Consolidated® communications

ILEC Pennsylvania Bargaining

2024
Benefit Guide

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal Law gives you choices about your prescription drug coverage. Please see page 25 for more details.

Benefits Overview

Consolidated Communications is proud to offer a comprehensive benefits package to all eligible, full-time ILEC Pennsylvania Bargaining employees who work at least 30 hours per week. The complete benefits package offered by Consolidated Communications is briefly summarized in this booklet. Consolidated Communications also has two great resources that are there to help you and your family understand and effectively use the benefits.

PLANselect

Simplify benefits research and selection with a guided experience. Consolidated Communications' virtual benefits guide, PLANselect, will help you understand your medical options, select the best plan for your personal situation and help you to understand the cost impact. Use the information you provide and your zip code to customize cost projections, PLANselect will derive a value score for each health plan option.

You can find the link to PLANselect on your benefit enrollment page: PeopleSoft > Employee Self-Service > Benefit Details > Benefits Enrollment > Medical.

Employee Benefits Website

We encourage our employees and families to become familiar with and use the resources offered on the customized Consolidated Communications Benefits Website as often as possible. You will find that almost all of your questions and concerns can be addressed with a simple click of a mouse!

On this website, you will find detailed information about our current employee benefits program as well as all of the necessary benefit summaries, claim forms, enrollment forms, customer service numbers, frequently asked questions, and direct links to your online provider network directories.

To access the Consolidated Communications Benefits Website and for more information on your benefits, please visit https://c2mb.ajg.com/ccinb/home/.

PeopleSoft eBenefits Online Enrollment

Enrolling online is easy! Simply log into PeopleSoft using your User ID and password. From the Main Menu, select Employee Self Service > Benefit Details > Benefits Enrollment.

- Select the links under the Benefits Enrollment menu to review, enroll in, or change plan options. The per pay period cost is displayed for each option.
- Once your elections have been made, click the "Done" button to save your changes for processing.
- The enrollment is not complete until you click the "Submit Enrollment" button to finalize your elections.
- Upon completion, a Benefit Statement will be generated in PeopleSoft to review your elections, PeopleSoft > Employee Self Service > Benefit Details > Benefit Statements.

Eligibility

You and your dependents are eligible for benefits with Consolidated Communications on the first of the month following date of hire.

Eligible dependents are your spouse, children up to age 26, or disabled dependents of any age.

Elections made now will remain until the next annual enrollment unless you or your family members experience a status change event. If you experience a qualified status change event, you must contact HR within 31 days.

Qualified life or family status changes are defined as:

- Marriage, divorce, or legal separation
- Gain or loss of an eligible dependent for reasons such as birth, adoption, court order, disability, death, marriage, or reaching the dependent-child age limit
- Changes in your dependent's employment affecting benefit eligibility
- Changes in your dependent's benefit coverage with another employer that affects benefit eligibility

Benefit Plans Offered:

- 401(k)
- Accident Plan
- Auto and Home Insurance
- Basic Life & AD&D
- Benefits Value Advisor with Rewards
- Critical Illness
- Dental
- Employee Assistance Program
- Flexible Spending Account (FSA)
- Funeral Planning
- Health Savings Account (HSA)
- Holidays/Vacation/Personal Days
- Identity Theft & Card Monitoring
- Long-Term Disability
- Telehealth
- Medical and Rx
- Musculoskeletal Virtual Program
- Pharmacy Advocate
- Pre-Tax Parking Benefit
- Short-Term Disability
- Supplemental AD&D
- Supplemental Life
- Travel Assistance
- Tuition Assistance Program
- Vision
- Wellness

This document is an outline of the coverage provided by the carrier(s) contracted with CCI. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy documents will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be directed to the insurance carrier or to HR Services.

Medical Benefits

Insured by BlueCross BlueShield of Texas (BCBSTX)

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses, but identifying the problems early, they can often be treated at little cost. Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through Consolidated Communications, Inc. We offer three plan options administered by BlueCross BlueShield of Texas. All three plans provide access to the BlueCross BlueShield nationwide PPO network. With any one of these medical options, you may select where you receive your medical services.

How the Plan Works

Benefits for most services require that you pay a deductible each year for in-network provider services and a higher deductible each year for out-of-network providers' services. Once you have met your deductible, you share the cost of your care through coinsurance. In some instances, BCBSTX can require precertification of medical necessity before certain medical and/or surgical services are provided. In other words, BlueCross BlueShield of Texas must approve the need for the care before you seek it.

The charts in this booklet display only In-Network coverage. For out-of-network benefits, refer to your Summary of Benefits and Coverage or Summary Plan Description, located on the Employee Benefits Website. Keep in mind that your health plan pays based upon the allowed price for services and supplies. In-network providers agree to accept the allowed price as payment in full. When you use out-of-network providers, you must pay the difference between the allowed price and the provider's charge in addition to any deductibles and coinsurance amounts that may apply. When you utilize an In-Network or Participating Provider, you avoid balance billing other than applicable deductibles, coinsurance and/or copayments and out-of-pocket maximums. Reimbursement for out-of-network services may be based on a "reasonable and customary (R&C)" or "usual, customary, and reasonable (UCR)" amount, such as 80% of R&C or 80% of UCR, or based on some percentage (110%-150%) of Medicare. Because there is no contract between the plan and the non-participating provider, the non-participating provider is not obligated to accept the plan's allowance as "reasonable and customary" and may bill you for any balance. *Please note, these differentials can be substantial and will result in significant additional out-of-pocket costs.*

Provider Finder® Supports Choice and Access

Find a provider that's right for you

Use Provider Finder – it's a quick and easy way to locate doctors and hospitals in your network. Make more informed health care decisions by viewing clinical quality ratings from BCBSTX as well as independent third parties.

Filter search results by provider type, specialty, ZIP code, language and gender. Get directions from Google Maps, too. It's now faster and simpler to do than ever before!

Online

Go to www.bcbstx.com and click on Find a Doctor from the home page. The improved search experience means you need fewer clicks and required fields to get your results!

On your mobile device

Either download the BCBS TX app, or go to www.bcbstx.com and click on Find a Doctor or Hospital. Register or log in to Blue Access for Members to stay connected to claims, your ID card, coverage, prescription reminders and health tips via text messages.

On the phone

You can also call a BCBSTX Customer Service Advocate at the toll-free telephone number on the back of your BCBSTX member ID card for help in locating a provider. The customer service number is 800.521.2227.

Pharmacy Advocate Program

Tria Health

Tria Health is a free and confidential benefit available for all members enrolled in the BCBS medical plans. If you have a chronic condition or take multiple medications, Tria Health's pharmacists are ready to support you in managing your health. Talk to a pharmacist over the phone and receive the personalized care you deserve.

By talking to a Tria Health pharmacist, you'll also receive these savings:

- Free generics on qualifying medications
- Reduced costs on select brand medications
- Free blood glucose meter & test supplies
- Free blood pressure cuff

To schedule your first appointment, visit www.triahealth.com/schedule or call 1.888.799.8742 to speak with a Tria Health member advocate.

BCBSTX Medical Plan Options

	HDP Plan	Low Premium HDP Plan (LPHDP)
	In-Network Benefits	In-Network Benefits
Calendar Year Deductible	$3,500 Single $7,000 Family (Aggregate)	$5,000 Individual $10,000 Family (Embedded)
Medical Out-of-Pocket Maximum (includes deductible)	$4,000 Single $8,000 Family	$5,000 Individual $10,000 Family
Prescription Drug Out-of-Pocket Maximum	N/A - combined with Medical	N/A - combined with Medical
Coinsurance	80%	100%
OFFICE VISITS		
Preventive Care	100%, no deductible	100%, no deductible
Primary Care Physician or Specialist	80% after calendar year deductible	100% after calendar year deductible
EMERGENCY MEDICAL SERVICES		
Urgent Care	80% after calendar year deductible	100% after calendar year deductible
Emergency Room	80% after calendar year deductible	100% after calendar year deductible
INPATIENT/OUTPATIENT FACILITY EXPENSES		
Inpatient Hospital Facility Expenses	80% after calendar year deductible	100% after calendar year deductible
Outpatient Surgery and Other Services	80% after calendar year deductible	100% after calendar year deductible
PHARMACY BENEFIT - BLUECROSS BLUESHIELD ADMINISTERED BY PRIME THERAPEUTICS		
Tier 1 – Generics		
Retail (30 day supply) Retail (90 day supply at participating pharmacies) Mail Order (90 day supply) Specialty (30 day supply)	You pay 20% once your medical deductible has been met.	You pay 0% once your medical deductible has been met.
Tier 2 – Preferred Brand		
Retail (30 day supply) Retail (90 day supply at participating pharmacies) Mail Order (90 day supply) Specialty (30 day supply)	You pay 20% once your medical deductible has been met.	You pay 0% once your medical deductible has been met.
Tier 3 – Non-Preferred Brand		
Retail (30 day supply) Retail (90 day supply at participating pharmacies) Mail Order (90 day supply) Specialty (30 day supply)	You pay 20% once your medical deductible has been met.	You pay 0% once your medical deductible has been met.

