Agreement, and EBS-RMSCO's standard claims administration procedures and practices. For LPFSA Plans, standard claim administration procedures means EBS-RMSCO's standard claim administration procedures for dental and vision only claims.

3) Determine and periodically provide EBS-RMSCO with a list (Web enrollment or electronic file preferred) of the employees eligible to participate in the Plan, including full enrollment records (demographic and Plan elections/contributions) at least thirty (30) days before the beginning of each Plan year.

4) Provide EBS-RMSCO, via electronic file, with a listing of employer Plan contributions, and FSA, LPFSA and/or QTB Plan contributions deducted from each participant's paycheck (including the amount and frequency). In the absence of a file, EBS-RMSCO will post contributions based on enrollment form data.

5) For HRA and QTB Plans only: Notify EBS-RMSCO of the date contributions which are not used to pay expenses incurred in a Plan year should be credited to participants' accounts and be available to pay expenses incurred in the next Plan year.

6) Comply with EBS-RMSCO's Electronic Data Interchange (EDI) formats for transfer of electronic data.

7) Send EBS-RMSCO any other information or data required and requested by EBS-RMSCO to perform the services specified in this Agreement.

8) Comply with all Plan reporting and disclosure requirements under the Internal Revenue Code of 1986 (the "Code") and, if applicable, the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, and other laws and regulations.

9) Authorize EBS-RMSCO to electronically withdraw funds from the Employer's specified account(s) for claim reimbursement payments.

10) For FSA and HRA Plans only: For each participant who elects the Automatic Claims Transfer option, authorize Excellus BlueCross BlueShield, Univera Healthcare, or authorize another entity agreed to by EBS-RMSCO, to transfer eligible expense information directly to EBS-RMSCO for processing FSA or HRA claims.

11) For HRA, FSA and LPFSA Plans only: EBS-RMSCO may rely on the accuracy and validity of information described in Section I(A)(10) and any other information received from Excellus BlueCross BlueShield, Univera Healthcare, or any other authorized entity agreed to by EBS-RMSCO, to process HRA, FSA and/or LPFSA claims and to adjudicate EBS Flex Card transactions.

12) If the Employer elects the EBS Flex Card option for VISA debit card payments to be made directly to service providers:

i) establish such accounts, enter into such written agreement(s), and sign such documents as are required by Evolution Benefits, Inc. (or other service provider selected by EBS-RMSCO) for participants to have claims paid through VISA debit cards, including entering into a deposit account agreement, unless waived by Evolution Benefits, Inc., and signing an "ACH authorization" for automatic debits and credits; and

ii) at all times, maintain in the account from which automatic debits will be drawn, and to which automated credits will be transferred, the minimum account balance required by Evolution Benefits, Inc. or required by the bank selected by Evolution Benefits, Inc. to present automatic debits and credits.

iii) Note: Notwithstanding the above and any other provision of the Agreement, the EBS Flex Card may not be elected for certain restricted purpose HRAs.

13) Disclose in writing and in advance to participants any fees, charges or expenses that may be deducted from their accounts, including, but not limited to, charges for reimbursement payments made outside the reimbursement schedule specified in this Agreement, check stop payment charges and charges for additional EBS Flex Cards.

B) EBS-RMSCO shall:

1) Provide the Employer with claims reimbursement forms and instructions, and provide participants reasonable customer service support for the Plan.

2) Provide the Employer with EDI specifications to conduct electronic file transfer.

3) Maintain a list of participants based on information provided by the Employer pursuant to paragraph I(A)(3) above.

4) Process claims and issue account statements in accordance with this Agreement; make participant statements accessible to participants on EBS-RMSCO's website; and, after the end of the third quarter of each Plan year, mail a year-to-date statement to active participants with a Plan account balance as of the end of that quarter.

5) Defer to the Employer's final decision on any disputed claim and any other claim that the Employer may specify.

