

**SUMMARY PLAN DESCRIPTION
OF THE MEDICAL BENEFITS
UNDER THE
REDDING-HUNTER, INC. HEALTH PLAN**

2025

**Summary Plan Description
of the Medical Benefits under the
Redding-Hunter, Inc. Health Plan**

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INTRODUCTION

Redding-Hunter, Inc. (the “Employer”) maintains the Redding-Hunter, Inc. Health Plan (the “Plan”) to provide health benefits for its eligible employees. This Summary Plan Description (“SPD”) presents a brief description of the Plan. It is not meant to interpret, extend, or change the official Plan document(s), including the health insurance policies or contracts issued by an insurer. If there is any conflict between this SPD and the Plan documents, the Plan documents(s) will govern your rights and benefits. Copies of the Plan documents are available for inspection in the Plan Office at Human Resources, Redding-hunter, Inc., 1089 Starr Road, Cortland, New York, 13045 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 SMMs attached when you refer to this SPD.

For purposes of this Plan, unless the context requires otherwise, whenever the masculine gender is used, it shall also be deemed to include the female gender.

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IMPORTANT PLAN INFORMATION YOU SHOULD KNOW

Plan Name:	Redding-Hunter, Inc. Health Plan
Plan Number:	503
Plan Type:	Health Insurance Plan providing dental benefits
Plan Year:	The Plan Year begins on January 1 and ends on December 31.
Employer and Plan Sponsor:	Redding Hunter Inc 1089 Starr Road Cortland, New York 13045 607-753-3331
Employer Identification Number:	15-0583652
Plan Administrator:	Redding Hunter Inc 1089 Starr Road Cortland, New York 13045 607-753-3331
Type of Plan Administration:	The Plan is insured through one or more insurers. The insurer(s) also processes claims and pays benefits. The Employer is responsible for other aspects of the Plan, such as choosing the type(s) of health insurance coverage available under the Plan, deciding requirements for eligibility to participate in the Plan, and determining the portion of insurance premiums that participants must pay. Human Resources is the primary source for information about these aspects of the Plan.

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Insurer(s):

Excellus BlueCross BlueShield
333 Butternut Drive
Syracuse, NY 13214-1803

**Plan Agent for Services
Of Legal Process:**

Redding Hunter Inc
1089 Starr Road
Cortland, New York 13045

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1. Who is eligible to participate in the Plan and when are they eligible?

Generally, to participate in the Plan you must be an employee of the Employer or an Affiliated Employer that has adapted the Plan (both are referred to herein as Employer), and satisfy the requirements described below. (The Appendix attached to this SPD lists any Affiliated Employer that has adopted the Plan.) However, any person providing services through a temporary agency, leasing organization, or independent contractor arrangement is not considered an employee eligible to participate in the Plan, 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.

An employee who satisfies the requirements above is eligible to participate in the Plan (i.e., eligible for Plan coverage) if he is expected to work at least thirty (30) hours per week for the Employer (the “hours requirement”). An employee must participate in the medical plan in order to be eligible for this dental plan.

These employees are eligible for Plan coverage on the first day of the month following the date they have satisfied the requirement(s) for sixty (60) days.

The Appendix attached to this SPD contains rules that apply to an employee whose work schedule is such that it is not certain whether he will be reasonably expected to satisfy the hours requirement (“variable hour employees”) but who satisfies the Plan’s other eligibility requirements.

2. Are there any other requirements for Plan coverage?

Yes. An employee eligible for Plan coverage must complete an enrollment form and return it to the Human Resources no later than:

- Within 30 days after he satisfies the requirements for eligibility
- Or before the end of any open enrollment period announced by the Employer

The employee must indicate his choice for the level of coverage (single, employee and spouse (or domestic partner), employee and child(ren), or family coverage) on the enrollment form. By returning a completed enrollment form, he agrees to pay his portion of the cost for Plan

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coverage through payroll deductions. If an employee does not enroll in Plan coverage during the periods described above, he may be able to enroll during special enrollment periods described in the Answer to Question 4.

3. When does Plan coverage for an employee's spouse (or domestic partner) or child begin?

Except when a special enrollment rule applies (see Question & Answer 4), if an employee's spouse, domestic partner or child satisfies all the requirements for coverage, his or her Plan coverage will begin on the date the employee's Plan coverage begins, provided the employee has enrolled the spouse, domestic partner or child for coverage.