EMPLOYEE BI-WEEKLY CONTRIBUTIONS (24 PAY PERIODS)		
Employee Only	$59.46	$28.07
Employee + Spouse	$140.94	$77.72
Employee + Child(ren)	$126.84	$69.95
Employee + Family	$197.31	$108.81
HSA Contribution (Employee Only)	$312.50 per year (pro-rated for new enrollments)	
HSA Contribution (Employee + Dependents)	$625.00 per year (pro-rated for new enrollments)	
Wellness Credit*	$648 per year ($27 bi-weekly for 24 pay periods)	

*Wellness credit will not exceed the employee's bi-weekly contributions

BCBSTX Medical Plan Options Continued

	PPO Plan
	In-Network Benefits
Calendar Year Deductible	$2,500 Individual $5,000 Family (Embedded)
Medical Out-of-Pocket Maximum (includes deductible)	$5,000 Individual $10,000 Family
Prescription Drug Out-of-Pocket Maximum	$2,500 Individual $5,000 Family
Coinsurance	80%
OFFICE VISITS	
Preventive Care	100%, no deductible
Primary Care Physician or Specialist	$35 copay
EMERGENCY MEDICAL SERVICES	
Urgent Care	$35 copay
Emergency Room	80% after calendar year deductible
INPATIENT/OUTPATIENT FACILITY EXPENSES	
Inpatient Hospital Facility Expenses	80% after calendar year deductible
Outpatient Surgery and Other Services	80% after calendar year deductible
PHARMACY BENEFIT - BLUECROSS BLUESHIELD ADMINISTERED BY PRIME THERAPEUTICS	
Tier 1 – Generics	
Retail (30 day supply)	You pay 10% ($50 maximum)
Retail (90 day supply at participating pharmacies)	You pay 10% ($50 maximum)
Mail Order (90 day supply)	You pay 10% ($50 maximum)
Specialty (30 day supply)	You pay 10% ($150 maximum)
Tier 2 – Preferred Brand	
Retail (30 day supply)	You pay 20% ($50 maximum)
Retail (90 day supply at participating pharmacies)	You pay 20% ($100 maximum)
Mail Order (90 day supply)	You pay 20% ($100 maximum)
Specialty (30 day supply)	You pay 20% ($150 maximum)
Tier 3 – Non-Preferred Brand	
Retail (30 day supply)	You pay 40% (no maximum)
Retail (90 day supply at participating pharmacies)	You pay 40% (no maximum)
Mail Order (90 day supply)	You pay 40% (no maximum)
Specialty (30 day supply)	You pay 40% (no maximum)

EMPLOYEE BI-WEEKLY CONTRIBUTIONS (24 PAY PERIODS)	
Employee Only	$105.46
Employee + Spouse	$231.48
Employee + Child(ren)	$208.34
Employee + Family	$324.08
Wellness Credit	$648 per year ($27 bi-weekly for 24 pay periods)

Medical Benefits

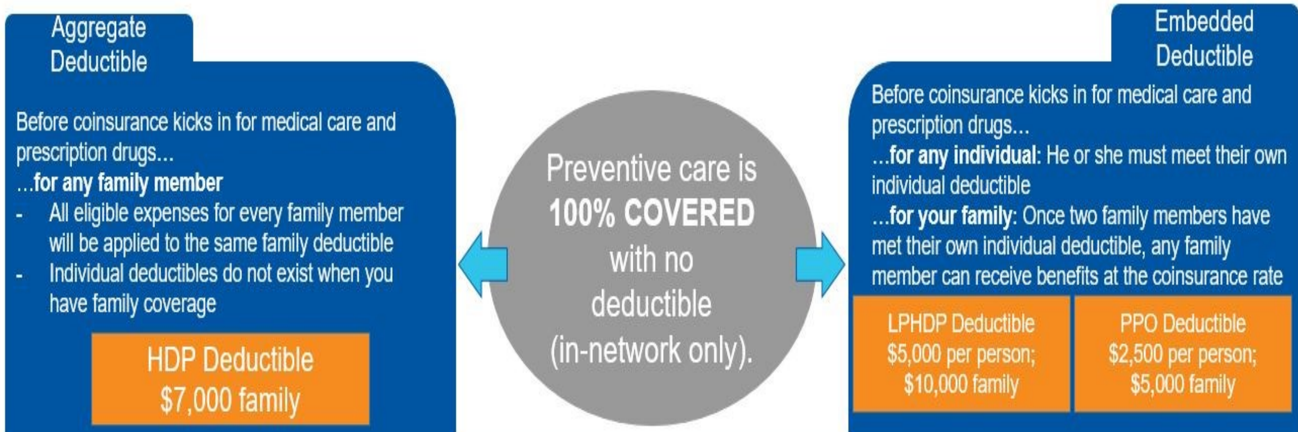
Administered by BlueCross BlueShield of Texas (BCBSTX)

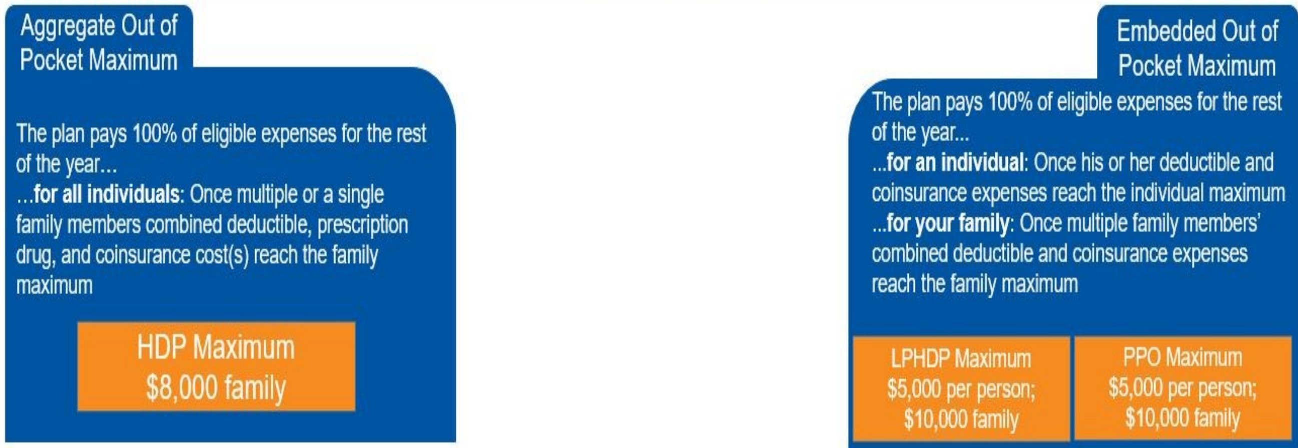
If You Cover Dependents

There are two types of deductibles for family coverage, and knowing which one you have and how it works will help you plan for out-of-pocket health care expenses. Plans with family coverage can have either an embedded or an aggregate deductible.

The HDP plan has an **aggregate** deductible: Expenses of all covered family members (even just one) are also combined to meet an aggregate family out of pocket maximum.

The PPO and LPHDP plans have an **embedded** deductible: Each covered individual must meet a per-person deductible. When a family member meets his or her own deductible, the insurance company will begin paying according to the plan's coverage for that member. If only one member meets an individual deductible, the rest of the family still has to pay their deductibles. Once multiple family members together meet the family deductible, any family member can receive benefits. You meet the out-of-pocket maximum the same way you meet the deductible.





Pharmacy Benefits

BlueCross BlueShield (Administered by Prime Therapeutics)

- Visit bcbstx.com to view medicines, find pharmacies and view your prescription history
- BCBSTX offers a large network of participating retail pharmacies
- The 90DayMyWay program offers a 90 day supply of most maintenance medications at the same price as mail order when filled at an Extended Supply Network retail pharmacy
- Certain medications may be subject to quantity limits, step therapy, or prior authorization requirements

Mail Order

- Convenient home delivery services are provided by Express Scripts Pharmacy. Visit express-scripts.com/rx

Specialty Medications

Payer Matrix

Most Specialty Branded medications will be managed by Payer Matrix. Payer Matrix is a team of dedicated healthcare professionals who have partnered with Consolidated Communications to reduce the cost of your high dollar specialty prescription drugs. We advocate on your behalf with the pharmaceutical manufacturer. Our Reimbursement Care Coordinators facilitate the process and coordinate with multiple entities to lower the cost of your specialty prescription drugs. A Reimbursement Care Coordinator will be assigned to work directly with you to complete the necessary paperwork to enroll you in the patient assistance program. Members end up paying little to nothing out of their own pocket once they are admitted into our programs in the majority of cases.