6) Issue claims reimbursement payments weekly. However: (i) if the normal claims reimbursement payment day is not a business day, claims reimbursement payments will be issued no later than the next business day, and (ii) if the Employer elects the EBS Flex Card option for Visa debit card payments to be made directly to service providers, payments made directly to the service providers shall be made at any frequency and amount, subject to any minimum amount that may be required by an individual service provider.

7) Request substantiation receipts from participants for EBS Flex Card transactions, unless EBS-RMSCO can substantiate transactions. If a participant transaction cannot be substantiated, EBS-RMSCO has the right to discontinue the EBS Flex Card for that participant.

8) Enforce a minimum, as established in Appendix A - Fees and Charges, on claim reimbursement payments, except: (i) as noted above, for payments to service providers in accordance with the EBS Flex Card option; and (ii) final payment for claims made before the end of the run-out period (described in subsection (9) below).

9) Allow a run-out period, as identified in the Plan Document, following the end of each Plan year for submission of claims incurred during the Plan year. Note: Run-out periods for clients with both an HRA and an FSA/LPFSA shall be the same.

10) Make reports accessible to the Employer on EBS-RMSCO's website.

11) Make EBS-RMSCO's Enrollment website service available to the Employer to: (i) allow the Employer to input enrollment information; or (ii) for FSA, LPFSA and QTB Plans, allow the participant to input enrollment information.

12) If requested by the Employer, produce special reports of a non-routine nature and provide special services; provided, however, the cost of such reports and services shall be borne by the Employer and shall be in addition to the fees provided in Appendix A - Fees and Charges.

13) Maintain a record of all Plan claims, standard and special reports, employee elections and/or employer contributions, and design specifications for a period of one year following the Plan year the report was created, the Plan year for which the employee election and/or employer contribution was made, or the last Plan year the design specification applied (as the case may be), unless its obligation to retain the same ends sooner pursuant to Section

VII. EBS-RMSCO will scan and retain manually submitted claims in electronic form for a period of six years. EBS-RMSCO will retain EBS Flex Card claims data in electronic form for a period of six years and such Flex Card claim data will include the participant's name and Social Security number, the transaction number, payment date and payment amount. It shall be the Employer's responsibility to maintain records, data and information relating to the Plan for any longer period of time required under the Code, and if applicable, ERISA and other law.

14) Be available to consult with the Employer concerning any disputed claim, any changes to the claims administration procedures and practices, and benefit and Plan design issues.

15) Periodically report to the Employer on matters of general interest with respect to the Plan including, by way of example, problems of a recurring nature, local situations, and potential misuses of benefits.

II. Relationship of the Parties

The legal relationship of EBS-RMSCO to the Employer shall be exclusively that of an independent contractor. EBS-RMSCO shall process claims in strict accordance with the claims criteria determined by the Employer and communicated to EBS-RMSCO. EBS-RMSCO shall not:

1) have any discretion to approve or deny Plan claims, or any other discretionary authority or responsibility in the administration of the Plan;

2) have any authority or control with respect to the management or disposition of Plan assets, or hold any Plan assets;

3) if ERISA is applicable, be the "administrator" of the Plan as defined in Section 3(16) of ERISA, or a "named fiduciary" as defined in Section 402(a)(2) of ERISA, or a "fiduciary" as defined in Section 3(21) of ERISA, with respect to the Plan;

4) be responsible for ensuring that the Plan complies with any requirement under the Code and, if applicable, ERISA or other law, or be liable to the Employer or any person if the Plan fails to comply with any such requirement;

5) except for EBS-RMSCO's obligations set forth in Section V below, be responsible for ensuring that the Plan complies with HIPAA requirements, or be liable to any person if the Employer fails to comply with any such requirement; or

6) ensure payment of any Plan claim, or have any duty or authority to enforce the Employer's obligation to pay any Plan claim.