For purposes of the Plan, "spouse" means the person to whom a participant is legally married for Federal income tax purposes. However, if the spouse is covered under the Plan but is not considered the participant's spouse for State income tax purposes, the participant will have imputed taxable income for State income tax purposes equal to the fair market value of his spouse's coverage (less any amount paid for that coverage on an after-tax basis).

For purposes of applying any Plan benefit limit or other Plan provision, if two participants are legally married to each other, the applicable insurance policy or contract may limit any benefit payable under the Plan with respect to either participant to an amount not greater than the benefit payable if that participant were not married to another participant.

For a person to be considered an employee's domestic partner for purposes of Plan coverage, the employee and domestic partner must satisfy the following requirements:

- The employee and domestic partner must share a close committed personal relationship, and have shared the same regular permanent residence for at least six (6) months.
- The employee and domestic partner must be financially interdependent.
- The employee and domestic partner cannot have a blood relationship that would bar them from marrying in the State where they reside.
- The employee and domestic partner must both be at least eighteen (18) years old.

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- The employee and domestic partner must each be the other's sole domestic partner and intend to remain so indefinitely.
- During the last six (6) months, both the employee and domestic partner must have been unmarried and neither could have had another domestic partner relationship with anyone else during that time.
- The domestic partner must not be eligible for coverage as an employee under this plan or any dental plan sponsored by his or her employer.
- The employee and domestic partner must sign and file an affidavit with the employer stating: (i) the date your domestic relationship began; (ii) that they satisfy all of the requirements above; and (iii) that they will give the employer written notice no later than thirty (30) days after the date they fail to satisfy any of the requirements above. The affidavit must also state whether the domestic partner qualifies as the employee's dependent for federal income tax purposes.

The employee and domestic partner must also provide other information and documentation that the employer may require to verify the domestic partner relationship.

The fair market value of Plan coverage for an employee's domestic partner (less any amount paid for that coverage on an after-tax basis) is treated as taxable income to the employee if the domestic partner does not qualify as a dependent under tax law. The employer will comply with all federal and state tax withholding and reporting requirements for domestic partner coverage.

An employee's child is eligible for Plan coverage:

- until the end of the calendar year in which the child reaches age 26
- if the child is unmarried and (i) is incapable of self-sustaining employment because of a mental or physical condition; (ii) became incapable of self-sustaining employment while he was covered under the Plan; and (iii) is dependent on the employee for health care, financial support and maintenance.

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Your child is:

- a newborn, natural child, or a child placed with you for adoption;
- a stepchild who receives more than one-half of his or her support from you;
- any other child for whom you have legal guardianship or court-ordered custody, provided that the child receives more than one-half of his or her support from you.

Note that a domestic partner's child is not eligible for Plan coverage unless the child qualifies as the employee's child.

For purposes of applying any Plan benefit limit or other Plan provision, the applicable insurance contract or policy may treat a child as the child of only one participant (i.e., any benefit payable under the Plan will not be greater than the benefit payable if he were the child of only one participant.)

4. What are the special enrollment periods?

- If an employee initially declines Plan coverage because he has other dental care coverage, but he later loses that other coverage through no fault of his own, he can enroll himself, his spouse (or domestic partner) and his children in Plan coverage within thirty (30) days after losing the other dental care coverage. Note, in order for this special enrollment rule to apply, at the time the employee initially declines Plan coverage he must provide, in writing, his reason for declining it.
- If an employee initially declines Plan coverage because he has other dental care coverage from another employer, but that employer stops contributing towards the cost of that other coverage, he can enroll himself, his spouse (or domestic partner) and his children in Plan coverage within thirty (30) days after that employer stops contributing toward the cost of the other coverage. Note, in order for this special enrollment rule to apply, at the time he initially declines Plan coverage he must provide, in writing, his reason for declining it.
- If an employee declines Plan coverage and he later acquires a new spouse (or domestic partner) or a new child (through birth or adoption of a child), and he wishes to cover his

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new spouse (or new domestic partner) or new child, he can enroll himself, his spouse (or domestic partner) and his children in Plan coverage within thirty (30) day period after the marriage, birth, adoption or placement for adoption.