For more information on targeted medications and the program, please contact 877.305.6202 or email customerservice@payermatrix.com.

For all other specialty medications not managed by Payer Matrix, please contact Accredo. Visit accredo.com or call 833.721.1619.

Benefits Value Advisor with Member Rewards

BlueCross BlueShield of Texas (BCBSTX)

To help you get the most of your medical benefits with quality and cost-effective care, use the Benefits Value Advisor, a support tool from BlueCross BlueShield of Texas. It's a one-call solution designed to help you make smart choices and save money. To reach a Benefits Value Advisor, call 800.521.2227 for help with health care services.

Benefits Value Advisor can also:

- Help you understand your benefits
- Estimate costs for services or procedures
- Schedule appointments
- Provide information on your condition or diagnosis
- Help you take advantage of Member Rewards incentives
- Assist with pre-authorization
- Tell you about online educational tools

Member Rewards

Member Rewards works together with the Benefits Value Advisor to help you become an efficient shopper of health care services. Take the time to shop around before receiving a procedure and get cash rewards for your efforts. Not only will you be rewarded for shopping, but you may lower your out-of-pocket expenses as well.

- Call the Benefits Value Advisor using the number on the back of your ID card to compare costs and quality for a number of procedures
- Select a lower-cost, quality provider from the selected in-network list
- Earn cash rewards after your procedure is completed and verified
- Per IRS regulations participants earning $600+ Member Rewards in one calendar year will receive tax Form 1099

Note: Participation in Member Rewards does not change any prior authorization requirements on the plan. You must work with your providers to ensure prior authorization requirements have been satisfied prior to your procedure.

Oncology Navigator

BlueCross BlueShield

BCBS offers Cancer Services and Support as a solution to bridge the cancer care gap, while providing access to leading cancer expertise and reducing oncology medical costs. This program offers oncology care management, expert advisory view and peer-to-peer review for rare and complex cancers.

BCBS Cancer Services will reach out to the participant when a claim with a cancer diagnosis is processed to discuss the program.

Prior Authorization

BlueCross BlueShield

Sometimes you may need to get approval from BlueCross and BlueShield of Texas (BCBSTX) before they will cover certain inpatient, outpatient and home health care services and prescription drugs. This is called **prior authorization, preauthorization** or **prior approval**. These terms all refer to the requirements that you may need to meet before treatment may begin on any of the following:

- CAT or CT scans
- MRIs
- Endoscopy/colonoscopy procedures
- Orthopedic surgery (back/spinal, knee, shoulder, hip/joint replacement)
- And many more

During this process, BCBSTX reviews the requested service or drug to see if it is covered by your plan, and meets your health plan's definition of "medically necessary." **This review does not replace the advice of your provider.**

When BCBSTX is contacted with a prior authorization request, they will ask for the following:

- Your name, subscriber ID number and date of birth
- Your doctor's name, address and National Provider Identifier (NPI)
- Information about your medical or behavioral health condition
- The proposed treatment plan, including any diagnostic or procedure codes (your provider can help you with these)
- The date you'll receive service and the estimated length of stay (if you are being admitted)
- The place you're being treated including the provider's name, address and National Provider Identifier (NPI)

Usually, your health care providers will take care of prior authorization before they perform a service. But, it is always a good idea to check if your providers have gotten the needed approval. If your providers are not in-network, they will not request prior authorization. You will be responsible for getting this approval. If you do not get this approval via the prior authorization process, the costs may not be covered by BCBSTX. Your Benefits Value Advisor can assist with obtaining the necessary information from your doctors.

A Closer Look at the Health Savings Account (HSA)

Administered by Optum Financial

Here are some key features of the HSA:

If you enroll in the High Deductible Plan (HDP) or the Low Premium High Deductible Plan (LPHDP), you will have access to the HSA - a tax-advantaged savings account that's partially funded by Consolidated Communications. Funds are deposited, grow and are available tax-free - and if you leave Consolidated Communications, the account goes with you! Only participants in one of the HDP medical plans can open this account and receive company funding. You own the account, and the money can be used today or for future expenses - even in retirement.

- All money in the account is tax-free (including interest and investment earnings) when used to pay eligible healthcare expenses
- Consolidated Communications contributes to the HSA to help cover your out-of-pocket medical expenses, and you can also make your own contributions. The funding is yours to keep in your HSA until you need it
- If you don't spend your full HSA balance during the current year, the unused money rolls forward to each following year

HSA Contribution Limits:

2024 IRS Limits*	
Single (employee only) coverage	$4,150
Family (employee plus one or more) coverage	$8,300
Catch-up contribution (age 55 or older)	$1,000

*The above limits are reduced by the amount that CCI contributes to your account.

HSA: Things You Should Know

- **Eligibility for the HSA is limited**
  - You are only eligible for the HSA when you enroll in the HDP or LPHDP plans
  - You cannot be covered by any other non-HSA compatible health plan, including Medicare Parts A & B, TRICARE, or TRICARE for Life
  - You cannot be claimed as a dependent on someone else's tax return
  - You haven't received Veterans Affairs (VA) benefits within the last 3 months, except for preventative care. If you have a disability rating from the VA, this exclusion does not apply
  - You do not have a health care spending account (FSA) or health reimbursement account (HRA). Alternative plan designs, such as a limited-purpose FSA, are permitted
- If you are enrolling in the HDP or LPHDP for the first time in 2024, you will receive a welcome kit from Optum Financial that provides account information. The kit will be mailed shortly after the annual enrollment has ended
- Once your account has been opened, you will receive a debit card that can be used to pay for qualified medical expenses at many merchants. You can also access your funds by using another form of payment, then reimbursing yourself from your Optum Financial HSA by check or ACH
- Funds that are withdrawn from your HSA prior to age 65 and not used for eligible medical expenses are subject to income tax and a 20% excise penalty
- After age of 65, you aren't penalized for withdrawing funds for reasons other than medical expenses. The account can be treated like another retirement account
- For a full list of eligible expenses, please see the resources available on the Optum Financial Website
- Save your receipts! You may be asked to substantiate any funds used if you are ever audited by the IRS

Flexible Spending Account (FSA)

Administered by WEX

FSAs allow you to have pre-tax money deducted from your paycheck to pay for certain expenses. Since contributions are made through payroll deductions with pre-tax dollars, you decrease your taxable income and thereby increase your take-home pay.

There are two types of FSAs available:

- Healthcare
- Dependent Care

You are eligible for FSA on the first day of the month following your date of hire.

Healthcare FSA

Using pretax payroll contributions, you can receive reimbursement from your Healthcare FSA for eligible medical, dental and vision expenses incurred by you or an eligible dependent, as long as the expenses are not covered or reimbursed by other plans.

- You can elect to contribute up to $3,050 per year
- Some eligible expenses include:
  - o Office visit and prescription drug copays
  - o Medical and dental deductibles and copays
  - o Prescription and over-the-counter drugs
  - o Feminine products
  - o Vision care, including prescription glasses, contact lenses and solution, nonprescription glasses if for vision correction, and LASIK

Important Note for HDP or LPDHP Medical Plan Participants:

If you are enrolled in the High Deductible Plan or Low Premium High Deductible Health Plan with BlueCross, and also elect the Healthcare FSA, you will be enrolled into a special Limited Purpose FSA plan. **With this account, you can receive tax-free reimbursement for dental and vision expenses only**. Medical expenses should be reimbursed through your Optum Financial Health Savings Account.

Important Note: Healthcare Tax Deduction

A healthcare tax deduction is available on your federal income tax return if you have expenses that are more than 10% of you and your spouse's taxable pay. Most people do not have medical expenses of more than 10% of income. If you think your expenses will be more than 10%, you should consult your tax advisor before using this account because you may not use the a FSA or HSA and the tax deduction for the same expenses.

Dependent Care FSA

Consolidated Communications offers an opportunity for you to save money for daycare for eligible dependents through the Dependent Care FSA. You decide how much to contribute, up to $5,000 per year, per household.