III. Employer's Representations

The Employer represents to EBS-RMSCO that:

1) if ERISA is applicable, the Employer is the "administrator" of the Plan as defined in Section 3(16) of ERISA, or that another person (other than EBS-RMSCO) has been duly appointed by the Employer to be the "administrator";

2) all instructions and information received by EBS-RMSCO from the Employer or its representatives shall be authorized by the Employer and shall be in accordance with the terms of the Plan and HIPAA; and

3) the Employer shall notify EBS-RMSCO in writing prior to any sale, acquisition, merger, reorganization or other similar change relating to the Employer's status as the sponsor of the Plan.

IV. Fees

The Employer shall pay to EBS-RMSCO a monthly administration fee during the continuance of this Agreement, and such other fees as set forth in Appendix A - Fees and Charges, subject to any changes made in accordance with this Section IV.

1) EBS-RMSCO may change any of its fees set forth in Appendix A - Fees and Charges by giving the Employer written notice of the change at least ninety (90) days prior to the effective date of the change.

2) If EBS-RMSCO will incur increased expenses as a result of a significant Plan change, EBS-RMSCO may also increase its monthly administration fee set forth in Appendix A - Fees and Charges. Such increase shall be commensurate with any anticipated increased expenses, and shall be effective as of the date such Plan change takes effect, provided EBS-RMSCO gives the Employer written notice of the increase within thirty (30) days after being informed by the Employer of the Plan change.

3) For FSA, LPFSA and HRA Plans, if there is a significant change in the number of Plan participants, EBS-RMSCO may also increase or decrease its annual Plan compliance service fee set forth in Appendix A - Fees and Charges as of the first day of the Plan year in which the change occurs provided EBS-RMSCO gives the Employer written notice of the increase or decrease within thirty (30) days after the change in the number of participants. Such increase or decrease shall be commensurate with any anticipated increased expenses resulting from the change in the number of participants.

V. HIPAA Privacy Requirements

This Section V applies to FSA, LPFSA and HRA Plans only.

In the course of providing services for the Plan, EBS-RMSCO has access to, creates, receives, and/or maintains certain confidential protected health information concerning individuals covered by the Plan ("PHI"), which the Employer, the Plan and EBS-RMSCO are obligated to appropriately safeguard under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations issued thereunder ("Privacy Rules"). The Privacy Rules restricting the use and disclosure of PHI by the Plan shall also apply to EBS-RMSCO's use and disclosure of PHI, and this Section shall be interpreted and applied in a manner consistent with the Privacy Rules.

1) EBS-RMSCO will keep PHI strictly confidential. It will use and disclose PHI only as required or permitted under this Agreement, the Privacy Rules and other applicable law.

2) EBS-RMSCO may also use or disclose PHI for the proper management and administration of EBS-RMSCO, or to carry out its legal responsibilities. Such use and/or disclosure must be either required by law or, prior to making use of PHI or disclosing PHI, EBS-RMSCO must obtain reasonable assurance from the person to whom PHI will be disclosed that PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed. Furthermore, the person to whom it is disclosed must agree to notify EBS-RMSCO of any instance of which the person becomes aware in which the confidentiality of PHI has been breached.

3) EBS-RMSCO may also use PHI to provide data aggregation services to the Plan. Data aggregation means, the combining of PHI received by EBS-RMSCO in its capacity as a business associate of the Plan with PHI received by EBS-RMSCO in its capacity as a business associate of one or more other entities covered by HIPAA, to permit the creation of data for analyses that relate to the health care operations of the Plan and other covered entities.

4) EBS-RMSCO will use appropriate safeguards to prevent any use or disclosure of PHI that is not permitted under the terms of this Agreement, including appropriate administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI that is transmitted by or maintained in electronic media.

5) EBS-RMSCO will ensure that any of its agents, including any subcontractor, to whom EBS-RMSCO provides PHI, will agree to the same restrictions and conditions that apply to EBS-RMSCO under the terms of this Agreement with respect to such PHI, including (but not limited to) implementation of reasonable and appropriate safeguards to protect PHI that is transmitted by or maintained in electronic media.

