SUMMARY PLAN DESCRIPTION

OF THE

CONSOLIDATED COMMUNICATIONS, INC. FLEXIBLE EMPLOYEE BENEFITS PLAN

(Amended and Restated Effective as of January 1, 2021)

Updated Effective January 1, 2021

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I. Plan Introduction

The Better You Plan, The More You Save.

It's more than a slogan. The Consolidated Communications, Inc. Flexible Employee Benefits Plan (the "**Plan**") is a real solution to issues facing all of us. Simply stated, by taking advantage of tax laws, the Plan works to save you money.

The Plan offers you three tax-advantaged ways to help pay for (1) coverage for you and your eligible dependents under the group health plans (the "**Group Health Plans**") and other welfare benefit plans maintained by Consolidated Communications Holdings, Inc. (the "**Company**") which are available as optional Covered Benefits under the Plan, (2) dependent care expenses that allow you and your spouse to work, and (3) out-of-pocket health care expenses that are not covered by a health benefit plan or insurance.

The Company is pleased to sponsor the Plan for you and your fellow employees. Under federal tax laws, the Plan is considered a "cafeteria plan". It is so-called because it lets you choose from several different benefit programs according to your individual needs. The Plan provides you with the opportunity to use pre-tax dollars to pay for your benefits simply by entering into a Covered Benefits Agreement instead of using a corresponding amount of your after-tax regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save Social Security and income taxes on the amount of your Covered Benefits.

This Summary Plan Description ("**Summary**") describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it.

The various Covered Benefits options available under the Plan are described in information materials distributed prior to each open enrollment period. For the details regarding eligibility provisions, benefit amounts, and contribution or premium schedules applicable to each Covered Benefit, please refer to the summary plan description of each Covered Benefit.

This Summary will help you understand the Plan. It covers how the Plan works, the Plan's Dependent Care and Medical Reimbursement Account Benefits and Health Savings Account Funding Benefit, how the Plan can save you money, the Plan's rules, and how you can elect to participate in the Plan.

Because using the Plan wisely can save you a significant amount of money each year, it is important that you understand how the Plan works and how you can make the most of the advantages that the Plan has to offer.

After you read this material, if you have any questions or if you would like a copy of the official Plan document, please feel free to contact the Benefits Department. Whenever appropriate, the use of masculine pronouns in this Summary includes the feminine gender and the singular tense includes the plural.

Plan Controls

This booklet contains only a summary of the Plan. In the event of any discrepancy between the Plan and this Summary, the Plan will control.

II. Important Terms

The following is a list of defined terms that are used in this Summary.

1. "**Benefits Department**" means the Benefits Department of the Plan Administrator.

2. "**Change in Status Event**" means an event described in the Plan which will permit a participant to change his Covered Benefit election during a Plan Year.

3. "**Claims Administrator**" means the person or third-party entity that has been retained by the Company or Plan Administrator to provide claims processing and other administrative services on behalf of the Plan.

4. "**Code**" means the Internal Revenue Code of 1986, as amended, and the regulations and other authority issued thereunder by the IRS or other appropriate governmental authority.

5. **"Company"** means Consolidated Communications Holdings, Inc. or its successor in interest.

6. "**Compensation**" means your earned wages or salary from the Employer.

7. "**Covered Benefit**" means (1) contribution or insurance premium reimbursement benefits for any of the separate Group Health Plans or other welfare benefit plans maintained by the Employers, as referenced in the Covered Benefits Appendix to this Summary, (2) reimbursement of eligible dependent care expenses under the Dependent Care Reimbursement Account Benefit described in this Summary, (3) reimbursement of eligible medical care expenses under the Medical Reimbursement Account Benefit described in this Summary, or (4) the Health Savings Account Funding Benefit described in this Summary. The types and costs of coverage available under a particular Employer's Group Health Plan or other welfare benefit plan, and the other terms, conditions and limitations of coverage and benefits, are set forth in the summary plan description which describes each such plan. You can obtain copies upon request to the Benefits Department. However, the rules affecting the Dependent Care Reimbursement Account Benefit, the Medical Reimbursement Account Benefit and the Health Savings Account Funding Benefit are described in more detail in the Plan and this Summary, and not in a separate summary plan description.

8. "**Covered Benefits Agreement**" means a written or electronic agreement whereby your Compensation is reduced each payroll period in an amount equal to your elected contributions to the Plan

9. "**COVID Disregarded Period**" means as applicable to each Participant individually, and with respect to each elapsed timeframe ("**Compliance Timeframe**") or specified deadline date ("**Compliance Deadline Date**") under the Medical Reimbursement Account that is subject to relief under the "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak", at 86 FR 26351 (May 4, 2020) (the "**Relief Notice**"), the period described as follows.

    (a) With respect to any such Compliance Timeframe:

        (i) If the first day of the Compliance Timeframe ("**Timeframe Start Date**") occurs on or prior to March 1, 2020, the period which (A) begins on March 1, 2020 and (B) ends on the 60th day following the

announced end of the COVID National Emergency or such other date announced by the DOL in authoritative guidance issued subsequent to the Relief Notice ("**Relief End Date**"), or February 28, 2021, if earlier; or

(ii) If the Timeframe Start Date occurs after March 1, 2020 (but on or prior to the Relief End Date), the period which begins on the Timeframe Start Date and ends on the Relief End Date (or the date that is 364 days following the Timeframe Start Date, if earlier); and

(b) With respect to any such Compliance Deadline Date that occurs on or after March 1, 2020 and on or prior to the Relief End Date, the period which (i) begins on March 1, 2020 and (ii) ends on the Relief End Date (or the date that is 364 days following the Compliance Deadline Date, if earlier).

The COVID Disregarded Period shall be inapplicable in the case of a Compliance Timeframe that begins after the Relief End Date or a Compliance Deadline Date that occurs prior to March 1, 2020 or after the Relief End Date. The COVID Disregarded Period is intended to comply with ERISA Section 518, Code Section 7508A(b), the Relief Notice, and any applicable authoritative guidance related to the foregoing, as issued or adopted by the appropriate government agencies, and shall be interpreted and construed accordingly.

10. "**COVID National Emergency**" means the national emergency beginning on March 1, 2020, as determined by the President of the United States on March 13, 2020, under Section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 USC § 5121 *et seq.*, as a result of the COVID-19 outbreak and declared by the President on March 13, 2020, in the "Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak".

11. "**Dependent**" means an individual who qualifies as your dependent for federal income tax purposes, as defined in Code Section 152, with the following exceptions:

(a) For purposes of accident or health coverage under a Covered Benefit, including the Medical Reimbursement Account Benefit, "Dependent" means an individual who qualifies as your dependent as defined in Code Sections 105(b) and 106, as amended by the Patient Protection and Affordable Care Act of 2010; and

(b) For purposes of the Dependent Care Reimbursement Account Benefit, "Dependent" means a Qualifying Individual.

The Plan Administrator and/or Claims Administrator each reserve the right to require evidence from a Participant of an individual's status as a "Dependent". If the Plan Administrator and/or Claims Administrator so requires, the Participant must provide such evidence to the Plan Administrator and/or the Claims Administrator (or the delegate of either) in the form and manner, and within the timeframe, specified by the Plan Administrator and/or the Claims Administrator (or the delegate of either). Such evidence may include, but is not limited to, certifications, affidavits or other written or electronic documentation. The Plan Administrator and/or the Claims Administrator (or the delegate of either) shall determine, in its or their discretion, whether such evidence reasonably substantiates such individual's status as a "Dependent" under the Plan.

Nothing in this section is intended to restrict or enlarge the definition of "Dependent" established by any Covered Benefit offered under the Plan.

12. "**Dependent Care Reimbursement Account**" means the account to which your elected pre-tax payroll deductions are allocated to be applied to reimburse your eligible dependent care expenses.

13. "**Dependent Care Reimbursement Account Benefit**" means the Covered Benefit described in Article VI of this Summary.

14. "**Employee**" means an employee or officer of an Employer whose income is reportable by the Employer on an IRS Form W-2; provided, however the term "Employee" does not include (a) any person who is employed as an independent contractor or is designated in the Employer's payroll records as a temporary employee, or (b) any sole proprietors, partners in a partnership, and 2% shareholders of a S corporation.

15. "**Employer**" means the Plan Sponsor or any affiliate that is part of a controlled group of entities that includes the Plan Sponsor, as defined in Code Section 414(b) or (c). Any other entity that adopts the Plan with the consent of the Plan Sponsor will be listed in the Adopting Employers Appendix.

16. "**Entry Date**" means the first day of each Plan Year. However, for an Employee who first satisfies the requirements for eligibility and enrolls in a Covered Benefit during a Plan Year (outside the annual enrollment period), Entry Date means the effective date of the Eligible Employee's coverage under the respective Covered Benefit.