Plan Forfeitures and Healthcare FSA Rollover Provision

In general, expenses must be incurred during the 2024 plan year, and filed before March 31, 2025. You may be eligible to roll over up to $610 ($25 minimum) remaining in your Healthcare FSA account, to be used during the 2025 plan year. Anything over $610 left in your 2024 plan year account will be forfeited. This rollover does not apply to the Dependent Care FSA. Any funds remaining in your Dependent Care FSA account at the end of the plan year will be forfeited per IRS regulations.

FSA Debit Card

The FSA Debit Card allows you to pay for your eligible Healthcare expenses directly at the point of service. This allows you to avoid the traditional problems of a FSA such as paying cash for services (in addition to your payroll deduction) and waiting for a reimbursement check or direct deposit.

When paying for an FSA eligible expense, such as an office copay, simply provide your flex debit card for payment instead of cash/ credit/ check. There is no need to complete a claim form. Simply keep a copy of your itemized receipt or Explanation of Benefits in case it is needed for verification/substantiation.

Substantiation Requirements

For medical expenses, the IRS requires you to substantiate:

- Date service was received or purchase made
- Description of service or item purchased
- Dollar amount
- Provider or store name
- In some cases, a Medical Necessity Form or physician letter may be required

NOTE: In some cases, the plan's design requires that your health insurer's Explanation Of Benefits (EOB) is provided as substantiation for your expense. If you receive an itemized receipt from your provider for a copay amount, make sure the receipt says "copay." If not, ask your provider to write "copay" on your receipt before leaving the office.

For dependent care expenses, the IRS requires you to substantiate:

- Dates of service
- Dollar amount incurred
- Daycare provider name
- Daycare provider signature

NOTE: Daycare expenses must be incurred (not just paid) in order to receive reimbursement. Registration fees cannot be reimbursed until the services are actually incurred. You will be required to report your dependent care provider's Tax ID (TIN) or SSN on IRS Form 2441 when you file your federal income tax return.

Vague or missing information causes your reimbursements to be held up, become ineligible, or result in deactivation of your FSA debit card. Keep your receipts and documentation.

Dental Benefits

Administered by Cigna

Good oral care enhances overall physical health, appearance, and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Consolidated Communications dental benefit plan.

Under a PPO dental plan, you may use the dentist of your choice. However, if you utilize in-network providers, your out of pocket costs will be lower.

	PPO NETWORK
	In-Network
Annual Deductible	$50 individual /$150 family
Annual Maximum Benefit	$2,500
Preventive Services (4 cleanings per year)	100% (deductible waived)
Basic Services (fillings, extractions periodontal treatment)	80%
Major Services (dentures, bridges, crown, implants)	50%
Root Canals	80%
Oral Surgery	80%
Orthodontia Services Dependent Children up to age 19	50% $2,000 lifetime maximum per child
Percentile R&C	90th

EMPLOYEE BI-WEEKLY CONTRIBUTIONS (24 PAY PERIODS)	
Employee Only	$13.18
Employee + Spouse	$25.57
Employee + Child(ren)	$27.28
Employee + Family	$40.19

Vision Benefits

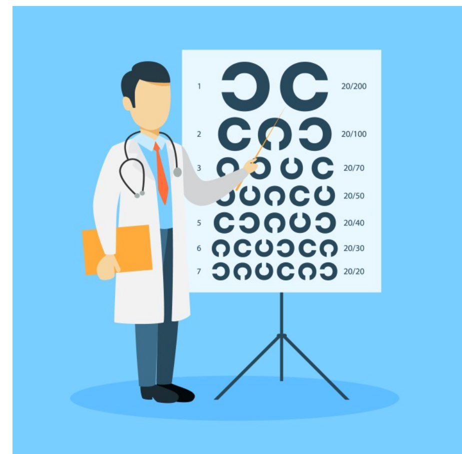
Insured by VSP

Regular eye examinations cannot only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

With the VSP vision plan, participants may choose between glasses or contacts each year. When contact lenses are chosen, participant will be eligible for frames 12 months from the date contact lenses were obtained.

	SIGNATURE NETWORK
	In-Network
Eye Exam With Dilation as Necessary	$10 copay
Contact Lens Fitting and Follow-up	Copay up to $55
Frames (once per 24 months)	$0 copay; $130 retail allowance
Lenses (once per 12 months)	
Single Vision	$25 copay
Bifocal	$25 copay
Trifocal	$25 copay
Contact Lenses (once per 12 months)	
Elective	$0 copay; $130 allowance
Medically Necessary	Covered in full

EMPLOYEE BI-WEEKLY CONTRIBUTIONS (24 PAY PERIODS)	
Employee Only	$1.90
Employee + Spouse	$3.81
Employee + Child(ren)	$4.07
Employee + Family	$6.51



Wellness

Administered by Navigate

There are many positive influences living a healthy lifestyle will have upon each and every one of us. In addition to increasing the quality time with our families, feeling better will increase work attendance resulting in having a fully staffed team, increased productivity because we all feel better, increased life-span, and in general, a higher quality of life which will be realized when we raise our own consciousness towards our individual health.

You and your family can take some simple steps toward living a healthier life by having your annual physical, by being proactive about improving your lifestyle choices, by taking charge of your health, and by participating in the Health and Wellness Program.

There are three parts to achieve the 2025 wellness discount:

1. Health screening with your personal physician
   - Upload completed physician form to Navigate (no fax or email)
2. Online health assessment through Navigate
3. Visit one (1) of our EAP services
   - EAP Achieve Solutions
   - Carelon
   - eMLife
4. **NEW:** Update your 401(k) beneficiary.

The wellness program must be completed between October 1, 2023 and September 30, 2024.

Those that complete the program will receive a wellness credit equal to $648 per year ($27.00 bi-weekly for 24 pay periods), if enrolled in your own Consolidated Communications medical plan starting January 1, 2025. The wellness credit will not exceed bi-weekly medical premium.

Telehealth

MDLive Virtual Visits

If you enroll in the BCBS medical plans, you have access to MDLive, which provides you and your covered dependents access to care 24 hours a day, 7 days a week for non-emergency medical issues and behavioral health needs.

- You can speak to a doctor immediately or schedule an appointment based on your availability
- Virtual visits can be a better alternative than going to the emergency room or urgent care
- MDLive doctors can help treat the following conditions and more: allergies, cold and flu, earache, fever, headache, insect bites, nausea, pinkeye, sore throat, and more
- MDLive can assist with behavioral health issues and have family therapists, psychologists and psychiatrists on staff

Musculoskeletal Virtual Program

Administered by SWORD

If you enroll in the BCBS medical plans, you have access to the musculoskeletal virtual program at no cost to you. SWORD is a virtual physical care program designed to help you overcome your back, joint or muscle pain all from the comfort of your home.

- A dedicated physical therapist will design exercise programs just for you and they are available to support you at any time
- SWORD will ship you a tablet and motion sensors to guide you and provide real-time feedback during your exercises
- Exercises will be completed at home whenever it is convenient for you

  Register today at https://enroll.swordhealth.com/CCI

- Bloom is a comprehensive, mind-body program connecting individuals with vaginal anatomy to the next-generation of pelvic -health care from the comfort, convenience, and privacy of home. It is designed to address pelvic dysfunctions such as pain, discomfort, pressure, urinary leakage and, bowel issues, as well as life stages including pregnancy, postpartum and menopause.

  Here's how it works:

  1. Bloom pairs members with Pelvic Health Specialists, all of whom have Doctor of Physical Therapy Degrees.
  2. After a virtual consultation, members receive a Bloom kit, including an intravaginal pod so the Specialist can monitor biofeedback and customize pelvic exercise programs in the mobile app
  3. The Pelvic Health Specialist gives ongoing 1-1 guidance and support while the content hub provides a safe space to learn about stigmatized topics and seek relief.

  To get started, go to https://join.hibloom.com/CCI

- **New Enhancement:** Sword Move is a digital health solution that connects members with a Personal Trainer who uses real-time insights from an integrated wearable device to deliver personalized movement programs. Move is for members who are looking for a whole body focus to their physical health and also provides a care continuum for members that complete Digital physical therapy. It helps members increase their activity levels whilst addressing gaps in their balance, mobility and strength.

  To get started, go to https://enroll.swordhealth.com/CCI

Choose to Lose Weight Loss Program

Tria Health

Committing to weight loss can be crucial for your overall health. Tria Health's Choose to Lose program offers a comprehensive solution with several benefits, including:

- **Designated Health Coach** — All health coaches are trained in matters of food, nutrition & their impacts on human health.
- **Industry-Leading Health & Fitness App** — Members can track their daily food intake, fitness activity, and can create goals. You can also receive a free scale when you download the LoseIt! fitness app.
- **Access to a Clinical Pharmacist** — If you and your coach determine medication to be beneficial, you'll then be able to meet with your Tria Health pharmacist.