6) EBS-RMSCO will report to the Plan any use or disclosure of PHI that is not permitted under the terms of this Agreement, any security incident, or any attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with a system operation in an information system, of which it becomes aware.

7) At the time and manner requested by the Plan, EBS-RMSCO will make its internal books and records relating to the use and disclosure of PHI (including its policies, procedures and documents relating to safeguards for PHI that is transmitted by or maintained in electronic media) available to the Plan and to the Secretary of Health and Human Services, so that the Secretary may determine whether the Plan has complied with the Privacy Rules.

8) At the time and in the manner requested by the Plan, EBS-RMSCO will provide access to PHI in its possession to the Plan or, as directed by the Plan, to an individual, in a "designated record set" (as defined under the Privacy Rules) if any, so that the Plan may satisfy its obligations to provide access to PHI to an individual.

9) At the time and in the manner requested by the Plan, EBS-RMSCO will provide access to PHI in its possession to the Plan so that the Plan can amend PHI as required under the Privacy Rules. EBS-RMSCO will also make any amendment to PHI in a designated record set, if any, that is requested by the Plan as a result of an individual having requested such an amendment.

10) At the time and in the manner requested by the Plan, EBS-RMSCO will maintain and make available an accounting of disclosures of PHI so that the Plan may provide any accounting of disclosures it is required to provide under the Privacy Rules.

11) EBS-RMSCO will mitigate, to the extent practicable, any harmful effect that is known to EBS-RMSCO of a use or disclosure of PHI in violation of this Agreement.

12) If feasible, when EBS-RMSCO stops providing services to the Plan, EBS-RMSCO will return or destroy all PHI and retain no copies of PHI. If such return or destruction is not feasible, EBS-RMSCO will extend the protections of this Agreement to PHI and limit further uses and disclosures to those purposes that make the return or the destruction of PHI not feasible.

The Employer or the Plan may terminate EBS-RMSCO's services, and any written contract for such services, if EBS-RMSCO materially breaches any of its obligations under this Section of the Agreement. If termination is not a feasible remedy, the Employer or the Plan may report the breach by EBS-RMSCO to the Secretary of Health and Human Services

VI. Liability and Indemnity

EBS-RMSCO does not insure or underwrite the liability of the Employer under the Plan. The Employer retains all responsibility for paying all claims made under the Plan and all expenses incident to the Plan.

EBS-RMSCO shall not be liable to the Employer, any participant, or any other person for: (i) any act or omission that is undertaken in good faith and is not found to constitute negligence, willful misconduct or a breach of this Agreement; (ii) relying on Plan documents, data or information provided to EBS-RMSCO by the Employer or its representatives; (iii) making any change to the Plan document, a Plan amendment, Summary Plan Description, Summary of Material Modification, or any other Plan related document, which EBS-RMSCO is directed to make by the Employer, its employee, broker, consultant, attorney or other agent; (iv) relying on instructions from the Employer or its representatives; and (v) following instructions of the Employer or its representatives before EBS-RMSCO has received written notice of any sale, acquisition, merger, reorganization or other similar change relating to the Employer's status as the sponsor of the Plan. EBS-RMSCO is entitled to conclusively rely on the authenticity of any notice or other communication received from another party so long as it reasonably believes the notice or other communication to be genuine. Furthermore, EBS-RMSCO shall not be responsible for losses caused directly or indirectly by conditions beyond its reasonable

control, including but not limited to war, natural disaster, strikes, interruptions of power, communications or data processing services.