17. "**Group Health Plan**" means an employee healthcare plan (other than a health flexible spending arrangement) which is sponsored by the Company, as listed in the Covered Benefits Appendix, that provides certain types of health coverage to you and your covered dependents.

18. "**Health Savings Account**" or "**HSA**" means a health savings account established under Code Section 223 by an HSA-Covered Employee. The funding of contributions to an HSA is offered as a Covered Benefit under the Plan. No HSA itself is a Covered Benefit under the Plan.

19. "**Health Savings Account Funding Benefit**" means making a contribution to an HSA on a pre-tax basis as described in Article X of this Summary.

20. "**High Deductible Health Plan**" means a "high deductible health plan" as defined in Code Section 223.

21. "**HSA-Covered Employee**" means an Employee who is an HSA-Eligible Individual and has coverage under a Health Savings Account. Whether an Employee is an HSA-Covered Employee will be based solely on the Employee's certification of his HSA coverage status during the Plan's enrollment process. The Employee must provide certification of his HSA coverage status in a form and manner prescribed by the Plan Administrator; provided, however, the Plan Administrator will have no obligation to verify the Employee's status as an HSA-Covered Employee, except to the extent provided under the definition of "HSA-Eligible Individual".

22. "**HSA-Eligible Individual**" means an "eligible individual" for health savings account purposes, as defined in Section 223(c) of the Code. Whether an Employee is an HSA-Eligible Individual will be based solely on the Employee's certification of his HSA eligibility status during the Plan's enrollment process. The Employee must provide certification of his HSA eligibility status in a form and manner prescribed by the Plan Administrator; provided, however, the Plan Administrator will have no obligation to verify the Employee's status as an HSA-Eligible Individual except to the extent of determining whether, as of the first day of a given month, the Employee is covered under (a) a High Deductible Health Plan sponsored by an Employer, or (b) a low deductible health plan(s) sponsored by an Employer that disqualifies the Employee from being an HSA-Eligible Individual.

23. "**Limited Purpose Medical Reimbursement Account**" means a Medical Reimbursement Account for which reimbursement of eligible medical care expenses is limited to dental care and vision care expenses only.

24. "**Medical Reimbursement Account**" means the account to which your elected pre-tax payroll deductions are allocated to be applied to reimburse your eligible medical care expenses.

25. "**Medical Reimbursement Account Benefit**" means the Covered Benefit described in Article V and includes participation in either the Medical Reimbursement Account or the Limited Purpose Medical Reimbursement Account.

26. "**Participant**" means an Employee who is participating in the Plan.

27. "**Period of Coverage**" generally means the Plan Year; however, the initial Period of Coverage for a new Employee who becomes eligible to participate after a Plan Year has begun is the interval beginning on the new Employee's Entry Date and ending on the last day of the Plan Year. If an Employee's participation ceases for whatever reason (such as termination of employment with the Employer) during a Plan Year in accordance with the applicable provisions of the Plan, his Period of Coverage automatically ends on the date that his participation ceased.

28. "**Plan**" means the Consolidated Communications, Inc. Flexible Employee Benefits Plan, as it may be amended from time to time.

29. "**Plan Administrator**" means Consolidated Communications, Inc.

30. "**Plan Sponsor**" means the Company.

31. "**Plan Year**" means the 12-month calendar year ending on each December 31.

32. "**Qualifying Individual**" means, in accordance with Code Section 21(b)(1):

    (a) Your "qualifying child" dependent for federal income tax purposes (as defined in Code Section 152(a)(1)) who is under the age of thirteen (13);

    (b) Your dependent for federal income tax purposes, without regard to subsections (b)(1) (*i.e.*, the "exclusion of dependents of dependents"), (b)(2) (*i.e.*, the "exclusion of married dependents filing joint tax return"), and (d)(1)(B) (*i.e.*, the "gross income limit for qualifying relatives") of Section 152, who is physically or mentally

incapable of caring for himself and who has the same principal place of abode as you for more than half of the taxable year; or

(c) Your Spouse, if your Spouse is physically or mentally incapable of caring for himself, and who has the same principal place of abode as you for more than half of the taxable year.

Notwithstanding item (a) in the above paragraph, with respect to the Plan Year ending December 31, 2020, a Qualifying Individual shall include a "qualifying child" that attains age 13 during such Plan Year.

If you are divorced or separated, your child shall be treated as the "Qualifying Individual" of his custodial parent (in accordance with Code Section 21(e)(5)) for purposes of the Dependent Care Reimbursement Account Benefit, provided that your child (a) is under the age of thirteen (13) or is physically or mentally incapable of caring for himself, and (b) receives over half of his support during the taxable year from you and his other parent and is in the custody of either parent, or both of you, for more than half of the taxable year, in accordance with Code Section 152(e).

33. "**Reimbursement Account**" means the Dependent Care Reimbursement Account, Medical Reimbursement Account, or Limited Purpose Medical Reimbursement Account, as applicable in context.

34. "**Reimbursement Account Benefit**" means either the Dependent Care Reimbursement Account Benefit or the Medical Reimbursement Account Benefit, as applicable in context.

35. "**Spouse**" means a person to whom an Employee is lawfully married, which marriage was solemnized, authenticated and recorded as required by the state or foreign jurisdiction in which the marriage took place, to the extent such marriage is legally recognized as valid for purposes of applicable federal law (including, but not limited to, the Code and ERISA), and any regulations promulgated under such federal law, but shall not include an individual divorced or legally separated from the Employee by court decree. The term "Spouse" shall also include a common law spouse if the Employee and spouse were common law married in a state which recognizes common law marriages and meet all the requirements for common law marriage in that state. The Employee must provide proof of marriage if requested by the Plan Administrator, such as, for example, an affidavit of marriage, or a marriage license or certificate of common law marriage issued by the applicable state.

36. "**Summary**" means this summary plan description of the Plan.

III. Overview of the Plan

This Summary will tell you important information about the Plan, such as the requirements that you must satisfy before you can join and the laws that protect your rights. One of the most important features of the Plan is that the Covered Benefits can be purchased with a portion of your Compensation *before* federal income and Social Security taxes are withheld. This means that your payroll "redirection" contributions to the Plan are made before you pay taxes; therefore, you pay less tax and have more money to spend or save.

Please read this Summary carefully so that you will understand the key provisions of the Plan. You should direct any questions to the Benefits Department.

Eligibility and Enrollment Requirements

The Covered Benefits available under the Plan include coverage under the Company's Group Health Plans and other employee welfare benefit plans as described in the Covered Benefits Appendix. You are eligible to participate in the Covered Benefits portion of the Plan on your Entry Date for the respective Covered Benefit. Other Covered Benefits available under the Plan are the Medical Reimbursement Account Benefit, the Dependent Care Reimbursement Account Benefit and the Health Savings Account Funding Benefit. The eligibility requirements for these benefits are described later in this Summary. After you satisfy the eligibility requirements and before the Period of Coverage begins, you will be furnished with information regarding the Plan and the Covered Benefits. Employees classified in the Employer's records as "Local 601 Union Employees" are not eligible to participate in the Plan.

A former Employee who is rehired by an Employer will be eligible to join the Plan when he is entitled to receive coverage under a Covered Benefit. A former Employee who is rehired during the same Plan Year in which he terminated employment may be able to recommence participation in the Plan when he is entitled to receive coverage under a Covered Benefit, but only by continuing the same benefit election for the remainder of that Period of Coverage.

Except in limited circumstances, Employees who were eligible to participate in the Plan for a Plan Year, but who declined to do so, will not be eligible to participate in the Plan until the next January 1st, *i.e.*, the first day of the next Plan Year. Later in this Summary there is an explanation of the Change in Status Events which permit an Employee to elect to participate or modify a Plan election during a Plan Year.

If you are an Eligible Employee who is not yet a Participant, you become a Participant by completing an individual Covered Benefits Agreement, or posting it online if done electronically, on which you elect one or more of the Covered Benefits available under the Plan, as well as agree to a compensation deduction to pay for your elected benefits. You will be provided a Covered Benefits Agreement when you first become eligible to participate. You must complete the form and return it to the Benefits Department (or, if the application is electronic, post it to the Plan's online enrollment system) within the time period specified.

In addition, a new Covered Benefits Agreement will be made available to you by the first day of each annual enrollment period, and you will be given the opportunity to confirm or change your choices made for the previous Plan Year for the coming Plan Year, effective beginning on the first day of the next Plan Year. A Participant who fails to complete and return (or post online) a Covered Benefits Agreement as required will be deemed to have elected to continue participation in the Plan with the same benefit elections for the Group Health Plans and other employee welfare benefit plans as during the prior Plan Year (adjusted to reflect any increase/decrease in applicable contributions or premiums), and except for a Change in Status Event, will not be permitted to modify his election until the next annual enrollment period. Notwithstanding the foregoing, annual elections for participation in the Reimbursement Account Benefits and the Health Savings Account Funding Benefit must be made by submitting a Covered Benefits Agreement prior to the beginning of each Plan Year -- no deemed elections will occur for either Reimbursement Account Benefit or the Health Savings Account Funding Benefit.