Participants may also explore weight loss medication options with a Tria Health pharmacist, though it's not mandatory. This program is exclusively for eligible employees and their spouses enrolled in BCBS Medical Plans. You can enroll whenever you're ready to start your weight loss journey.

Call Tria Health to register, 1.888.799.8742 or visit www.triahealth.com/ctl-cci.

Accident Plan

Insured by Voya

Accident Insurance pays you benefits for specific injuries and events resulting from a covered accident on or after your coverage effective date[1]. You can use this money however you like, including: deductibles, child care, housecleaning, groceries or utilities. Accident Insurance is a limited benefit policy. This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. Changes to enrollment can only be made at open enrollment or with a qualifying life event.

Below are just some examples of benefits payable under the plan. Refer to your benefits summary or certificate of coverage for a full listing.

EVENT	BENEFIT
Hospital Admission	$1,250
Hospital Confinement	$375 per day, up to 365 days
Emergency Room Treatment	$225
Common Injuries	
Torn Knee Cartilage – surgical repair	$800
Laceration - with sutures up to 2”	$60
Shoulder Dislocation (Non-surgical)	$2,200
Leg Fracture (Non-surgical/Surgical)	$2,800/$5,600

EMPLOYEE BI-WEEKLY CONTRIBUTIONS	
Employee Only	$5.70
Employee + Spouse	$9.69
Employee + Child(ren)	$11.43
Employee + Family	$15.42

If you enroll in Accident Insurance coverage, you have access to a $75 Wellness Benefit, which provides an annual benefit if you complete a health screening test, whether or not there were any out-of-pocket costs. The Wellness Benefit is designed to encourage you to maintain a healthy lifestyle, since the tests screen for a wide range of potential illnesses and diseases.

[1]See the product brochure, certificate of coverage and any applicable riders for a list of covered accidents, along with complete provisions, exclusions and limitations.

Critical Illness Plan

Insured by Voya

Critical Illness Insurance pays a lump-sum benefit if you are diagnosed with a covered disease or condition on or after your coverage effective date[1]. You can use this money however you like, for example: to help pay for expenses not covered by your medical plan, lost wages, child care, travel, home health care costs or any of your regular household expenses. Critical Illness Insurance is a limited benefit policy. This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. Changes to enrollment can only be made at open enrollment or with a qualifying life event.

BENEFITS	
Employee	You may elect a Critical Illness benefit amount of $10,000, $20,000 or $30,000.
Spouse	Coverage is available only if employee coverage is selected. You may elect a spouse Critical Illness benefit amount of 100% of your benefit amount. There is a separate premium for spouse coverage.
Child	Birth to age 26; coverage is available only if employee coverage is selected. You may elect a children's Critical Illness benefit amount of 50% of your benefit amount, at no additional cost.

Examples of Covered Conditions:

- Heart attack
- Cancer
- Stroke
- Major organ transplant
- Coronary artery bypass (25%)
- Carcinoma in situ (25%)
- Benign brain tumor
- Bone marrow transplant (25%)
- Stem cell transplant (25%)
- Type 1 diabetes
- Severe burns
- Transient ischemic attacks (TIA) (10%)
- Aneurysm (10%)
- Open heart surgery for valve replacement or repair (25%)
- Transcatheter heart valve replacement or repair (10%)
- Coronary angioplasty (10%)
- Implantable cardioverter defibrillator (ICD) placement (25%)
- Pacemaker placement (10%)
- Permanent Paralysis
- Loss of sight, hearing or speech
- Coma
- Multiple Sclerosis
- Amyotrophic lateral sclerosis (ALS)
- Parkinson's disease
- Advanced dementia, including Alzheimer's
- Huntington's disease
- Muscular dystrophy
- Infectious disease (25%)
- Addison's disease (10%)
- Myasthenia gravis (50%)
- Systemic lupus erythematosus (SLE)
- Systemic sclerosis (scleroderma) (10%)

All coverage amounts are Guaranteed Issue, so there are no medical questions or tests required for coverage. Pre-existing condition exclusions may apply. Coverage is portable if you leave or retire.

If you enroll in Critical Illness Insurance coverage, you also have access to a $50 Wellness Benefit, which provides an annual benefit if you complete a health screening test, whether or not there were any out-of-pocket costs. The Wellness Benefit is designed to encourage you to maintain a healthy lifestyle, since the tests screen for a wide range of potential illnesses and diseases.

EMPLOYEE AND SPOUSE MONTHLY COST PER $10,000 OF COVERAGE*		
Employee Attained Age[2]	EE Only	EE + Spouse
Under 25	$3.10	$6.20
25-29	$3.60	$7.20
30-34	$4.60	$9.20
35-39	$7.00	$14.00
40-44	$9.10	$18.20
45-49	$14.00	$28.00
50-54	$16.50	$33.00
55-59	$27.00	$54.00
60-64	$32.70	$65.40
65-69	$35.50	$71.00
70+	$44.50	$89.00
*Children may be covered at 50% of your benefit amount at no additional cost to you.		

[1]See the product brochure, certificate of coverage and any applicable riders for a complete list of covered conditions, along with complete provisions, exclusions and limitations.

[2]Premiums are calculated based on the employee's age as of 12/31/2023.

Life and Accidental Death & Dismemberment

Insured by Voya

Life and Accidental Death Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by Consolidated Communications. Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident.

The company provides basic life and AD&D insurance in the amount of $75,000. Coverage levels change starting at age 65 - see Voya booklet. Full-time employees are eligible the first day of the month following your date of hire.

Supplemental Life and Supplemental Accidental Death & Dismemberment (Voluntary)

Insured by Voya

You may purchase life and/or AD&D insurance in addition to the company-provided coverage. You may also purchase insurance for your dependents when electing coverage for yourself. New employees are guaranteed supplemental life coverage (up to $250,000 and up to $50,000 for your spouse) without answering medical questions if you enroll when you are first eligible. There are no medical questions required for supplemental AD&D. Life and AD&D elections are separate, so you may elect one or the other, or both.

Full-time employees are eligible on the first day of the month following your two months of service. If you do not elect life insurance when first eligible, you will be considered a late entrant, and will have to submit Evidence Of Insurability (EOI), which is reviewed by Voya for coverage determination. Coverage levels change after age 65 - see Voya booklet. Life benefits are portable if requested within 30 days of termination of employment.

Employee — Increments of $25,000, up to a maximum of $750,000

Spouse — Increments of $25,000, up to a maximum of $300,000

Children — Birth to 26 years: $10,000 or $25,000

Supplemental Life monthly rate per $1,000 of coverage					
Age*	**Employee**	**Spouse**	**Age***	**Employee**	**Spouse**
<25	$.020	$.020	50 - 54	$.141	$.230
25 - 29	$.034	$.060	55 - 59	$.266	$.430
30 - 34	$.046	$.080	60 - 64	$.369	$.660
35 - 39	$.054	$.090	65 - 69	$.710	$1.270
40 - 44	$.058	$.100	70 - 74	$1.318	$1.270
45 - 49	$.090	$.150	75+	$2.060	n/a
Dependent Children up to age 26: $.091					

Supplemental AD&D (all ages) $.021 per $1,000 of coverage
Increments of $25,000, up to a maximum of $750,000

Per Pay Period Premium Calculation

$__________________ ÷ 1,000 = ___________________ x _________________ = $____________________ ÷2 = ____________________

Requested Volume | Benefit in 1,000's | Monthly Rate | Monthly Cost | Your bi-weekly cost

*Employee and Spouse rates are based on the employee's age as of December 31, 2023.

Short-Term Disability (STD)

Administered by Sedgwick Claims Management

Short-term disability coverage is provided at no cost to all full-time employees after one year of service. STD provides income replacement when you are disabled from an accident or illness, for up to 26 weeks. In the event of an illness, there is a 3 work day waiting period before benefits begin, and you must use available Personal Days or accrued vacation during the waiting period. The STD benefit amount is based on your length of service, and can last up to 26 weeks.

Claims are subject to approval by Sedgwick Claims Management. Payments are integrated and offset by any state mandated disability programs. FMLA runs concurrently with short term disability. Personal days and accrued vacation dates must be used before any unpaid time is taken under FMLA.

Length of Service	Full Weeks	Half Weeks
1-2 years	4	22
>2 years	6	20
>5 years	10	16
>10 years	14	12
>15 years	18	8
>20 years	22	4
>25 years	26	0

Long-Term Disability (LTD)

Insured by Reliance Matrix

What happens if you have an unexpected injury or illness that leaves you unable to work or earn a paycheck? Few people believe it will happen to them, but the truth is, your risk of becoming disabled is far greater than you may think. Consolidated Communications employees are provided LTD coverage through Reliance Matrix. Coverage is provided by CCI at no cost to you, following 12 months of full-time service.