The Employer and EBS-RMSCO each agree to indemnify and hold the other, and its directors, officers, employees, and agents, harmless against any and all claims, demands, losses, damages, penalties, liabilities, costs and expenses (including without limitation reasonable attorneys' fees and disbursements) (hereinafter collectively referred to as "liability") arising under this Agreement where such liability is the result of the negligent act or omission of, or breach of this Agreement by, the indemnifying party or its director(s), officer(s), employee(s), or agent(s). If the Employer elects the EBS-RMSCO Flex Card option for VISA debit card payments to be made directly to service providers, the parties agree that the Employer's indemnification obligation hereunder covers any liability EBS-RMSCO may incur as a result of any failure to maintain in the account from which automatic debits are drawn, and to which automated credits are transferred, the minimum account balance required by Evolution Benefits, Inc. (or such other service provider selected by EBS-RMSCO) or required by the bank selected by Evolution Benefits, Inc. (or such other service provider) to present automatic debits and credits. The Employer and EBS-RMSCO each agree to provide the other with prompt notice of any written or oral claim or demand or of any facts that could result in an indemnification claim against the other party pursuant to this provision, and to afford the other party all opportunity, as is permitted by applicable law, to participate in the defense and/or settlement of such matter.

The provisions of this Section VI shall survive the termination of this Agreement.

VII. Term of Agreement

A. This Agreement is effective as of the date established in Appendix A - Fees and Charges and shall continue until terminated in accordance with one of the following provisions:

1) By mutual consent of the parties.

2) If the Employer elects the EBS Flex Card option for VISA debit card payments to be made directly to service providers, by EBS-RMSCO immediately upon notice after any failure to maintain in the account from which automatic debits are drawn, and to which automated credits are transferred, the minimum account balance required by Evolution Benefits, Inc. (or such other service provider selected by EBS-RMSCO) or by the bank selected by Evolution Benefits, Inc. (or such other service provider) to present automatic debits and credits.

3) Upon thirty (30) days advance written notice to given to EBS-RMSCO following EBS-RMSCO's failure to correct any material breach of this Agreement within thirty (30) days after receiving written notice of such breach.

4) On the last day of the calendar month following the month in which one party gives the other parties written notice of its intention to terminate this Agreement (or on such later date specified in the notice).

5) Upon the Employer's non-payment of any of the fees or charges set forth in Appendix A - Fees and Charges (or any additional fees or charges for services as agreed upon by the Employer and EBS-RMSCO) for a period of 30 days.

6) For FSA, LPFSA and HRA Plans only, in accordance with Section V in the event of a breach of EBS-RMSCO's obligations under Section V.

B. Provided the Employer has paid all fees and charges owed to EBS-RMSCO under this Agreement, upon termination of this Agreement and at the request of the Employer, EBS-RMSCO shall use its best efforts to transfer to the Employer (or successor service provider designated in writing by the Employer) such records, reports, data and information necessary for the continued administration of the Plan. The cost for transferring records, reports, data and information shall be billed to the Employer at the rate specified in Appendix A - Fees and Charges for non-routine services. If EBS-RMSCO does not receive a request to transfer such records, reports data or information by the earlier of the date 12 months after the date this Agreement is terminated or the date its obligation to retain the same ends under Section I, EBS-RMSCO shall have no further duty to retain any records, reports, data and information in its possession relating to the Plan.

VIII. Miscellaneous

1) The Employer and the Plan agree not to disclose this Agreement, or any terms of this Agreement, to any other party without EBS-RMSCO's prior written consent, except as such disclosure may be required by law.

2) Any notice given to a party under the terms of this Agreement shall be in writing and shall be delivered personally, or sent by registered mail, or by certified mail return receipt requested, to the address for that party shown above, or to any new address for that party designated by notice. Any notice that is mailed shall be deemed to have been given on the second business day after the day of mailing (not counting the day mailed), irrespective of the date of receipt.

3) All understandings and agreements previously made by and among the parties are merged in this Agreement, which alone fully and completely expresses their agreement. This Agreement may not be changed or terminated, nor any of its provisions modified or waived, except in a writing signed by all of the parties to this Agreement.