The Plan is comprised of three basic types of tax-advantaged components:

(1) Contribution/Premium Benefit. When you enroll for coverage under a Group Health Plan or other employee welfare benefit plan described in the Covered Benefits

Appendix and the Plan, your portion of the cost for such coverage will be deducted from your salary or wages on a *pre-tax* basis under the Plan, if you so elect. Your share of the cost for coverage under the Group Health Plan or other employee welfare benefit plan may be changed periodically. Any such adjustment will be made on a nondiscriminatory basis with respect to similarly situated participants. No other changes to your election for Group Health Plan or other employee welfare benefit plan coverage will be allowed during a Period of Coverage, except if you have a Change in Status Event as described in the section below entitled "Plan Rules and Limitations." Before the start of each new Plan Year, you will also have an opportunity to modify your coverage elections for the next Plan Year.

(2) Reimbursement Account Benefits. The second basic component of the Plan are the Reimbursement Account Benefits. Each eligible Employee may participate in the Dependent Care Reimbursement Account and in either the Medical Reimbursement Account or the Limited Purpose Medical Reimbursement Account. If you elect to participate in either or both of these Reimbursement Account Benefits, you may set aside part of your Compensation to pay qualifying medical and/or dependent care expenses on a pre-tax basis. The Reimbursement Account Benefits are discussed in more detail later in this Summary.

(3) Health Savings Account Funding Benefit. Each HSA-Covered Employee may set aside a part of his Compensation to contribute to his HSA as described in Article X of this Summary.

Subsequent Plan Elections

After you enroll in the Plan, your coverage elections, if any, under any Covered Benefit (except either of the Reimbursement Account Benefits and the Health Savings Account Funding Benefit) will be automatically renewed each year unless you otherwise notify the Benefits Department, in writing or posted online, *before the start of the next Plan Year* through the Plan's enrollment process, that you desire to change your coverage elections for the ensuing year.

You must make a new election before the start of the next Plan Year regarding the amounts that you want to contribute to your Reimbursement Accounts or your Health Savings Account. Annual elections for participation in the Reimbursement Account Benefits or Health Savings Account Funding Benefit must be made by submitting a new Covered Benefits Agreement, in writing or posted online, prior to the beginning of each Plan Year.

You may also change your coverage elections during a Plan Year if you have a Change in Status Event and your requested election change is consistent with the Change in Status Event (for example, if you want to add dependent coverage under a Group Health Plan because you had a newborn during the year). However, you may change your election with respect to your Health Savings Account Funding Benefit at any time during the Plan Year prospectively, even if you do not have a Change in Status Event. Change in Status Events are discussed in more detail later in this Summary.

Employee's Consent

By joining the Plan, you will be deemed (1) to consent to and abide by the terms, conditions and limitations of the Plan, including any decision made by the responsible person with respect to your rights or entitlement to benefits under the Plan, (2) to agree to provide satisfactory proof to

support any claim, and (3) to consent to, and fully and honestly respond to, inquiries made by the Company, health care service providers, and their agents regarding any claim that you submit.

Your Employer may change the Covered Benefits Agreement at any time to satisfy the requirements of the Code, IRS Regulations, and other authority issued thereunder.

IV. The Plan's Reimbursement Accounts at a Glance

The Reimbursement Accounts

It's the easy way to cut your out-of-pocket family care expenses by 30% or more.

There are two Reimbursement Account Benefits available to you under the Plan:

- A ***Medical Reimbursement Account Benefit*** which allows you to set aside money tax-free to help pay for expenses not covered by the other Covered Benefits; and

- A ***Dependent Care Reimbursement Account Benefit*** which lets you use tax-free money to help pay for dependent care services that are necessary in order for you (or, if married, for you and your Spouse) to go to work.

These Reimbursement Account Benefits let you deduct dollars from your paycheck on a pre-tax basis. These accounts are exempt from federal income taxes, Social Security (FICA) taxes and, in most cases, state income taxes (if applicable). The more money you put in, the less tax you pay. When you use the money in your account to pay for qualifying out-of-pocket expenses, you avoid paying taxes on those dollars. Depending on your tax bracket, you may save 1/3 or more on such expenses.

Eligibility for Reimbursement Account Benefits

- Only Employees who are eligible to participate in one of the Employer's group major medical plans that is a Covered Benefit are eligible to enroll in either Reimbursement Account Benefit. However, if you are a union employee who is covered by a collective bargaining agreement that specifically excludes your participation in the Reimbursement Account Benefits, you are not eligible to enroll in the Reimbursement Account Benefits.

- An Employee will be eligible to enroll in the Dependent Care Reimbursement Account Benefit effective as of the date that he becomes eligible for coverage under a Group Health Plan.

- An Employee will be eligible to enroll in the Medical Reimbursement Account Benefit effective as of the date he becomes eligible for coverage under a Group Health Plan. An HSA-Covered Employee is not eligible to contribute to a Medical Reimbursement Account, other than a Limited Purpose Medical Reimbursement Account, under the Medical Reimbursement Account Benefit, and only HSA-Covered Employees are eligible to contribute to a Limited Purpose Medical Reimbursement Account under the Medical Reimbursement Account Benefit.

- If you are eligible and want to participate, you must complete an enrollment form to authorize contributions under one or both of the Reimbursement Account Benefits.

How You Use the Plan's Reimbursement Accounts

In short, the Plan lets you set aside tax-free money to reimburse yourself for eligible expenses that you pay out of your own pocket. During an open enrollment period prior to the beginning of each year, you will be asked if you want to participate in the Reimbursement Account Benefits for the next Plan Year. The Reimbursement Accounts are non-interest bearing.

First, you should carefully estimate your upcoming health care and dependent care expenses that would be eligible for reimbursement. Later in this booklet are worksheets to help you estimate your expenses. You might also want to consult a tax adviser to investigate various alternatives and determine which of your expenses qualify.

After that, you decide how much of your Compensation you would like to contribute into your Reimbursement Accounts. When you participate, you designate how much of your wages will be contributed to your Medical Reimbursement Account or Limited Purpose Medical Reimbursement Account, and how much should go to your Dependent Care Reimbursement Account. You do not have to contribute to any Reimbursement Account or you can participate in the Medical Reimbursement Account Benefit but not the Dependent Care Reimbursement Account Benefit, or vice versa. The money that you elect to set aside will be "redirected" from your paychecks in equal amounts throughout the year.

We say the money is "redirected" because it is contributed to your Reimbursement Accounts before federal income or Social Security taxes are taken out. By doing this, you lower your taxable income, and thus pay less in taxes.

When you have eligible out-of-pocket medical expenses or dependent care expenses, you can be reimbursed from either your Medical Reimbursement Account, Limited Purpose Medical Reimbursement Account, or Dependent Care Reimbursement Account, as applicable depending on the nature of the claim and the Reimbursement Account in which you are enrolled. You can file for payment or reimbursement of your expenses and your eligible dependents' expenses after each expense has been incurred or you can use a debit card, as explained later in this Summary. Your eligible dependent care expenses are reimbursable through your Dependent Care Reimbursement Account Benefit, and your eligible medical expenses are reimbursable through your Medical Reimbursement Account Benefit. The amount that may be reimbursed through the Reimbursement Account Benefits depends on your election at the beginning of the Plan Year. With respect to your Medical Reimbursement Account Benefit, your eligible dependents are those individuals who satisfy the definition of "Spouse" or "Dependent."

Generally, you will have 90 days after the end of the calendar year in which to submit a claim for reimbursement for eligible expenses incurred during the previous calendar year. However, if you terminate employment before the end of a Plan Year, you must submit any claims for reimbursement of eligible expenses ***within 90 days after your termination of employment***. Notwithstanding the foregoing, effective as of March 1, 2020, and with respect to the Medical Reimbursement Account Benefit only, if the deadline to file a claim with the Claims Administrator would fall during the COVID Disregarded Period, then the deadline to file such claim with the Claims Administrator shall instead be the date that immediately follows the last day of the COVID Disregarded Period, or such later date as determined by the Plan Sponsor and communicated to Participants.

The amount reimbursed is not subject to taxes. Since that money originally came out of your pay *before* taxes were calculated, the result of the Plan is that you pay for the eligible expenses on a tax-free basis.

Periodically, you will receive a statement showing how much is in your Reimbursement Accounts. That way you will know how much you have spent and how much you have left. You may also review your Reimbursement Account balances by logging into your online account.

Special Plan Information

As you read this booklet and decide how the Plan can help you, there are some very important points to remember. Because you do not pay taxes on the money you put in, the IRS has placed some restrictions on the Plan.