Your LTD monthly benefit is paid at 50% of your monthly earnings to a maximum monthly benefit of $3,000. You must be disabled for a total of six months before payments begin. You are provided long term disability for two years when unable to perform your OWN occupation; if after two years you are unable to perform ANY occupation, your disability payments may continue until social security normal retirement age.

There are no benefits for pre-existing conditions during your first 12 months of coverage. Pre-existing conditions include any condition for which the employee would have sought medical treatment for and/or had symptoms that a reasonably prudent person would have sought treatment for. Employment with the company is terminated after 12 months of continuous disability.

Tuition Assistance Program

Administered by CCI

- 100% of tuition cost is paid, up to $5,250 per year maximum
- Course must be job related or a requirement of a degree that is job related
- School must be accredited
- Must be discussed with your supervisor prior to application
- Tuition assistance may be a taxable benefit

Funeral Planning

Provided by Voya

Downloadable funeral planning guide to document vital information your loved ones will need when making final arrangements.

- 24/7 Advisor Planning Assistance from highly trained advisors
- PriceFinder Research Reports
- Online Funeral Planning Tools
- Family Assistance and Plan Implementation
- Negotiation Assistance

Visit join.empathy.com/voya

Pre-Tax Parking Benefits

Administered by WEX

Pre-Tax parking benefits allow you to set aside pre-tax dollars to pay for expenses related to and including parking passes.

- You may set aside up to $300 per month to be used for eligible parking expenses
- Parking elections are submitted monthly via PeopleSoft: Self Service > Payroll and Compensation > Voluntary Deductions
- You can pay for services using your debit card, or by paying out of pocket and submitting a reimbursement request to WEX
- If you terminate employment, you may submit claims that were incurred prior to your termination. Any unused funds will be forfeited

Employee Assistance Program

Carelon

Whatever life throws at you – throw it our way.

Employees and household members can confidentially address and resolve personal and workplace challenges through the Employee Assistance Program (EAP).

- Counseling and Relationship Support - unlimited phone calls to a clinician, available 24/7, plus up to 5 free face-to-face counseling sessions per issue per year
- Virtual appointments are available
- Web-based Resources - tools and resources on behavioral health and work/life balance topics including depression, strengthening marriage and relationships, stress management, anxiety, conflict management, weight management, and communication
- Work/life Balance Services - assistance with care services, education resources, concierge services, and daily living services such as pet sitters, parenting, adoption and more
- Legal Services - free 1/2 hour in-person consultation with an attorney, related to specified topics, and a discount of 25% off the fees for service beyond the initial consultation
- Financial Services - free 1/2 hour in-person consultation with a financial planner, and a discount of 25% if that financial planner is retained for services

These are just a few examples of the support available to you. Call to get the assistance you need to help resolve life's challenges.

Log in to https://www.carelonwellbeing.com/cci or call 866.723.4332.

eM Life

Provided by Carelon

You, your spouse and your dependents now have access to eM Life™ a mindfulness platform on the web and mobile devices. It offers interactive, live and on-demand mindfulness programs led by expert mindfulness teachers for everyday life. Mindfulness is being fully aware and in the present moment without judgment. eM Life™ helps you create connections with yourself and others while building skills to manage stress and anxiety, improve focus and enhance your overall well-being. eM Life™ also offers immersive multi-week programs led by expert mindfulness teachers that address a range of topics such as weight management, anxiety, addiction and pain.

When you enroll in eM Life, you will have 24/7 access from any device to:

- Live daily 14-minute mindfulness programs led by experts multiple times a day
- Live monthly online programs led by experts covering everything from stress to weight balance
- Hundreds of hours of on-demand content on a wide range of topics including leadership, diversity and inclusion and anxiety
- Expert-led community to gain support and purpose
- Game and meditation timer to help you build and sustain healthy habits
- Available in multiple languages on the web and mobile app (iOS and Android)

To sign up visit https://vibe.emindful.com/signup/cci or contact Carelon at 866.723.4332.

Auto and Home Insurance

Consolidated Communications has partnered with American Benefits Consulting to offer an Auto and Home Insurance Program. This voluntary benefit gives you access to reliable coverage and special savings on insurance not available to the general public. Coverage is offered through your choice of three carriers: Farmers, Liberty Mutual, and Travelers Insurance. Program enrollment applications are accepted year-round. Your insurance coverage request is individually underwritten.

It's easy to protect yourself and your property with special savings available to you as a Consolidated Communications employee. To start reviewing your voluntary benefit options, call 888.299.9220 or visit consolidatedautohome.com.

Identity Theft Recovery Program and Card Monitoring

Provided by Reliance Matrix

Card Monitoring provides online credential monitoring of personal information. InfoArmor's encrypted vault secures and monitors the following:

- User IDs & Passwords
- ATM Cards, Credit Cards
- Checking Accounts
- Driver's Licenses
- Health Insurance Cards
- Vehicle Insurance Cards, etc.

Enroll online at www.reliancestandard.com/infoarmor

The Identity Theft Recovery Program investigates and confirms fraudulent activity.

- Assistance in issuing fraud alerts and victim's statements with consumer credit reporting agencies, FTC, SSA, and USPS
- Place phone calls / prepare documentation on your behalf
- Call 855.246.7347 to reach a Privacy Advocate

Identity Theft Recovery Program

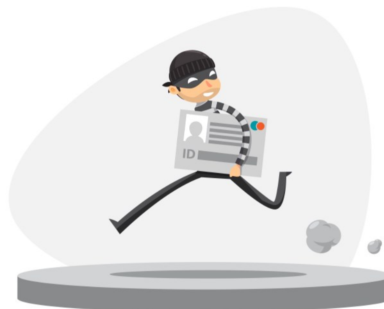
Provided by BlueCross BlueShield of Texas

BCBSTX provides identity theft protection services to eligible members and their families at no cost through Experian®, an independent company.

The IdentityWorks program includes:

- Credit Monitoring
- Identity Restoration
- Up to $1 million in Identity Theft Insurance

You must be enrolled in a BlueCross health plan to enroll. Enrollment is completed online through your Blue Access for Members account. On Blue Access for Members (BAM), you will obtain an activation code allowing you to access the program for one year. Each member over 18 will be required to enroll in the program to receive the offering; however, adults can enroll their minor dependents.



Holidays

Holidays include: New Year's Day, Memorial Day, Good Friday, Fourth of July, Labor Day, Thanksgiving Day, Day after Thanksgiving, Christmas. Full time employees are eligible after six months of service.

Personal Leave Days

- Full time employees are eligible for 3 personal days after 90 days of continuous service
- After 6 months of continuous service, full-time employees are eligible for 3 additional personal holidays (employee's birthday, employment date, and floating holiday)
- Scheduling of personal days is subject to the operational requirements of the company
- Personal days are awarded January 1 of each calendar year, and may be taken in half day increments. Unused days are not carried over

Vacation

Vacation time is granted to full time employees during a vacation period that extends from January 1 through December 31. Vacation time is based on net credited service and is granted in order of seniority, subject to the ability of the company to grand the requested dates. If an employee is requested by the company to work during scheduled vacation time, the payment for and usage of those vacation days will follow the specifications in the CCI/CWA contract.

You may carry over a maximum of forty (40) hours of vacation time into the next vacation period, which may be used throughout the year. Unused vacation time is paid out at termination in accordance with the CCI/CWA contract. Refer to your contract for further details.

Length of Service	Paid Days
6 months	5
1 year	10
8 years	15
17 years	20
25 years & up	25

401(k) Plan

T. Rowe Price

You are eligible to participate immediately upon hire. New employees will be automatically enrolled at 3% pre-tax, 30 to 90 days after their date of hire. Contact T. Rowe Price to increase, decrease, or stop the auto enrollment.

- You may contribute up to 50% of your salary, a combination of pre-tax or Roth after-tax contributions, up to IRS annual employee maximums
- Contributions may be increased/decreased at any time
- 100% immediate vesting in employee contributions and company match
- Investment allocations and transfer of funds can be done daily
- Visit www.rps.troweprice.com for more information and to make contribution or investment changes

Employee Deferral	Company Match
1%	1%
2%	2%
3%	3%
4%	4%
5%	5%
6% & up	6%

Pension (if eligible)

For questions about your pension benefits, eligible employees should contact the Consolidated Communications Pension Service Center at 855.409.9592 or visit www.eepoint.com/CCI.