4) Headings herein are inserted for convenience of reference only and are not intended to be a part of or to affect the meaning or interpretation of this Agreement.

5) This Agreement shall be binding upon and will inure to the benefit of the parties, their heirs, distributees, legal representatives, transferees, successors and assigns.

6) All legal questions pertaining to this Agreement shall be determined in accordance with the laws of the State of New York. The venue of any action arising under this Agreement shall be in Monroe County, New York. The parties hereby waive all rights to a jury trial of any action arising out of this Agreement to the extent permitted by law.

7) This Agreement may be executed, as evidenced in Appendix A - Fees and Charges hereto, in duplicate, and each shall be deemed an original for all purposes.

From: Mark Foley [Mfoley@csdd.net]
Sent: Monday, February 14, 2011 11:45 AM
To: Keels, Lisa (HHS/OCIIO)
Subject: RE: Community Services for the Developmentally Disabled - Waiver of the Annual Limits Requirements of PHS Act Section 2711

Follow Up Flag: Follow up
Flag Status: Flagged

Lisa,

We have received this email, with your attached response. Thanks!

Mark R. Foley, President and CEO
Community Services for the Developmentally Disabled
180 Oak Street
Buffalo, NY 14203-1610
Phone - 716-883-8888, ext 120
Fax - 716-362-0720
MFoley@csdd.net
www.csdd.info

*Striving for Excellence * Supporting Partnerships * Creating Solutions * Fulfilling Dreams*

COMMUNITY SERVICES
FOR THE DEVELOPMENTALLY DISABLED

From: Keels, Lisa (HHS/OCIIO) [mailto:Lisa.Keels@hhs.gov]
Sent: Monday, February 14, 2011 11:31 AM
To: Mark Foley
Subject: Community Services for the Developmentally Disabled - Waiver of the Annual Limits Requirements of PHS Act Section 2711

Dear Mr. Foley,

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section 2711 for Community Services for the Developmentally Disabled. HHS has reviewed your application and made its determination. Please see the attached letter.

Please confirm receipt of this letter by replying to this e-mail.

Please let me know if I can be of further assistance.

Thank you again,
Lisa

Lisa M. Keels, J.D.
U.S. Department of Health & Human Services

Center for Consumer Information and Insurance Oversight
Division of Oversight
lisa.keels@hhs.gov
301-492-4168

From: Keels, Lisa (HHS/OCIIO)
Sent: Monday, February 14, 2011 12:03 PM
To: 'Mark Foley'
Subject: RE: Community Services for the Developmentally Disabled - Waiver of the Annual Limits Requirements of PHS Act Section 2711

Follow Up Flag: Follow up
Flag Status: Flagged

Thank you, Mark.

All the best,
Lisa

From: Mark Foley [mailto:Mfoley@csdd.net]
Sent: Monday, February 14, 2011 11:45 AM
To: Keels, Lisa (HHS/OCIIO)
Subject: RE: Community Services for the Developmentally Disabled - Waiver of the Annual Limits Requirements of PHS Act Section 2711

Lisa,

We have received this email, with your attached response. Thanks!

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From: Keels, Lisa (HHS/OCIIO) [mailto:Lisa.Keels@hhs.gov]
Sent: Monday, February 14, 2011 11:31 AM
To: Mark Foley
Subject: Community Services for the Developmentally Disabled - Waiver of the Annual Limits Requirements of PHS Act Section 2711

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Thank you again,
Lisa

Lisa M. Keels, J.D.
U.S. Department of Health & Human Services
Center for Consumer Information and Insurance Oversight
Division of Oversight
lisa.keels@hhs.gov
301-492-4168

From: Keels, Lisa (HHS/OCIIO)
Sent: Monday, February 14, 2011 11:31 AM
To: 'mfoley@csdd.net'
Subject: Community Services for the Developmentally Disabled - Waiver of the Annual Limits Requirements of PHS Act Section 2711
Attachments: March 1 Approval.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Mr. Foley,

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section 2711 for Community Services for the Developmentally Disabled. HHS has reviewed your application and made its determination. Please see the attached letter.