- If an employee, his spouse (or domestic partner) or his child loses eligibility for Medicaid coverage or coverage under a State Children's Health Insurance Program, he can enroll himself, his spouse (or domestic partner) and his children in Plan coverage within sixty (60) day period following the loss of that coverage.
- If an employee, his spouse (or domestic partner), or his child becomes eligible to participate in a premium assistance program under Medicaid or a State Children's Health Insurance Program, he can enroll himself, his spouse (or domestic partner) and his children in Plan coverage within the sixty (60) day period following the eligibility determination.

5. How much must participants pay for Plan coverage?

- Participants are required. To pay for Plan coverage they select. The following chart shows their cost for coverage.

Option	Monthly Premium	Employer Contribution	Employee Cost
Single	598.22	497.34	100.88
Subscriber & Children	1016.96	549.46	296.01
Subscriber & Spouse	1196.43	849.46	346.97
Family	1704.90	1163.41	541.49

If there are ordinary increases or decreases in participants' costs for coverage, their payroll deductions will automatically be adjusted to reflect the change in cost. The Employer will provide advanced written notice of any cost changes.

6. When can a participant change his Plan coverage?

In general, once a participant has enrolled (or decided not to enroll) in the Plan and selected his level of Plan coverage, he cannot change his decision until an open enrollment period,

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which is usually just before the next Plan year. However, he may be able to change his enrollment decision, and/or his type or level of coverage, if any event occurs that entitles him to enroll during a special enrollment period (see Question & Answer 4). He may also be able to make a change if any of the following occurs during a Plan year:

- a change in health coverage available through his spouse's (or domestic partner's) employment
- a change in his legal marital status (e.g., through marriage, divorce, legal separation, annulment or death of spouse)
- his domestic partner relationship terminates (i.e., the date he and his domestic partner no longer satisfy the requirements listed in Answer to Question 3).
- a change in his employment status, or the employment status of his spouse (or domestic partner) or child
- a change in the number of his children eligible for coverage
- his residence changes to a place outside the area for the type of coverage he chose
- a change in his work schedule or the schedule of his spouse (or domestic partner) or his child (e.g., an unpaid leave of absence, switch between full-time and part-time, or a strike or lockout)
- the coverage he chose is eliminated or is significantly curtailed
- the cost of the coverage he chose significantly increases

Contact Human Resources immediately if any of these events occurs and you want to change your enrollment decision and/or your type or level of coverage. Even if you can make the change you desire; you will have a limited period of time after the event (30 days) to make it.

An employee can also revoke his Plan coverage at any time.

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7. What insurance is available to a Plan participant?

One or more types of health insurance coverage are available from Excellus BlueCross BlueShield. The insurer guarantees benefits under the insurance it provides, and is responsible for processing claims and paying benefits. Descriptions of the benefits available under each type of insurance coverage are contained in the benefit booklets and other materials which should accompany, and are part of, this SPD. You should also receive a “Summary of Coverage and Benefits” with this SPD. If you do not have the booklets, materials and Summary of Coverage and Benefits, you should request them from Human Resources.

Also see benefit summary and prescription drug information attached to this SPD.

The Employer does not guarantee that every employee, his spouse (or domestic partner) and children will be eligible for health insurance. To obtain and continue insurance coverage, you must meet any requirements imposed by the insurer. You should refer to the benefit booklets and summaries for such requirements.

8. When does an employee’s Plan coverage end?

Unless he is eligible for and elects COBRA coverage (see Answer to Question 17 for an explanation of COBRA coverage), his Plan ends on:

- the last day of the month in which his employment terminates or he no longer satisfies the eligibility requirements for Plan coverage
- the last day of the month for which he paid his cost for Plan coverage

9. When does Plan coverage for a spouse (or domestic partner) or child end?

Unless the spouse or child is eligible for and elects COBRA coverage (see Question & Answer 17 for explanation of this coverage), his or her coverage under the Plan will end on the earlier of:

- the date the employee’s Plan coverage ends
- the date as of which the employee removes the spouse or child from coverage

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- in the case of the employee's spouse, upon divorce
- in the case of a child, when he or she no longer qualifies as a child for purposes of the Plan (See Question & Answer 3)

Plan coverage for a domestic partner will end on the earlier:

- the date the employee's Plan coverage ends;
- the date of which the employee removes his domestic partner from Plan coverage
- the date the domestic partner relationship terminates (i.e., the date the domestic partner requirements listed in the Answer to Question 3 are no longer satisfied)

Note that employees' domestic partners are not eligible for COBRA coverage

10. Can a person's Plan coverage be rescinded?

Consistent with Federal law, a person's coverage under the Plan may be rescinded (i.e., retroactively cancelled or discontinued) if the person (or 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 advanced 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.