Contact Information

If you have specific questions about a benefit plan, please contact HR Services at 833.CCI.1300, or email HRServices@consolidated.com.

Benefit	Administrator	Phone	Website/Email	Group or Policy #
Benefits Plan Info and Forms			https://c2mb.ajg.com/ccinb/home/	
401(k) Plan	T. Rowe Price	800.922.9945	www.rps.troweprice.com	105908
Accident Illness Plan	Voya	877.236.7564	https://presents.voya.com/EBRC/ConsolidatedCommunications	706515
Benefits Value Advisor with Member Rewards	BlueCross BlueShield	800.521.2227	www.bcbstx.com	PPO Plan - 048598 HDP Plan - 048599 LPHDP Plan - 048599
COBRA & Direct Bill	UnifyHR	800.519.8366	www.unifyhr.com	n/a
Critical Illness Plan	Voya	877.236.7564	https://presents.voya.com/EBRC/ConsolidatedCommunications	706515
Dental	Cigna	800.CIGNA24	www.mycigna.com	3328447
Employee Assistance Program	Carelon	866.723.4332	https://www.carelonwellbeing.com/CCI	n/a
FMLA and Short Term Disability	Sedgwick Claims Management	888.436.9530	https://timeoff.sedgwick.com	n/a
FSA/Parking Plans	WEX	866.451.3399	www.wexinc.com	n/a
Health Savings Accounts	Optum Financial	844.881.4439	www.optum.com	n/a
Home & Auto	Group Home and Auto	888.299.9220	www.consolidatedautohome.com	n/a
Life Insurance	Voya	800.955.7736	www.voya.com	706515
Long Term Disability	Reliance Matrix	877.202.0055	www.reliancematrix.com	127359
Medical	BlueCross BlueShield	800.521.2227	www.bcbstx.com	PPO Plan - 048598 HDP Plan - 048599 LPHDP Plan - 048599
Musculoskeletal Virtual Program	SWORD Health	n/a	https://enroll.swordhealth.com/CCI Email: ask@swordhealth.com	n/a
Pension	Consolidated Communications Pension Service Center	855.409.9592	www.eepoint.com/CCI	n/a
Pharmacy Advocate Program	Tria Health	888.799.8742	https://myportal.triahealth.com/Account/Login	n/a
Prescription Drugs (BlueCross plans)	Retail: BlueCross BlueShield Specialty: Payer Matrix Specialty: Accredo Pharmacy Mail Order: Express Scripts	800.521.2227 877.305.6202 833.721.1619 833.715.0942	www.bcbstx.com www.payermatrix.com www.accredo.com www.express-scripts.com/rx	n/a
Telemedicine	MDLive	866.680.8646	www.mdlive.com/bcbstx	n/a
Tuition Reimbursement	HR Services	833.CCI.1300	HRServices@consolidated.com	n/a
Vision	VSP	800.877.7195	www.vsp.com	30084834
Wellness	Navigate	888.282.0822	https://cci.livehealthyignite.com	n/a

Legal Updates

HIPAA Special Enrollment Rights

Loss of Other Coverage — If you are declining or have declined enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may in the future be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards you or your dependent's coverage. To be eligible for this special enrollment opportunity, you must request enrollment within 31 days after your other coverage ends or after the employer stops contributing towards the other non-COBRA coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption — If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your dependents.

To be eligible for this special enrollment opportunity, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Medicaid Coverage - The Consolidated Communications, Inc. Health Benefits Plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

1. **TERMINATION OF MEDICAID OR CHIP COVERAGE — If** the employee or dependent is covered under a Medicaid plan or under a State child health plan and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.

2. **ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP -** If the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than provide direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP or the date you or your dependent's Medicaid or state sponsored CHIP coverage ends.

HIPAA Privacy Notice

HIPAA requires Consolidated Communications, Inc. to notify you that a privacy notice is available by obtaining a copy from your Human Resource department. Please contact Human Resources if you have any questions.

Newborns' and Mothers' Health Protection Act

Federal law (Newborns' and Mothers' Health Protection Act of 1996) prohibits the plan from limiting a mother's or newborn's length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery or from requiring the provider to obtain pre-authorization for a stay of 48 hours or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for cesarean delivery.

Pretax Contributions

In most cases, Consolidated Communications, Inc. employees' contributions for health coverage are deducted from their paychecks on a pretax basis meaning before federal income taxes, state income taxes (in most cases), and FICA taxes are calculated. Internal Revenue Code (I.R.C.) Section 152 defines what dependent contributions are eligible for pretax deductions. The IRS does not allow employees' contributions for dependent health coverage to be deducted on a pretax basis unless the dependent(s) meet the definition of a tax dependent under I.R.C. Section 152. If they do not meet the definition of a tax dependent, they may be either ineligible for the Plan, or in some cases, the IRS taxes the additional fair market value of these benefits and treats it as Imputed Income. Contributions for medical, dental and vision coverage for eligible dependents that do not meet the definition of a tax dependent will be made on a post-tax basis and the Imputed Income will be included on your paycheck and IRS Form W-2.

With the signing of the Affordable Care Act and new regulations by the Treasury Department, the value of any employer-provided health coverage for an employee's child is excluded from the employee's income through the end of the taxable year in which the child turns 26.

Under IRS Notice 2010-38, a child is defined as son/daughter, step son/daughter, adopted child or eligible foster child, without regard to whether the child is financially supported by the employee or resides with the employee or is a full-time student.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. This law also requires that written notice of the availability of the coverage be delivered to all plan participants upon enrollment and annually thereafter. This language serves to fulfill that requirement for this year. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed
- Surgery/reconstruction of the other breast to produce a symmetrical appearance
- Prostheses; and
- Treatment for physical complications during all stages of mastectomy, including lymphedemas

In addition, the plan may not:

- Interfere with a participant's rights under the plan to avoid these requirements; or
- Offer inducements to the healthcare provider, or assess penalties against the provider, in an attempt to interfere with the requirements of the law

However, the plan may apply deductibles, coinsurance, and copays consistent with other coverage provided by the Plan.

Disclaimer

This 2024 Benefits Summary highlights recent plan design changes and is intended to fully comply with the requirements under the Employee Retirement Income Security Act (ERISA) as a Summary Material Modification (SMM) and should be kept with your most recent Summary Plan Description (SPD). This document does not guarantee any benefits.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=enUS Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium- assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Medicare Part D

Important Notice from Consolidated Communications, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Consolidated Communications, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Consolidated Communications, Inc. has determined that the prescription drug coverage offered by the Consolidated Communications, Inc. Health Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Consolidated Communications, Inc. coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current Consolidated Communications, Inc. coverage, be aware that you and your dependents will be able to get this coverage back during the annual enrollment period under the Consolidated Communications, Inc. Health and Welfare Benefits Plan.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Consolidated Communications, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the HR Services listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Consolidated Communications, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available.

For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

Date: October 15, 2023

Name of Entity/Sender: Consolidated Communications, Inc.

Contact: HR Services

Address: 508 Old Magnolia
Conroe, TX 77304

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of September 15, 2022, and shall remain in effect until you are notified of any changes, modifications or amendments. This Notice applies to health information the following plans (collectively referred to herein as the "Plan") create or receive about you:

Consolidated Communications, Inc. Health Benefits Plan

Consolidated Communications, Inc. Employee Assistance Program

Consolidated Communications, Inc. Flexible Employee Benefits Plan

Consolidated Communications, Inc. Texas Bargaining Health Benefits Plan

Consolidated Communications, Inc. Retiree Health Benefits Plan

Consolidated Communications, Inc. Texas Bargaining Retiree Health Benefits Plan

Consolidated Communications, Inc. Medical Premium Reimbursement Program for Eligible Union Retirees

Consolidated Communications, Inc. Retiree Health Reimbursement Arrangement

You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). Since their initial publication, the Privacy Regulations were amended by the Genetic Information Nondiscrimination Act of 2008 ("GINA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") under the American Recovery and Reinvestment Act of 2009 ("ARRA"), and by modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, as published in the Federal Register on January 25, 2013. As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information, including "genetic information" (as defined in Section 105 of GINA), that is created or received by the Plan (your "Protected Health Information" or "PHI"). This Notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan's duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services ("HHS") and the office to contact for further information about the Plan's privacy practices.