Please confirm receipt of this letter by replying to this e-mail.

Please let me know if I can be of further assistance.

Thank you again,
Lisa

Lisa M. Keels, J.D.
U.S. Department of Health & Human Services
Center for Consumer Information and Insurance Oversight
Division of Oversight
lisa.keels@hhs.gov
301-492-4168

From: Mindy Cervoni [MCervoni@csdd.net]
Sent: Tuesday, February 15, 2011 1:57 PM
To: Keels, Lisa (HHS/OCIIO)
Subject: Automatic reply: Community Services for the Developmentally Disabled - Waiver of the Annual Limits Requirements of PHS Act Section 2711

I wlll be out of the office until March 7th, 2011. If you need anything before I return, please contact Karen Bradley @ 883-8888 ext. 170. Thank you.

From: Karen Bradley [kbradley@csdd.net]
Sent: Tuesday, February 15, 2011 1:06 PM
To: Keels, Lisa (HHS/OCIIO)
Cc: Mindy Cervoni; Mark Foley
Subject: FW: Community Services for the Developmentally Disabled - Waiver of the Annual Limits Requirements of PHS Act Section 2711
Attachments: March 1 Approval.pdf

Ms. Keels,

As requested, I am responding to your email in order to confirm receipt of your letter.

Thank you,

Karen Bradley
Director of Human Resources
Community Services for the Developmentally Disabled
kbradley@csdd.net

From: Mark Foley
Sent: Monday, February 14, 2011 11:45 AM
To: Mindy Cervoni; Karen Bradley
Subject: FW: Community Services for the Developmentally Disabled - Waiver of the Annual Limits Requirements of PHS Act Section 2711

Mark R. Foley, President and CEO
Community Services for the Developmentally Disabled
180 Oak Street
Buffalo, NY 14203-1610
Phone - 716-883-8888, ext 120
Fax - 716-362-0720
MFoley@csdd.net
www.csdd.info

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From: Keels, Lisa (HHS/OCIIO) [mailto:Lisa.Keels@hhs.gov]
Sent: Monday, February 14, 2011 11:31 AM
To: Mark Foley
Subject: Community Services for the Developmentally Disabled - Waiver of the Annual Limits Requirements of PHS Act Section 2711

Dear Mr. Foley,

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Please confirm receipt of this letter by replying to this e-mail.

Please let me know if I can be of further assistance.

Thank you again,
Lisa

Lisa M. Keels, J.D.
U.S. Department of Health & Human Services
Center for Consumer Information and Insurance Oversight
Division of Oversight
lisa.keels@hhs.gov
301-492-4168

From: Keels, Lisa (HHS/OCIIO)
Sent: Tuesday, February 15, 2011 1:55 PM
To: 'Karen Bradley'
Cc: Mindy Cervoni; Mark Foley
Subject: RE: Community Services for the Developmentally Disabled - Waiver of the Annual Limits Requirements of PHS Act Section 2711

Thank you, Karen.

All the best,
Lisa

From: Karen Bradley [mailto:kbradley@csdd.net]
Sent: Tuesday, February 15, 2011 1:06 PM
To: Keels, Lisa (HHS/OCIIO)
Cc: Mindy Cervoni; Mark Foley
Subject: FW: Community Services for the Developmentally Disabled - Waiver of the Annual Limits Requirements of PHS Act Section 2711

Ms. Keels,

As requested, I am responding to your email in order to confirm receipt of your letter.