Generally, once you are participating in the Plan, you cannot change the amount of money you redirect until the beginning of the next Plan Year (January 1). You may be able to change the amounts if you have a Change in Status Event. Change in Status Events are described below in the section entitled "Plan Rules and Limitations".

Another IRS limitation concerns the money you set aside in a Reimbursement Account. Any money you do not use from your Dependent Care Reimbursement Account for expenses incurred during the same Plan Year will be forfeited. Similarly, unused amounts in excess of $550 in your Medical Reimbursement Account or Limited Purpose Medical Reimbursement Account for a Plan Year must be forfeited. If you plan ahead carefully, you can avoid being affected by this restriction. However, for the Plan Years ending on December 31, 2020 and December 31, 2021, respectively, any amount remaining in your Medical Reimbursement Account, Limited Purpose Medical Reimbursement Account, or Dependent Care Reimbursement Account at the end of such Plan Years will be carried over to reimburse you for valid benefits claims that are incurred for the immediately following Period of Coverage.

V. Medical Reimbursement Account Benefit

Benefit Description

You can use your Medical Reimbursement Account Benefit to pay for certain health care expenses that are not covered, or only partially covered, by the Group Health Plan or other health plans; *i.e.*, expenses that you would normally pay out of your own pocket for yourself and your eligible Spouse and Dependents. Depending on whether you have a Medical Reimbursement Account or Limited Purpose Medical Reimbursement Account, these expenses may include deductibles and copayments, routine physical exams, eye exams, eyeglasses and contact lenses, and orthodontia and other types of health expenses listed below.

The Medical Reimbursement Account Benefit helps you save money on out-of-pocket health care expenses for you and your Spouse and Dependents.

By using this Covered Benefit, you pay for qualifying health expenses with pre-tax dollars. You save a percentage of each dollar you spend on eligible expenses that are not covered or fully covered for payment under your health care or other plans.

Depending on whether you have a Medical Reimbursement Account or Limited Purpose Medical Reimbursement Account, eligible health care expenses may include:

- Health care plan deductibles;
- Copayments;

- Amounts over the maximum each Group Health Plan pays; and

- Other eligible health expenses not covered by the Group Health Plan or other plans.

If you have a Limited Purpose Medical Reimbursement Account, eligible expenses are limited to dental and vision care expenses.

Out-of-pocket expenses incurred by you, your spouse or any dependent that qualifies as your Dependent are eligible for reimbursement. But you must enroll in the Medical Reimbursement Account Benefit to take advantage of the tax savings, and the expenses must be incurred while you are participating.

Contributions, insurance premiums and expenses paid by your (or your spouse's) health care plan are generally not eligible for reimbursement under the Medical Reimbursement Account Benefit. Also, you cannot receive reimbursement for an expense if you also itemize that expense as a deduction on your tax return.

All submitted expenses are reviewed according to Internal Revenue Code Section 125.

Your deposits to your Medical Reimbursement Account or Limited Purpose Medical Reimbursement Account cannot exceed $229.17 per month (i.e., $2,750 for each full year), as indexed for inflation, and must be a minimum of $100 for each full year while you are a Participant. However, the Plan Administrator may adjust the maximum and minimum amounts for future Plan Years (subject to any limits imposed by law). If the maximum or minimum amount is adjusted, you will be informed of such adjustment before the start of the applicable Plan Year. In any event, your elected contributions will be deducted from your pay on a pro rata basis each payroll period.

Tax Deduction vs. Medical Reimbursement Account Benefit?

The IRS allows you to deduct eligible health care expenses on your tax return only if they exceed a specified percentage of your adjusted gross income. If your total out-of-pocket health care expenses exceed that amount, you may prefer to claim them as itemized deductions on your tax return. However, you may not do so if those same expenses have already been paid with money through your Medical Reimbursement Account Benefit.

You can use both the Medical Reimbursement Account Benefit and the tax deduction, but you may not claim the same expenses for both.

Requesting Reimbursement

For reimbursement of expenses not covered under the Covered Benefits or other plans, a special reimbursement request form should be completed, unless you used a debit card as described later in this Summary. This form may be obtained from the Benefits Department, the Plan Administrator's website, or from the Claims Administrator and should be submitted, along with all related bills, to the address on the form, or if the form is electronic, posted online in accordance with the instructions of the Plan Administrator.

An account statement will be made available periodically or can be found by logging into your online account. When you submit an acceptable claim, you will receive payment up to the full amount you elected for the year, less any amounts previously reimbursed.

A description of the specific procedures for filing benefit claims, providing notification of benefit determinations, and the appeal process of adverse benefit determinations, is contained in the attached "Claims Procedures For Medical Reimbursement Account Benefit Appendix".

Eligible Health Expenses

Health care expenses that are eligible for reimbursement ("eligible expenses") under the Medical Reimbursement Account include most medical, dental and vision care expenses that are not covered by a Group Health Plan or other plans. Eligible expenses under the Limited Purpose Medical Reimbursement Account include ***only*** dental and vision care expenses that are not covered by a Group Health Plan or other plans. Please keep in mind that expenses for your Spouse and any dependents who qualify as Dependents may also be eligible expenses. (IRS publications 17 and 502 have more information on eligible expenses, the IRS will provide you with free copies upon request.)

An eligible expense is a medical expense, as defined in Code Section 213(d), for which you have not otherwise been reimbursed from insurance or some other source. You should note, however, that Code Section 125 places additional restrictions on the reimbursement of such expenses. For example, premiums for accident or health insurance and expenses for long-term care services are generally not eligible expenses.

In addition, IRS regulations require that a medical service be actually rendered prior to the time that the medical expense is reimbursed. For example, even if your doctor requires that an expense be paid in advance, you cannot be reimbursed until the service relating to the expense has been rendered. In order to ensure compliance with this IRS requirement, you (and/or your doctor) may be required to submit additional substantiation (such as a proposed treatment plan) with respect to certain long-term treatments (*e.g.*, orthodontic or obstetric expenses). Failure to submit the required forms could result in your reimbursement being pended and/or denied. There is an exception to this rule for orthodontia services. If you are required to make payments before you, your Spouse or your Dependent receives orthodontia services, you can be reimbursed after you make this payment, even if it is before the orthodontia services are rendered.

For purposes of clarity, expenses incurred for medicines or drugs on or after January 1, 2020 shall be treated as eligible medical expenses even if such medicines or drugs are not prescribed (*i.e.*, they are "over-the-counter" medicines or drugs) or are not insulin.

Notwithstanding the foregoing provisions of this Section, expenses incurred on or after January 1, 2020, for (A) a "menstrual care product" (as defined in Code Section 223(d)(2)(D)) or (B) personal protective equipment, such as masks, hand sanitizer and sanitizing wipes, for the primary purpose of preventing the spread of COVID-19, shall be treated as eligible medical expenses.

The following is a *partial list* of some of the more common eligible expenses for individual personal use. For many of these expenses, you will first file a claim for coverage under the Group Health Plan. Any amount not paid by that plan may then be submitted for payment through your Medical Reimbursement Account or your Limited Purpose Medical Reimbursement Account (for eligible expenses related to dental and vision care only). ***Inclusion on the list below does not guarantee that the expense will be eligible for reimbursement from you Medical Reimbursement Account.***

Type of Expense	**Note**
Acupuncture	Performed by a licensed practitioner

Type of Expense	Note
Alcoholism or Drug Dependency	Payment to a treatment center
Allergy and Antihistamine Medicine	
Ambulance	
Analysis	Psychotherapy by a licensed practitioner
Antacid and Heartburn Medicines	
Aspirin and Other Pain Medications	
Birth Control Pills and Devices	Only if obtained with a valid prescription
Breast Reconstruction Surgery	Following a mastectomy to ameliorate a deformity related to a disease
Car Controls	Special controls for the handicapped
Chiropractors	
Christian Science Practitioners	
Cold and Flu Medicine	
Contact Lenses	
Deductibles and Copayment	Balance not paid by a health benefit plan or other medical insurance
Dental Fees	X-rays, fillings, braces, extractions, false teeth, etc.
Doctor's Fees	
Equipment, Supplies and Diagnostic Devices	Equipment such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits may be deductible medical expenses
Exercise Programs	Not reimbursable unless prescribed by a physician to treat a specific medical condition
Eyeglasses	Lenses, frames, exams
Fertility	Medical expenses related to the treatment of infertility
Guide Dog	
Hearing Aids	
Hospitalization	Including private room coverage
Hypnosis	For health reasons
Impotence or Sexual Inadequacy	Medical expenses are reimbursable if substantiated by a physician
Insulin	
LASIK and Radial Keratotomy	
Laboratory Fees	

Type of Expense	Note
Learning Disability	Tutoring by licensed school or therapist for child with severe disability
Medicines	Only if obtained with a valid prescription
Nursing Home	Confinement for treatment of illness or injury
Nursing Service	By registered nurse or licensed practical nurse for medical care
Optometrist	
Orthodontia	Except care for cosmetic purposes
Oxygen	
Physical Exams	Except employment-related physicals
Physical Therapy	
Psychologist	
Smoking Cessation Program and Medications	
Speech and hearing therapy	
Sterilization	
Syringes, Needles, and Injections	
Transplants	
Transportation expenses for medical care	
Vaccinations and Immunizations	
Weight Loss Program	The cost of a weight loss program for general health is not reimbursable, even if a physician prescribes the program, except in two instances. First, if attendance at a weight loss program is to treat *a specific illness* (*e.g.*, heart disease) and the physician substantiates the necessity of this treatment. Second, weight loss programs to treat obesity as a disease are reimbursable expenses if the disease of obesity is diagnosed by a physician.
Wheelchairs	
X-Ray Fees	

Expenses for cosmetic surgery or other similar procedures are *not* eligible health care expenses, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.