11. What happens when an employee retires?

Retirement is treated as the termination of employment and his Plan coverage will end as described above. (See the question 8 "When does an employee's Plan coverage end?")

12. What happens if an insurer pays or provides a benefit that it should not have paid or provided?

Depending on applicable law and the applicable policy, if payments are made, or benefits

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are provided, by an insurer which exceed the applicable insurance policy's benefit limits, or are inconsistent with some other policy provision, the insurer *may* be able to recover the excess amount paid, or value of the benefit provided, from the person who received the payment or benefit, the person for whom the payment was made or the benefit was provided, or from any other insurer or other party that should pay the expense or provide the benefit. The insurer may also have other rights under the policy.

13. What happens if an insurer pays a benefit for a participant, spouse, domestic partner, or child relating to an injury, sickness or condition caused by another person?

Depending on applicable law and the applicable policy, the insurer *may* be subrogated to any right the participant, spouse, domestic partner or child (or his or her legal representative, heirs or beneficiaries) have against the person(s) who caused the injury, sickness or condition, and the insurer may require the participant, spouse, domestic partner or child (and his legal representative, heirs or beneficiaries) to sign an agreement acknowledging these subrogation rights as a condition to receiving payment from insurer.

14. Who decides what insurance coverage is available under the Plan and who is eligible to participate in the Plan?

The Employer has the power and discretion to: change the terms of the Plan (including rules for eligibility to participate); change the type of insurance coverage available under the Plan; decide issues of fact relevant to the eligibility of a person to participate in the Plan; administer the Plan; interpret any ambiguous or uncertain provision of the Plan; and reconcile any inconsistency that may appear in the Plan. However, neither the Employer nor the Plan Administrator has the power to change to interpret the insurance policy through which dental coverage is provided. Only the insurer can change the policy and make determinations on when and what benefits are payable under the policy.

15. Can the Employer ever amend or terminate the Plan?

Yes. The employer maintains the Plan on a voluntarily basis and has the right to amend or terminate the Plan, and terminate any insurance coverage provided under the Plan, any time with respect to any individual, group, or class of employees or former employees. No person ever has a vested right to insurance coverage.

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

If you have questions about eligibility under the Plan or cost of insurance coverage, you should contact Human Resources, Redding Hunter Inc, 1089 Starr Rd, Cortland, New York, 13045, (607) 753-3331. If you have questions about specific benefits under your dental insurance, you should contact:

Excellus BlueCross BlueShield
333 Butternut Drive
Syracuse, New York 13214-1803

The insurer is responsible for processing claims and paying benefits. If you believe you are entitled to specific benefits you should submit a benefit claim directly to the insurer at the following address.

Excellus BCBS
PO Box 22999
Rochester, New York 14692

The claim procedures are different for “concurrent claims,” “pre-service claims,” “post-service claims,” and “urgent claims.” A concurrent claim is a request for an extension of health treatment (i.e., treatment provided over a period of time or a number of treatments). A pre-service claim is a claim requiring advance approval to receive all or part of the benefit. A post-service claim is any claim that is not a preservice claim. An urgent claim is any claim for medical care or treatment that, of non-urgent claim procedures were followed, could seriously jeopardize the life or health of the patient or his ability to regain maximum function, or in the opinion of a physician with knowledge of the patient’s medical condition would subject the patient to severe pain that cannot be adequately managed without care or treatment requested.

You may appoint someone to file a claim on your behalf; provided you give the Plan signed written notification of the appointment. In case of an urgent claim, a health care professional with knowledge of your medical condition will be permitted to act as your representative.

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Post-service claims must be filed within 90 days after the service or expense claimed was incurred. All claims must be filed on forms provided by the insurer and submitted by mail, except urgent claims may be made orally and information may be transmitted to Excellus BlueCross BlueShield, by telephone 800-724-1675 or by facsimile 315-671-7077, provided that any necessary written forms are later completed and filed.