Thank you,

Karen Bradley
Director of Human Resources
Community Services for the Developmentally Disabled
kbradley@csdd.net

From: Mark Foley
Sent: Monday, February 14, 2011 11:45 AM
To: Mindy Cervoni; Karen Bradley
Subject: FW: Community Services for the Developmentally Disabled - Waiver of the Annual Limits Requirements of PHS Act Section 2711

Mark R. Foley, President and CEO
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From: Keels, Lisa (HHS/OCIIO) [mailto:Lisa.Keels@hhs.gov]
Sent: Monday, February 14, 2011 11:31 AM
To: Mark Foley
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Lisa

Lisa M. Keels, J.D.
U.S. Department of Health & Human Services
Center for Consumer Information and Insurance Oversight
Division of Oversight
lisa.keels@hhs.gov
301-492-4168

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Consumer Information and
Insurance Oversight
Washington, DC 20201

Date: November 2010

From: Steve Larsen, Director, Office of Oversight

Subject: Application for Waiver of the Annual Limits Requirements of PHS Act Section 2711

Dear Waiver Applicant:

Section 2711(a)(2) of the Public Health Service Act (PHS Act), as added by the Patient Protection and Affordable Care Act (Affordable Care Act), requires the Secretary to impose restrictions on the imposition of annual limits on the dollar value of essential health benefits (as defined in section 1302(b) of the Affordable Care Act) for any participant or beneficiary in a new or existing group health plan or a new policy in the individual market for plan or policy years beginning on or after September 23, 2010 and prior to January 1, 2014. Specifically, the Secretary is granted the authority to determine what constitutes a "restricted annual limit" that can still be imposed under such plans or policies prior to January 1, 2014.

The interim final regulations published on June 28, 2010 (codified at 26 CFR § 54.9815-2719T; 29 CFR § 2590.715-2719; and 45 CFR §147.126) established such restricted annual limits. The regulations also provided that these restricted annual limits may be waived by the Secretary of Health and Human Services (HHS) if compliance with the interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums. Pursuant to the regulation, HHS issued guidance on September 3 regarding the scope and process for applying for a waiver.

The Office of Consumer Information and Insurance Oversight, Office of Insurance Oversight received and processed your application for the plan(s) or policy(ies) year beginning February 1, 2011. We have determined that your application has met the criteria to obtain a waiver of the restricted annual limits requirements because compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies. To the extent you make any change to your benefit package after March 23, 2010, you must determine whether the change(s) will trigger loss of grandfathering status pursuant to 45 CFR §147.140(g)(1).

An approval of your request for waiver of the restricted annual limits requirements granted under this process applies only to the annual limit(s) provided in your application for the plan or policy year beginning between September 23, 2010 and September 23, 2011. This waiver only applies to the annual limits requirements in Section 2711 of the ACA and does not apply to any other requirement of the Affordable Care Act, ERISA, the IRS Code or the PHS Act. Further, a group

health plan or health insurance issuer must reapply for any subsequent plan or policy year prior to January 1, 2014 when this waiver expires in accordance with future guidance from HHS. HHS may modify this waiver approval process memorandum and other relevant information.

If you have any questions regarding this letter, please email OCIIOOversight@hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Consumer Information and
Insurance Oversight
Washington, DC 20201

Date: October 2010

From: Steve Larsen, Director, Office of Oversight

Subject: Application for Waiver of the Annual Limits Requirements of PHS Act Section 2711

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An approval of your request for waiver of the restricted annual limits requirements granted under this process applies only to the annual limit(s) provided in your application for the plan or policy year beginning between September 23, 2010 and September 23, 2011. This waiver only applies to the annual limits requirements in Section 2711 of the ACA and does not apply to any other requirement of the Affordable Care Act, ERISA, the IRS Code or the PHS Act. Further, a group

health plan or health insurance issuer must reapply for any subsequent plan or policy year prior to January 1, 2014 when this waiver expires in accordance with future guidance from HHS. HHS may modify this waiver approval process memorandum and other relevant information.

If you have any questions regarding this letter, please email OCIIOOversight@hhs.gov.