How the Plan Will Use or Disclose Your PHI

Other than the uses or disclosures discussed below, any use or disclosure of your PHI will be made only with your written authorization. Any authorization by you must be in writing. You will receive a copy of any authorization you sign. You may revoke your authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. Your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself provides such right.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. Effective for uses and disclosures on or after February 17, 2010 until the date the Secretary of HHS issues guidance on what constitutes the "minimum necessary" for purposes of the privacy requirements, the Plan shall limit the use, disclosure or request of PHI (1) to the extent practicable, to the limited data set or (2) if needed by such entity, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request. The minimum necessary standard will not apply in the following situations:

disclosures to or requests by a health care provider for treatment;

uses or disclosures made to the individual;

disclosures made to HHS;

uses or disclosures that are required by law;

uses or disclosures that are required for the Plan's compliance with legal regulations; and

uses and disclosures made pursuant to a valid authorization.

The following uses and disclosures of your PHI may be made by the Plan:

For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, are medically necessary, experimental or investigational, and disclosures to obtain reimbursement under insurance, reinsurance, stop loss or excessive loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by the Plan sponsor for any of the purposes described above. Uses and disclosures of PHI for payment purposes are limited by the minimum necessary standard.

For Treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you. One example would be if your doctor requests information on what other drugs you are currently receiving during the course of treating you.

For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations include quality assurance, underwriting and premium rating to obtain renewal coverage, and other activities that are related to creating, renewing, or replacing the contract of health insurance or health benefits or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and quality improvement activities, and customer service and resolution of internal grievances. The Plan is prohibited from using or disclosing your PHI that is genetic information for underwriting purposes. Uses and disclosures of PHI for health care operations are limited by the minimum necessary standard.

The following use and disclosure of your PHI may only be made by the Plan with your written authorization or by providing you with an opportunity to agree or object to the disclosure:

To Individuals Involved in Your Care. The Plan is permitted to disclose your PHI to your family members, other relatives and your close personal friends involved in your health care or the payment for your health care if:

- the PHI is directly relevant to the family or friend's involvement with your care or payment for that care;
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected; and
- the PHI is needed for notification purposes, or, if you are deceased, the PHI is relevant to such person's involvement, unless you have previously expressed to the Plan your preference that such information not be disclosed after your death.

The following uses and disclosures of your PHI may be made by the Plan without your authorization or without providing you with an opportunity to agree or object to the disclosure:

For Appointment Reminders. Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, refill reminders, information on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. PHI may be provided to the sponsor of the Plan provided that the sponsor has certified that this PHI will not be used for any other benefits, employee benefit plans or employment-related activities.

When Required by Law. The Plan may also be required to use or disclose your PHI as required by law. For example, the law may require reporting of certain types of wounds or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena received by the Plan.

For Workers' Compensation. The Plan may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.

For Public Health Activities. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.

To Report Abuse, Neglect or Domestic Violence. When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, the Plan is not required to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.

For School Records. The Plan may disclose immunization records for a student or prospective student to the school to comply with a state or other law requiring the student to provide proof of immunization prior to admitting the student to school.

For Public Health Oversight Activities. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

For Judicial or Administrative Proceedings. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

For Other Law Enforcement Purposes. The Plan may disclose your PHI for other law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

To a Coroner or Medical Examiner. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

For Research. The Plan may use or disclose PHI for research, subject to certain conditions.

To Prevent or Lessen a Serious and Imminent Threat. When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

State Privacy Laws. Some of the uses or disclosures described in this Notice may be prohibited or materially limited by other applicable state laws to the extent such laws are more stringent than the Privacy Regulations. The Plan shall comply with any applicable state laws that are more stringent when using or disclosing your PHI for any purposes described by this Notice.

Your Privacy Rights With Respect to PHI

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. The Plan is required to comply with your request only if (1) the disclosure is to a health care plan for purposes of carrying out payment or health care operations, and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has already been paid in full. Otherwise, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI, other than psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. Psychotherapy notes do not include summary information about your mental health treatment. To the extent that the Plan uses or maintains an electronic health record, you have a right to obtain a copy of your PHI from the Plan in an electronic format. In addition, you may direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person.

A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a statement of your review rights, a description of how you may exercise those review rights and a description of how you may complain to HHS.

Right to Amend

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. You must make requests for amendments in writing and provide a reason to support your requested amendment.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) to persons involved in your care; (6) for national security or intelligence purposes; (7) to correctional institutions or law enforcement officials; (8) as part of a limited data set; or (9) prior to the date the Privacy Regulations were effective for the Plan on either April 14, 2003 or 2004 depending on the size of the Plan. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. Notwithstanding the foregoing, if your Plan maintained electronic health records as of January 1, 2009, you can request an accounting of all disclosures of your electronic health records made by the Plan during the three years prior to the date of your request (but on and after January 1, 2014).

Right to Receive Confidential Communications

You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you.

Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Privacy Official at the address and telephone number set forth in the Contact Information section below.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan's Duties With Respect to Your PHI

- The Plan has the following duties with respect to your PHI:
- The Plan is required by law to maintain the privacy of PHI and provide individuals with notice of its legal duties and privacy practices with respect to the PHI.
- The Plan is required to abide by the terms of the notice that are currently in effect.
- The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this Notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains. In the event of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice, the Plan will post the change or the revised Notice on its customer service and benefits web site by the effective date of the material change to the Notice, and a copy of the revised Notice, or, alternatively, information about the change to the Notice and the means to obtain the revised Notice, will be provided to you in the Plan's next annual benefits (or similar) mailing.
- The Plan is required to notify you of any "breach" (as defined in 45 CFR 164.402 of the Privacy Regulations) of your unsecured PHI.

Your Right to File a Complaint

You have the right to file a complaint with the Plan or HHS if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Complaint Official, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

Contact Information

If you would like to exercise any of your rights described in this Notice or to receive further information regarding HIPAA privacy, how the Plan uses or discloses your PHI, or your rights under HIPAA, you should contact the Privacy Official: Vice President, Compensation & Benefits at 508 Old Magnolia, Conroe, TX 77304, telephone #: 936-788-7847 and Complaint Official for the Plan: Vice President, Legal at 508 Old Magnolia, Conroe TX 77304, telephone #:936-521-0027.

NOTICE REGARDING WELLNESS PROGRAM

Navigate is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary Medical History and voluntary Health Questionnaire (“Questionnaires”) that ask a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to obtain a preventive health screening with your personal physician, which should include basic preventive labs: height, weight, blood pressure, fasting glucose, and fasting lipid panel. You are not required to complete the Questionnaires or to participate in the health screenings or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive in the form of a premium credit towards their medical premiums. Although you are not required to complete the Questionnaires or participate in the health screening with your physician, only employees who do so will receive premium credit.

The information from your Questionnaires and the results from your preventive health screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as an individualized action plan based on your specific health risks. You also are encouraged to discuss your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Consolidated Communications, Inc. may use aggregate information it collects to design a program based on identified health risks in the workplace, Navigate will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a Navigate health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact HR Services at hrservices@consolidated.com.

Mental Health Parity Act

According to the Mental Health Parity Act of 1996, the lifetime maximum and annual maximum dollar limits for mental benefits under the Consolidated Communications, Inc. Health Benefits Plan are equal to the lifetime maximum and annual maximum dollar limits for medical and surgical benefits under this plan.

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. The SBC is available on the web at: https://c2mb.ajg.com/ccinb/home/. A paper copy is also available, free of charge, by calling HR Services at 833.CCI.1300.

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with job protected leave for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take up to 12 workweeks of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military service member.

An eligible employee who is the spouse, child, parent or next of kin of a covered service member with a serious injury or illness may take up to 26 work weeks of FMLA leave in a single 12-month period to care for the service member.

You have the right to use FMLA leave in one block of time. When it is medically necessary or otherwise permitted, you may take FMLA leave intermittently in separate blocks of time, or on a reduced schedule by working less hours each day or week. Read Fact Sheet #28M© for more information.

FMLA leave is not paid leave but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an eligible employee if all of the following apply:

- Your work for a covered employer
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before our leave, and
- Your employer has at least 50 employees within 75 miles of your work location

Airline flight crew employees have different "hours of service" requirements.

You work for a covered employer if one of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a locate, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, to request FMLA leave you must:

- Follow your employer's normal policies for requesting leaving,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You do not have to share a medical diagnosis but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You must also inform your employer if FMLA leave was previously taken or approved for the same reason when requesting additional leave.

Your employer may request certification from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state low prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitation in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S Office of Personnel Management Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your employer must:

- Allow you to take job-projected time off work for a qualifying reason,
- Continue our group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your employer cannot interfere with your FMLA rights or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your employer must confirm whether you are eligible or not eligible for FMLA leave. If your employer determinates that you are eligible, your employer must notify you in writing:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-projected leave.

Where can I find more information?

Call 1-866-487-9243 or visit dol.gov/fmla to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. Scan the QR code to learn about our WHD complaint process.

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