If you make a request for benefits that does not comply with the Plan's procedure for pre-service claims, you will be notified of the proper procedure within 24 hours if it involves an urgent pre-service claim, or within five days if it involves a non-urgent pre-service claim. (This notification may be oral, unless you request written notification.)

If a claimant fails to submit sufficient information for a determination on an urgent claim, he will be notified of the specific information necessary to complete the claim within 24 hours after the Plan receives the claim. He may then submit the additional information within 48 hours, and will be notified of the determination on his claim within 48 hours after the earlier of the receipt of the additional information or the end of the period the additional information could have been submitted.

A claimant will be notified of the determination on his claim within: 24 hours in the case of a concurrent claim involving urgent health care if the request is received at least 24 hours before the scheduled expiration of the treatments; 72 hours in the case of any urgent claim (or earlier if possible); 15 days in the case of non-urgent pre-service claim; or 30 days in the case of a post-service claim. However, if an extension to make a determination on a non-urgent claim is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to another 15 days. In that case, the claimant will receive written notice of the reasons for the extension, an additional information required from him to make the determination, and the date the determination is expected. Also, if the extension is necessary because additional information is needed from the claimant, the claimant will be given 45 days from the date he receives the notice to provide the information.

In an adverse determination is made, the claimant 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) the names of any medical or vocational experts whose advice was obtained by the Plan on connection with the determination; (iv) a description of any

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additional material or information necessary to complete the claim and an explanation of why it is necessary; (v) a description of the Plan's review procedures and time limits; (vi) a statement that the claimant has a right to sue under the Employee Retirement Income Security Act following an adverse determination upon review; (vii) if the Plan relied upon an internal rule, guideline, protocol or similar criterion in making the determination, either the criterion relied upon or a statement that the Plan relied upon such criterion and that copy of the criterion is available free of charge upon request; (viii) if the determination was based upon a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for the determination (applying the terms of the Plan to the claimant's medical circumstances), or a statement that such explanation will be provided free of charge upon request; and (ix) for urgent claims, a description of the expedited review procedure for such claims. This notice may be provided orally for an urgent claim, but will be sent to the claimant in writing within three days after oral notification.

Within 180 days after receiving an adverse determination, a claimant may file a written appeal to the Customer Advocate Division of Excellus BlueCross BlueShield for a full and fair review of the claim and determination. He 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. For an urgent claim, the claimant may request, in writing or orally, an expedited review of the initial determination, and information may be transmitted by telephone to Excellus BlueCross BlueShield by telephone 800-724-1675 or by facsimile 315-671-7077, provided that any necessary written forms are later completed and filed.

A reduction or termination of health treatment (other than by Plan amendment or termination) will be treated as an adverse determination, and the participant or beneficiary will be notified sufficiently in advance to allow him to appeal before the reduction or termination occurs.

The review on appeal will take into account all documents, records and information submitted by the claimant, and will be conducted by an appropriate named fiduciary who did not make the initial determination and who is not a subordinate of the person who did. For a claim based on medical judgement (e.g., whether a treatment or drug is experimental,

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investigational, or medically necessary or appropriate), the person conducting the review will consult with a state licensed or certified independent health care professional with appropriate training and experience in the field who was not consulted in connection with the initial determination and is not a subordinate of any health care professional who was consulted.

The claimant will be notified of the determination on review within 72 hours after the Plan receives the request for review of an urgent claim (or earlier if possible), 30 days after the Plan receives a request for review of a non-urgent pre-service claim, or 60 days after the Plan receives a request for review of a post-service claim.

The 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, the claimant is entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; (iv) if the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination, either 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; (v) if the determination is based upon a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; (vi) a statement that the claimant has a right to sue under the Employee Retirement Income Security Act; and (vii) 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."

External Claim review Procedure

An external claim review procedure applies to adverse benefit determinations and final internal adverse benefit determinations. Contact the appropriate insurer (Excellus BlueCross BlueShield) or information on how to make a request for an external claim review and other external claim review procedures.

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17. What additional rights does a participant have?

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

Health Insurance Portability and Accountability Act of 1996

You may be entitled to commence, continue, suspend and recommence participation in this Plan in accordance with your right under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"). Information concerning your HIPPA rights is available from Human Resources, Redding Hunter Inc, 1089 Starr Road, Cortland, New York, 13045, (607) 753-3331.