Use of Debit Card or Stored Value Card

A medical care expense incurred during the Period of Coverage may be paid or reimbursed through your use of a debit card or stored value card (referred to in this section as "**Card**").

Certification

If you are issued a Card, you must certify upon enrollment in the Plan (or issuance of the Card, if different) and each annual enrollment period thereafter that (1) the Card will be used only in payment of a qualifying medical care expense incurred during a Period of Coverage by you, your spouse or your eligible Dependent, and (2) any medical care expense for which payment is made by use of the Card has not previously been reimbursed to you, or on your behalf, nor will you seek payment or reimbursement for the same medical care expense under any other plan. You must reaffirm such certification each time the Card is presented for payment or reimbursement of a medical care expense.

Documentation

You must acquire and retain sufficient documentation for any expense paid or reimbursed with the Card.

Limitation on Expense

No payment or reimbursement of a claim made by use of the Card (referred to in this section as a "**Card Claim**") for a medical care expense incurred during a Period of Coverage can exceed the amount of coverage you elected under your Medical Reimbursement Account, less the amount of benefits paid from your Medical Reimbursement Account, at the time when the claim for reimbursement or payment is to be settled by the Plan's Claims Administrator.

Restriction on Medical Care Providers

The Card may only be used at merchants and service providers authorized as "medical care providers" by the Plan Sponsor based on their merchant category codes. The Plan Sponsor or Claims Administrator will adopt such policies and procedures as it deems necessary to help ensure that no merchant or service provider is authorized to receive payment by use of the Card unless it is a medical care provider.

Use of the Card is not permitted at any merchant or service provider with the "Drug Stores and Pharmacies" merchant category code unless the Card processor provides a system for approving and rejecting Card transactions using "inventory control information" (e.g., stock keeping units ("SKUs")) with such merchants or service providers.

Substantiation Procedures

Every Card Claim must be substantiated. However, a Card Claim with respect to the following will be deemed "substantiated" without meeting the Plan's ordinary substantiation requirements:

(1) Co-payments: Permitted if your group health plan has copayments in specific dollar amounts and:

(A) the dollar amount of the transaction at a medical care provider equals the dollar amount of the copayment for that service under your group health plan;

(B) the dollar amount of the transaction at a medical care provider equals an exact multiple of not more than five times the dollar amount of the copayment for the specific service under your group health plan; or

(C) your group health plan has multiple copayments for the same benefit, and the dollar amount of the transaction at a medical care provider equals an exact match of multiples or combinations of the copayments, but not more than the exact multiple of five times the maximum copayment.

The copayment schedule required under your group health plan must be independently verified by the Plan Sponsor, Claims Administrator or other independent third-party, in accordance with the Plan Sponsor's procedures. Statements or other representations by you are not sufficient to meet these requirements.

(2) Recurring transactions: Permitted if the expenses incurred are the same with respect to dollar amount, medical care provider, and time period as expenses previously approved under the Plan.

(3) Real-time substantiation: Permitted if the merchant, service provider, or other independent third party, at the time and point of sale, provides information to the Claims Administrator, electronically or otherwise, that the expense incurred is a qualifying medical care expense.

(4) Inventory Information Approval System: Permitted if the Card processor provides a system for approving and rejecting Card transactions using "inventory control information" (e.g., stock keeping units ("SKUs")) with merchants or service providers who need not be medical care providers.

(5) Direct Third Party Substantiation: Permitted if the Plan Sponsor or Claims Administrator is provided with information from an independent third-party (such as an explanation of benefits from an insurance company) indicating the date of the Medical Care Expense and your responsibility for payment for that service.

If your Card Claim does not meet the foregoing criteria for deemed substantiation, your entitlement to reimbursement for your claim will be conditional, pending substantiation of the claim according to the Plan's ordinary substantiation procedures and other applicable terms of the Plan.

Recovery Procedures

In the event that reimbursement of a Card Claim is made to you, or on your behalf, and is subsequently determined to be impermissible under the terms of the Plan, the following recovery procedures will be followed by the Plan Sponsor or Claims Administrator:

(1) First, you must repay to the Plan any amounts reimbursed to you, or on your behalf, with respect to the impermissible claim.

(2) Second, if you fail to repay to the Plan the amounts reimbursed under the impermissible claim, or any portion thereof, the Company will withhold such unpaid amount from your wages or other compensation to the extent not inconsistent with applicable law.

(3) Third, if wage or compensation withholding fails to result in complete recovery of the unpaid amount, the Claims Administrator will offset your future claims reimbursements with such unpaid amount.

(4) Fourth, if the recovery procedures described in this section fail to result in complete recovery of the unpaid amount, the Plan Sponsor will treat the unpaid amount as an ordinary business debt until such unpaid amount is recovered.

Pending complete recovery of the amounts reimbursed to you, or on your behalf, with respect to an impermissible claim, the Claims Administrator may, in its discretion, deny further use of the Card until all such amounts are recovered.

Estimating Your Reimbursable Medical Expenses

It is very important that you use all of the money in your Medical Reimbursement Account or Limited Purpose Medical Reimbursement Account for a Plan Year because unused amounts in excess of $550 must be forfeited. Good planning and careful estimating are the best ways to take full advantage of your account. Generally, you have 90 days after the end of the Plan Year to submit claims for reimbursement that were incurred during that Plan Year. However, if you terminate employment before the end of a Plan Year, you must submit any claims for reimbursement of eligible expenses ***within 90 days after your termination of employment***. Notwithstanding the foregoing, for the Plan Years ending on December 31, 2020 and December 31, 2021, respectively, any amount remaining in your Medical Reimbursement Account or Limited Purpose Medical Reimbursement Account at the end of such Plan Year shall be carried over to reimburse you for benefits claims incurred under the Plan for the immediately following Period of Coverage.

Remember that only eligible dental and vision care expenses can be reimbursed through your Limited Purpose Medical Reimbursement Account. You should conservatively estimate enough to cover your family's allowable medical expenses. When you estimate your expenses PLEASE BE SURE TO INCLUDE EXPENSES FOR YOU, YOUR SPOUSE, AND YOUR DEPENDENT CHILDREN.

Review your family's medical, dental and vision care bills to estimate your expected expenses for the next Plan Year. INCLUDE ONLY THOSE EXPENSES NOT PAID BY A GROUP HEALTH PLAN OR INSURANCE.

Remember that the maximum you can contribute to your Medical Reimbursement Account or your Limited Purpose Medical Reimbursement Account is **$2,750, as indexed for inflation, for a full year** while you are a Participant (the maximum limit may be adjusted, subject to any limitations imposed by law, by the Plan Administrator for future Plan Years and communicated to Participants before the start of the year), and the minimum for each 12-month Plan Year is $100, or such other amount as determined by the Plan Administrator and communicated to Participants prior to the start of a Plan Year.

The Carryover Rule

The Plan provides for the carryover to the subsequent Plan Year of up to $550 of unused amounts remaining in your Medical Reimbursement Account or Limited Purpose Medical Reimbursement Account at the end of a given Plan Year (the "**Carryover Rule**").

The amounts that carry over to the subsequent Plan Year under the Carryover Rule may be used at any time while you are a Participant. However, no more than $550 may carry over from one Plan Year to the next.

As a general example of the Carryover Rule, assume that you elected to contribute $2,750 to your Medical Reimbursement Account for Plan Year 1, but you only incur $1,600 of reimbursable claims during such Plan Year. Of the $1,150 balance remaining in your account following payment of the claims incurred in Plan Year 1, $600 will be forfeited. However, the other $550 (plus any amount that you elect to contribute to the Medical Reimbursement Account for Plan Year 2) will be available to reimburse you for eligible medical expenses that you incur during Plan Year 2 (or a later Plan Year, provided that no more than $550 may carry over from one Plan Year to the next).