Family and Medical Leave Act

If the Employer is subject to the Family and Medical Leave Act ("FMLA") and you are covered under the Plan immediately before you take an FMLA Leave, you may continue Plan coverage during the FMLA Leave, provided you would have been continuously employed during the entire FMLA Leave and you pay the participant cost for Plan coverage during the FMLA Leave. Plan coverage will continue as if you were actively employed by the Employer until the earlier of the date (i) the FMLA Leave ends or (ii) you notify the Employer that you will not return to work. If you choose not to continue Plans coverage during an FMLA Leave, you may resume Plan coverage when you return to work, provided you return when the FMLA Leave expires and you are still eligible to participate in the Plan (see Question and Answer 1).

You are also eligible to elect COBRA coverage after the FMLA Leave if you:

- were covered under the Plan on the day before FMLA Leave,
- do not return to work at the end of the FMLA Leave, and
- would otherwise lose coverage under the Plan

You may also elect COBRA coverage even if you chose not to continue regular Plan coverage

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during the FMLA Leave, or you stop paying your cost for Plan coverage during the FMLA Leave. Information concerning your right to and obligations during an FMLA Leave is available from Human Resources, Redding Hunter Inc, 1089 Starr Road, Cortland, New York, 13045, (607) 753-3331.

HIPPA Privacy Rights

The Plan has responsibilities under Health Insurance Portability and Accountability Act ("HIPPA") 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 clearing house; 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 you 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 Ms. Sherri D. Beebe, Redding Hunter, Inc., 1089 Starr Road, Cortland, New York, 13045, phone (607) 753-3331 or fax (607) 756-8445.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Woman's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy- related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;

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- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. If you would like more information on WHCRA benefits, call Human Resources at (607) 753-3331.

Newborn Mothers and Minimum Maternity Stay

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you choose to leave the hospital earlier, your inpatient coverage will be extended to include at least one home care visit.

Also, under Federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain provider or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact the Plan administrator.

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COBRA Continuation Coverage

You may have a right under “COBRA” to continue to participate in the Plan after you would otherwise lose coverage under the Plan by continuing to make payments to the Plan, plus administrative charge, on an 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 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 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;

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- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separate from your spouse.

Note that employees' domestic partners are not eligible for COBRA coverage.

Your 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-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 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 child's losing eligibility for coverage), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources, Redding-Hunter, Inc., 1089 Starr Road, Cortland, New York, 13045, (607) 753-3331. The notice must be in writing, and must contain your name and address, the name and address of any affected persons, a description of the qualifying event, and the date of the qualifying event. You may be asked to provide additional documentation after you have submitted the notice.

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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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation, or loss of a child's eligibility, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled and you provide proper and timely notice of the SSA determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last until the end of the 18-month period of continuation coverage. You must provide this notice to Human Resources, Redding-Hunter, Inc., 1089 Starr Road, Cortland, New York, 13045, (607) 753-3331 within 60 days of the date of the SSA determination and before the end of the 28-month period of COBRA continuation coverage. The notice must be in writing, and must contain your name and address, the name and address of the disabled qualified

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beneficiary, and the date the disability was determined to have begun. You must also attach a copy of the SSA determination. You may be asked to provide additional documentation information after you have submitted the notice.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage and you provide proper and timely notice of the second qualifying event, the spouse and children in your family may be entitled to up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse or any children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the child stops being eligible under the Plan, but only if the event would have caused the spouse to lose coverage under the Plan had the first qualifying event not occurred. You must provide this notice to Human Resources, Redding-Hunter, Inc., 1089 Starr Road, Cortland, New York, 13045, (607) 753-3331 within 60 days after the second qualifying event. The notice must be in writing, and must contain your name and address, the name and address of any affected persons, a description of the second qualifying event, and the date of the second qualifying event. You may be asked to provide additional documentation or information after you have submitted the notice.

If You Have Questions

Questions concerning your Plan or your COBRA continuation 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. (Address 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

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any changes in the address 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:

Redding-Hunter, Inc. Health Plan
Human Resources
Redding Hunter Inc
1089 Starr Road
Cortland, New York 13045
(607) 753-3331

Uniformed Services Employment and Reemployment Rights Act

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 continuation coverage under the Plan if the employee is covered under the Plan when the period of military service begins, and certain other requirements are satisfied. For example, the period of military service generally cannot exceed five years, and the employee (or an appropriate officer) must give advance oral or written notice of the absence to the Employer as early as is reasonable under the circumstances, unless notice is prevented by military or is otherwise impossible or unreasonable under the circumstances.

An employee entitled to USERRA continuation coverage may elect continuation coverage (for him/herself and him/her covered spouse and covered children) for a period of up to 24 months. 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 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.

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All election and premium payment procedures, rules and deadlines for USERRA continuation coverage under the Plan are the same as the COBRA continuation coverage election and premium payment procedures, rules and deadlines, except to the extent any of those procedure, 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).

New York State Insurance Law

Under New York State Insurance Law, if a child has reached the maximum age for child coverage under the Plan he may be entitled to extended health insurance coverage until he reaches age 30 ("New York extended child coverage"). This coverage is provided directly by the insurer directly to the child.

To be eligible for New York extended child coverage, the child must be unmarried and satisfy certain other requirements. If you have reached, or are about to reach, the maximum age for child coverage under the Plan and are interested in New York extended child coverage, you should contact the insurer providing your parent's health coverage for more information.

Under New York State Insurance Law. If the maximum period a person is entitled to federal COBRA continuation coverage is less than 36 months and he receives federal COBRA continuation coverage. through that period. He may be entitled to continued health insurance coverage under New York law ("New York continuation coverage"). The maximum period of combined federal COBRA continuation coverage and New York continuation

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coverage is 36 months. For example, if your maximum federal COBRA continuation coverage period is 18 months, the longest New York continuation coverage would be available is another 18 months. Note that the same circumstances and events would trigger termination of a person's federal COBRA continuation coverage also trigger termination of New York's continuation coverage. The cost for New York continuation coverage is equal to 102% of the full premium for insured health coverage and must be paid by the person receiving the New York continuation coverage.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is an order by a court for one 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 Plan Administrator.

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:

Receive Information About Your Plan and Benefits

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

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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 the 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 don 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 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 right, you may seek assistance from the U.S. Department of

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Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. Of 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 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 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 publication about your rights and responsibilities under ERISA by calling the publications hotline of the Employee benefits security Administration.

Participating Provider Information

To access current Participating Provider Information free of charge, go to the following website:

Excellus BlueCross BlueShield – www.excellusbcbs.com

Or you may contact Human Resources to request a copy of the Participating Provider List, free of charge.

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APPENDIX

VARIABLE HOUR EMPLOYEE RULES

The following rules apply to an employee whose work schedule is such that it is not certain whether he will be reasonably expected to satisfy the hours requirement but who satisfies the Plan's other substantive eligibility requirements.

- If he is a newly hired employee and he works an average of at least thirty (30) hours per week for the Employer during the twelve (12) consecutive month period commencing on the first of the month coinciding with or immediately following his date of hire (his "initial measurement period"), he is eligible for Plan coverage during twelve (12) consecutive months beginning with the second month following his initial measurement period (if he continues to satisfy the Plan's other substantive eligibility requirements).
- Whether or not he is a newly hired employee, if he works an average of at least thirty (30) hours per week for the Employer during the twelve (12) consecutive months beginning on the first day of any November (the "standard measurement period"), he is eligible for Plan coverage during the twelve (12) consecutive month period beginning on the first day of the Plan year following that standard measurement period (if he continues to satisfy the Plan's other substantive eligibility requirements).
- If his employment changes during his initial measurement period or a standard measurement period such that, thereafter, he is reasonably expected to satisfy the hours requirement, he is eligible for Plan coverage on the first day of the month following the change (and until he no longer satisfies the Plan's substantive eligibility requirements).
- An employee will not be considered a newly hired employee once he has been an employee for a full standard measurement period, unless he: (i) stops providing serviced to the Employer for a period of at least 13 consecutive weeks; and (ii) later starts

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providing services for the Employer again (in which case he will be considered a newly hired employee when he starts providing services for the Employer again).

- All hours for which an employee is paid are considered hours worked. If an employee is on an unpaid leave during a measurement period on account of jury duty or an unpaid leave subject to the Family and Medical Leave Act of 1993 (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the period of unpaid leave is excluded when determining whether he averaged the required number of hours during that measurement period.

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BENEFIT SUMMARY

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PRESCRIPTION DRUG FORMULARY INFORMATION