Notwithstanding the foregoing, for the Plan Years ending on December 31, 2020 and December 31, 2021, respectively, any amount remaining in your Medical Reimbursement Account or Limited Purpose Medical Reimbursement Account at the end of such Plan Year shall be carried over to reimburse you for benefits claims incurred under the Plan for the immediately following Period of Coverage.

The Plan Administrator and the Claims Administrator will apply and administer the Carryover Rule based on the Plan's procedures established in accordance with IRS Notice 2013-71 and any subsequent applicable authoritative guidance issued by an appropriate government authority.

Privacy of Your Health Information Received through the Medical Reimbursement Account Benefit

The Medical Reimbursement Account Benefit is subject to the standards for privacy ("**Privacy Standards**") issued under the Health Insurance Portability and Accountability Act of 1996, also known as "HIPAA." The Medical Reimbursement Account Benefit is also subject to a second set of regulations issued under HIPAA that govern the security of health information which is stored or transmitted electronically ("**Security Standards**"). The HIPAA Privacy and Security Standards require the Medical Reimbursement Account Benefit to protect the privacy and security of any health information that it receives or creates that either identifies you or can be used to identify you. This health information is called "Protected Health Information" or "PHI." It is called "Electronic Protected Health Information" or "ePHI" when it is stored or transmitted in an electronic format. Specifically, the Medical Reimbursement Account Benefit cannot use or disclose PHI (including ePHI) in any way that would violate the HIPAA Privacy or Security Standards or the Company's privacy and security policies for PHI and ePHI. The HIPAA Privacy and Security Standards also impose a number of other requirements on the Medical Reimbursement Account Benefit which are fully described in the attached HIPAA Medical Privacy and Security Appendix.

VI. Dependent Care Reimbursement Account Benefit

Benefit Description

In general, any dependent care service for which you file a claim must be necessary in order for you to work. If you are married, the service must be necessary for both you and your Spouse to work. Unless this applies to you, you are *not* eligible to participate in the Dependent Care Reimbursement Account Benefit.

Whether it is day care for children, or special care for disabled people of any age, dependent care is expensive. The Plan can help. You can convert taxable pay into tax-free money to reimburse yourself for out-of-pocket expenses for dependent care.

How Much You Can Convert

If you are eligible and choose to participate in the Dependent Care Reimbursement Account Benefit, the maximum you can contribute to your account **per month** is the ***smallest*** of:

- Your annual taxable pay divided by 12; or
- Your spouse's annual taxable pay divided by 12.

In addition, the maximum you can contribute for a full Plan Year is $5,000 (or $2,500 in the case of a separate return filed by a married individual, where marital status for this purpose is determined under Code Sections 21(e)(3) and (4)), provided, however, for the taxable year beginning after December 31, 2020 and before January 1, 2022, the $5,000 amount shall instead be $10,500, and the $2,500 amount shall instead be $5,250. The minimum amount that you can contribute for a full Plan Year is such amount as determined by the Plan Administrator and communicated to Participants prior to the start of a Plan Year.

Here are the reasons for the limitations on the maximum.

There are IRS limits on the amount of money you may convert each year into the Dependent Care Reimbursement Account. One limit is the lower of the taxable income earned by you or by your Spouse. For example, if your Spouse works part-time and has taxable income of $1,300 per year, you cannot redirect more than $1,300 to your account. For these guidelines, your taxable income is determined after reducing your wages for your pre-tax contributions to the Plan and any other employer-sponsored benefits plans.

The Plan also limits dependent care benefits for a family in any one calendar year to $5,000 ($10,500 for the 2021 Plan Year). If your Spouse contributes to a dependent care assistance program where he or she works, the two of you can contribute no more than a combined total of $5,000 each calendar year ($10,500 for the 2021 Plan Year). The IRS limit is $2,500 ($5,250 for the 2021 Plan Year) for a married person filing a separate tax return.

For each month your Spouse is a full-time student at an educational institution, he or she is considered to have an income of $250/month if you have one eligible Dependent, or $500/month for more than one. These limits also apply if your Spouse is a Qualifying Individual who is mentally or physically incapable of caring for himself or herself. A full-time student is someone who enrolls for at least five months during the taxable year for what is considered a full-time course of study in an on-going educational organization (defined in Code Section 170) and does not attend courses only at night.

Eligibility Requirements

For dependent care expenses to be eligible for reimbursement, you must be working during the time your eligible Dependent is receiving care. Your eligible Dependents are those individuals who meet the definition of a Qualifying Individual. If you are married, your Spouse must be:

- A wage-earner;

- A full-time student for at least five months during the year; or

- A Qualifying Individual who is mentally or physically disabled and unable to provide care for himself or herself.

If you are divorced or legally separated, you may be able to use the Dependent Care Reimbursement Account Benefit to reimburse yourself for dependent care expenses for your children who are under the age of 13, or physically or mentally incapable of caring for themselves, provided (a) your children resided with you for a longer period of the calendar year than with the other parent, (b) you and your child's other parent contribute more than half of the child's support, and (c) the child is in the custody of either one or both of you for more than half of the taxable year, in accordance with Code Section 21(e)(5).

If you file a federal income tax return, you may be eligible to receive a tax credit for dependent care expenses. However, you cannot claim the tax credit for any dependent care expenses that are paid from the Dependent Care Reimbursement Account. You should consult a tax advisor to help you determine whether the Dependent Care Reimbursement Account Benefit or the tax credit would be best for your particular situation. Some additional information is provided below. Also you may receive free information from the IRS (ask for Publications 17 and 503).

Expenses Eligible for Reimbursement

In general, if you meet the eligibility requirements, you may be able to use the money in your Dependent Care Reimbursement Account to pay yourself back for out-of-pocket expenses for the care of:

- Your child who is a Qualifying Individual; or

- Your Spouse and your eligible Dependents of any age, who (i) are Qualifying Individuals, (ii) normally spend at least eight hours in your home each day if the services are rendered outside the home, (iii) are mentally or physically incapable of caring for themselves, and (iv) have the same principle place of abode as you for more than half of the taxable year.

Notwithstanding the foregoing, you may incur eligible expenses and continue to receive reimbursements from your Dependent Care Reimbursement Account during the Plan Year ending December 31, 2020 for a Qualifying Individual who is a Dependent that attains age 13 during such Plan Year. To the extent an unused balance remains in the your Dependent Care Reimbursement Account at the end of such 2020 Plan Year, you may continue to incur eligible expenses and receive reimbursements from your Dependent Care Reimbursement Account, with respect to the unused amount carried over from the 2020 Plan Year, during the next following Plan Year for a Qualifying Individual who is a Dependent under the age of 14.

Generally, these expenses must meet all of the following conditions for them to be eligible dependent care expenses:

- The expenses are incurred for services rendered after the date that you elect to participate in the Dependent Care Reimbursement Account Benefit and during the Plan Year to which it applies.

- The expenses are incurred for the care of an eligible Dependent (as described above), or for related household services, and are incurred to enable you to be gainfully employed.

- If the expenses are incurred for services outside your household and such expenses are incurred for the care of an eligible Dependent who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.

- If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

- The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a dependent.

These expenses include charges for such things as:

- Licensed nursery school and day care centers for children;

- Licensed day care centers for disabled dependents; and

- Individuals who have the responsibility of providing care for your eligible Dependents, either inside or outside your home. If outside your home, generally the provider must meet all licensing requirements.

IRS regulations do not allow reimbursement for such expenses as:

- Days you are not working, including sick leave, vacation days, or breaks between semesters;

- Care provided by your children who are under the age of 19 or by anyone you claim as a dependent for federal income tax purposes;

- Transportation, education, clothing, or entertainment; and

- Babysitting for social events.

Only expenses that are adequately documented will be reimbursed.

Food and education will be covered if provided by the nursery school or day care center as part of its preschool care services. Food and education expenses are not covered for kindergarten or higher.

The IRS requires the reporting of the Taxpayer Identification Number or Social Security Number and name and address of the dependent care provider with each request for reimbursement.

Tax Credit vs. Dependent Care Reimbursement Account Benefit?

You can pay eligible expenses through the Dependent Care Reimbursement Account Benefit with pre-tax dollars, or take a tax credit for these expenses on your federal income tax return. You cannot have expenses paid through your account and then take the tax credit for the same expenses. The method that produces the greater tax savings for you depends on your personal situation.

Therefore you should determine, before enrolling in the account, that reimbursement is more advantageous than a tax credit. Here are some general guidelines to keep in mind as you make your decision.

The dependent care tax credit is a reduction of your federal income tax for dependent care expenses that permits you – or, if you are married, you and your Spouse – to continue to work. It is subtracted from your actual tax liability. In contrast, the Dependent Care Reimbursement Account Benefit reduces your taxable income before your taxes are calculated.

The amount of the federal tax credit is a percentage of your eligible dependent care expenses. Your income level determines the percentage used in calculating the tax credit. The percentage decreases gradually – from 35% for those who have an adjusted gross income of $15,000 or less, to 20% for those with an adjusted gross income of over $43,000 (and these limits may be revised from time to time).

The IRS limits the amount of dependent care expenses which are eligible for a tax credit on your federal income tax return. The actual amount of your tax credit is determined by applying a percentage to your total work-related, dependent care expenses. These expenses may not exceed $3,000 for one eligible Dependent or $6,000 for two or more eligible Dependents.

You do not have to itemize expenses on your income tax return to qualify for a tax credit for dependent care expenses. In general, the higher your tax bracket, the more advantageous it is for you to use the Dependent Care Reimbursement Account Benefit rather than take a tax credit. Keep in mind that your tax credit will be reduced by the amount excluded from your income under the Dependent Care Reimbursement Account Benefit. For example, if you have two eligible Dependents, incur $6,000 in day care expenses, and pay $4,800 on a tax-free basis through your account, you could be eligible for a tax credit with respect to the remaining $1,200, since the maximum tax credit is based on $6,000 in dependent care expenses (for two or more Dependents), and $4,800 has been offset by the $4,800 you contributed to your account. You are advised to consult with your personal tax advisor to decide what is best for your particular situation.

Amounts used to calculate your tax credit will be reduced, dollar for dollar, by any amounts paid from the Dependent Care Reimbursement Account. For example, if you have one child, $3,000 in eligible dependent care expenses for that child, and elected to pay $1,000 of those expenses through your Dependent Care Reimbursement Account Benefit, the expenses you could claim under the tax credit would be reduced by that $1,000 reimbursement to $2,000 ($3,000 limit - $1,000). However, you could elect during open enrollment to pay the entire $3,000 in expenses through your Dependent Care Reimbursement Account Benefit by redirecting $3,000 of your compensation to such Account.

Estimating Your Reimbursable Dependent Care Expenses

It is very important that you use all of the money in your Dependent Care Reimbursement Account for a Plan Year because unused amounts by law must be forfeited. Good planning and careful estimating are the best ways to take full advantage of your account. Generally, you have 90 days after the end of the Plan Year to submit claims for reimbursement that were incurred during that Plan Year. However, if you terminate employment before the end of a Plan Year, you must submit any claims for reimbursement of eligible expenses ***within 90 days after your termination of employment***. Notwithstanding the foregoing, for the Plan Years ending on December 31, 2020 and December 31, 2021, respectively, any amount remaining in your Dependent Care Reimbursement

Account at the end of such Plan Year shall be carried over to reimburse you for benefits claims incurred under the Plan for the immediately following Period of Coverage.

The worksheet below can help you determine the amount of your Compensation that you might consider redirecting into a Dependent Care Reimbursement Account. Part of the worksheet shows an example of estimated amounts for a sample employee. The example assumes an employee who is married and has one child. This is an illustrative example that is only an estimate and is not tax advice.

Review your records for the last few months and estimate your expected dependent care expenses for the Plan Year:

	Example	**You**
1.Child Day Care Expenses	$2,400	_____
2.Pre-School Expenses	_____	_____
3.Summer Day Camp Expenses	_____	_____
4.Adult Day Care Expenses	_____	_____
5.Other Eligible Expenses	_____	_____
TOTAL ESTIMATED DEPENDENT CARE EXPENSES	$2,400	_____
6.*Divide the total amount by 12*	$ 200	_____

This is the *monthly* figure you might consider contributing to your Dependent Care Reimbursement Account. Remember, if you participate, the maximum you can contribute in any month is the ***smallest*** of:

- Your annual taxable pay divided by 12; or
- Your Spouse's annual taxable pay divided by 12.

The annual limits for a full year are as follows:

- $5,000 (or $2,500 in the case of a separate return filed by a married individual, where marital status for this purpose is determined under Code Sections 21(e)(3) and (4)), provided, however, for the taxable year beginning after December 31, 2020, the $5,000 amount shall instead be $10,500, and the $2,500 amount shall instead be $5,250; or
- The IRS limits explained earlier in this Summary.

Requesting Reimbursement

If you have a Dependent Care Reimbursement Account, you may submit your dependent care expenses using a special request form that is available in the Benefits Department, on the Plan Administrator's website, or from the Claims Administrator. This form, along with all related bills and receipts, should be submitted to the address on the form, or if the form is electronic, posted online in accordance with the instructions of the Plan Administrator to obtain reimbursement. IRS regulations require you to provide the name, address, and taxpayer identification (the Social Security Number or Employer Identification Number in most cases) of your dependent care service provider on your reimbursement request form.

An account statement will be made available periodically or can be found by logging into your account with the Plan Administrator. If you submit a request for more than your account balance, partial payment will be made with the funds available. Remaining amounts will be paid when additional deposits have been credited to your account.

If you terminate employment, you may submit reimbursement claims for eligible dependent care expenses incurred prior to the the earlier of (1) the end of the Plan Year in which you terminate, or (2) 90 days after your termination of employment. You cannot elect COBRA continuation coverage for your Dependent Care Reimbursement Account Benefit.

VII. The Reimbursement Accounts' Tax Advantages

By using the Plan to help pay for your contributions and premiums for coverage under the Group Health Plans and the other Covered Benefits on a pre-tax basis, as well as for medical and dependent care expense reimbursements, you may take home more of your pay. The two examples below will illustrate how this works.

Example 1

Susan is married and has two children. Both she and her husband work and their combined annual income is $40,000. After carefully estimating their expenses, Susan contributes these amounts to the Plan on a pre-tax basis:

• Contributions for family Group Health Plan coverage	$1,080
• Medical Reimbursement Account	2,470
• Dependent Care Reimbursement Account	4,200
Total in Plan	$7,750

Here's how Plan would affect Susan's taxes and net pay. The example is based on estimated federal income tax rates and the standard federal deduction. The effect of state and local taxes is not considered.

	With Plan	**Without Plan**
Annual Income	$40,000	$40,000
Medical/Dental Contributions	-1,080	- -
Medical Reimbursement Account	-2,470	- -
Dependent Care Reimbursement Account	-4,200	- -
Adjusted Gross Income	$32,250	$40,000
Estimated Social Security Tax (7.65%)	-2,467	-3,060
Estimated Federal Income Tax	-2,558	-3,240*
After-Tax Medical/Dental Contributions	- -	-1,080
After-Tax Medical Expenses	- -	-2,470
After-Tax Dependent Care Expenses	- -	-4,200
Pay Remaining For Other Family Expenses	$27,225	$25,950

SAVINGS WITH PLAN = $1,275

*This estimate includes a federal income tax credit for dependent care expenses.

By taking advantage of the Plan, Susan and her husband pay $1,275 less in taxes.

Note: This example is provided for illustration purposes only.

Example 2

John is a single father with one child. He earns $18,000 per year. He works out his eligible expenses like this:

• Contributions for coverage under the Group Health Plan	$1,000
• Medical Reimbursement Account	300
• Dependent Care Reimbursement Account	0
Total in Plan	$1,300

Although John estimates he will have $2,400 in dependent care expenses, he decides that he would be better off by using the federal dependent care income tax credit instead of the Dependent Care Reimbursement Account. Consequently, he chooses not to participate in that Account.

	With Plan	**Without Plan**
Annual Income	$18,000	$18,000
Medical/Dental Contributions	-1,000	- -
Medical Reimbursement Account	-300	- -
Dependent Care Reimbursement Account	- -	- -
Adjusted Gross Income	$16,700	$18,000
Estimated Social Security Tax (7.65%)	-1,278	-1,377
Estimated Federal Income Tax	-338*	-599*
After-Tax Medical/Dental Contributions	- -	-1,000
After-Tax Medical Expenses	- -	-300
After-Tax Dependent Care Expenses	-2,400	-2,400
Pay Remaining For Other Family Expenses	$12,684	$12,324

SAVINGS WITH PLAN = $360

*This estimate includes a federal income tax credit for dependent care expenses.

Here, John saves $360 a year in taxes simply by using the Plan and paying for his medical plan contributions and out-of-pocket medical expenses on a pre-tax basis.

Note: This example is provided for illustration purposes only.

Fact: You do not pay federal income taxes or Social Security taxes on the money you convert into the Plan.

Your actual tax savings under the Plan depend on such things as your taxable income, number of dependents, state of residence, etc. You are advised to consult with your tax advisor to see how the Plan can benefit you personally. *The Employer does not provide any tax advice to any*

employee, and the Employer provides no assurances regarding the tax consequences of your participation.

VIII. Reimbursement Rules for Reimbursement Accounts

If you submit a claim for dependent care expense reimbursement for more than is currently in your Dependent Care Reimbursement Account, a partial reimbursement (up to the amount you have in your account) will be made. Then, as more money goes into your account, you will continue to be reimbursed until the entire eligible expense is covered. On the other hand, the limit on medical expense reimbursement claims is based on the dollar amount of coverage you elected for the entire Plan Year, even though you may not have currently contributed amounts to your Medical Reimbursement Account equal to the health expense reimbursement claimed.

If you terminate employment during the year, any eligible expenses you incurred (1) while still employed by the Employer are reimbursable under your Medical Reimbursement Account or Limited Purpose Medical Reimbursement Account to the extent of your previously elected coverage limit for the Plan Year, and (2) during the remainder of the Plan Year in which you terminated employment (or, if shorter, during the 90-day period following your termination of employment) are reimbursable under your Dependent Care Reimbursement Account to the extent of the remaining cash in such Account. You must file all claims for reimbursement against your Dependent Care Reimbursement Account, Medical Reimbursement Account, or Limited Purpose Medical Reimbursement Account within 90 days after your employment terminates. Your Spouse and Dependents may continue submitting claims during that period if you should die (provided that such claims were incurred prior to your death). Notwithstanding the foregoing, effective as of March 1, 2020, and with respect to the Medical Reimbursement Account Benefit only, if the deadline to file a claim with the Claims Administrator would fall during the COVID Disregarded Period, then the deadline to file such claim with the Claims Administrator shall instead be the date that immediately follows the last day of the COVID Disregarded Period, or such later date as determined by the Plan Sponsor and communicated to Participants.

IX. How to Participate in the Reimbursement Accounts and Health Savings Account Funding Benefit

If you are a current Employee who is eligible to participate in the Reimbursement Account Benefits, you must fill out a written or electronic enrollment form and return it to the Benefits Department, or post it online, according to the Plan's procedures, by the designated due date. The form must be completed and returned or posted during the open enrollment period unless you incur a Change in Status Event. Employees who are hired during a Plan Year should contact the Benefits Department to obtain an enrollment form. If you are an Employee who is eligible to participate in the Health Savings Account Funding Benefit, you must fill out an enrollment form and either (i) post it online or (ii) submit to the Plan Administrator no later than the designated due date before you can participate. Employees classified in the Employer's records as "Local 601 Union Employees" are not eligible to participate in the Plan.

X. Health Savings Account Funding Benefit

The Health Savings Account Funding Benefit under the Plan allows you to contribute to your Health Savings Account on a pre-tax basis. This means that your Employer will deduct the amount you elect as salary reduction contributions from your paycheck and contribute it, along with any Employer nonelective contributions, to your Health Savings Account on your behalf. You have the

responsibility of establishing and maintaining your Health Savings Account with the HSA Custodian if you are eligible.

Your Health Savings Account itself is not a Covered Benefit under the Plan, and the Plan Sponsor does not sponsor any Health Savings Account to any extent.

Eligibility

An Employee will be eligible to participate in the Health Savings Account Funding Benefit during any month in which the Employee meets the following requirements on the first day of such month:

- Is a participant in the Employer's High Deductible Health Plan that is a Covered Benefit;
- Is an HSA-Eligible Individual (as defined in the section above entitled "Important Terms"); and
- Is an HSA-Covered Employee (as defined in the section above entitled "Important Terms") with HSA coverage established through the HSA Custodian.

If you meet the eligibility criteria above, you may reduce your Compensation pursuant to a Covered Benefits Agreement in order to fund contributions to your HSA.

Contribution Amounts

The amount that you can contribute to your Health Savings Account is regulated by the Internal Revenue Service. The maximum you can contribute depends on whether you have employee-only coverage, family or any other level of coverage under the Employer's High Deductible Health Plan. For 2021, the annual maximum that can be contributed to your Health Savings Account is $3,600 if you have employee-only coverage, or $7,200 if you have any other coverage level. In addition, you may be eligible to make age-related "catch up contributions" of up to $1,000 in the aggregate if you (i) will have attained age 55 by the end of the taxable year, and (ii) are not enrolled in Medicare. The foregoing limits may be indexed for inflation in subsequent years.

It is your responsibility to ensure that you comply with the foregoing limits.

Employer Nonelective Contribution

Your Employer may decide to make a nonelective contribution to your Health Savings Account. If so, you will be notified of the amount of the contribution before the beginning of the Plan Year. Any Employer nonelective contribution to your Health Savings Account counts towards the maximum amount that you may contribute for the year.

Election Changes

At any time, you can change the amount you want to contribute to your Health Savings Account. Any such change will be effective as of the next administratively feasible payroll period. However, you must make a new election before the start of each Plan Year. If you do not make an election before the start of the Plan Year, you will not be able to participate in the Health Savings Account Funding Benefit for the Plan Year, unless you prospectively change your election for this benefit during the Plan Year.

Additional Information

For more information on how HSAs work, and possible tax implications, you can refer to IRS Publication 969, which can be found online at www.irs.gov.

The Health Savings Account Funding Benefit is not a plan subject to ERISA. Except for the funding feature, the HSA Custodian is responsible for all administration related to your HSA, which will be based on the terms of the individual custodial agreement between you and the HSA Custodian. *You cannot elect COBRA continuation coverage under the Health Savings Account Funding Benefit*.

XI. Plan Rules and Limitations

Possible Effect of Plan On Social Security Benefits

Because you do not pay Social Security taxes on your Compensation that is contributed to the Plan, your eventual Social Security benefits at retirement or disability may be reduced. Any reduction will depend on the length of time between now and when you retire (or become disabled) and whether or not your taxable income exceeds the Social Security maximum wage level.

For most Employees, the advantages of using the money tax-free would likely outweigh any potential reduction in Social Security benefits in the future.

When Coverage Ends

Your coverage under the Plan (or a particular Covered Benefit) ends when you choose not to participate for a Plan Year. Also, your coverage ends when:

- You are no longer an eligible Employee;
- You terminate employment for whatever reason;
- You validly revoke your existing elections or fail to make a required contribution to the Plan;
- The Plan is amended to terminate participation with respect to the class of Employees of which you are a member; or
- The Plan is terminated.

What Expenses Are Not Covered

In addition to the IRS restrictions listed in the above sections about the Medical Reimbursement Account, Limited Purpose Medical Reimbursement Account, and the Dependent Care Reimbursement Account, there are some general rules about expenses that are not eligible for reimbursement. Expenses that are not covered under the Plan include:

- Expenses claimed as a deduction or credit for federal income tax purposes;
- Expenses reimbursed under any other policy or plan, including Medicare or other federal programs;

- Expenses reimbursed by your HSA; and

- Expenses incurred before you enrolled in the Plan.

To be eligible for reimbursement, the expense must be incurred during your Period of Coverage. *An expense will be incurred when the service is rendered regardless of when the claim is paid*. You should remember this when you estimate your expenses.

There is an exception to the above rule for orthodontia services. If you are required to make payments before you or your Dependent receives orthodontia services, you can be reimbursed after you make this payment, even if it is before the orthodontia services are rendered.

The money in your Medical Reimbursement Account can only be used for qualifying health care expenses, and the money in your Limited Purpose Medical Reimbursement Account can only be used for qualifying dental and vision care expenses. Likewise, the money in your Dependent Care Reimbursement Account can only be used for qualifying dependent care expenses. You cannot transfer money between these accounts.

Changing Your Plan Election (Change in Status Events)

Because the Plan allows you to save money on your taxes, the IRS has placed some restrictions on "cafeteria plans" like the Plan.

Under these rules, once you have made your Plan elections for the Plan Year, you cannot change them unless you experience a "Change in Status Event" for which changes are allowed. This does not apply to the Health Savings Account Funding Benefit; you can change your HSA contributions at any time, as provided in Article X. The IRS considers the following events to be examples of Change in Status Events that may permit you to change your Plan elections:

- You get married or divorced.

- You have a child or adopt one.

- Your Spouse or one or more of your children dies.

- You, your Spouse, or your Dependent commences or terminates employment.

- Your or your spouse's employment status changes.

- You or your Spouse take an unpaid leave of absence.

- Your Spouse has a change in coverage directly attributable to your Spouse's employment.

There are other events which are considered to be Change in Status Events, as described in the Plan and IRS regulations. Any election change must be *consistent* with the reason that such change was permitted.

With respect to the Group Health Plan, in addition to the events listed above, the following events are examples of other events that may also qualify as Change in Status Events:

- You qualify for special enrollment under a Group Health Plan due to the Health Insurance Portability and Accountability Act **("HIPAA")**, including special enrollment rights provided under the Children's Health Insurance Program Reauthorization Act of 2009.

- You (or your Spouse or Dependent) change your place of residence or work.

- You receive a court order resulting from a divorce, legal separation, annulment, or change in legal custody that requires health coverage for your child.

- You or your Spouse or Dependent become entitled to Medicare or Medicaid coverage.

- You change employment status so that you are expected to work on average less than 30 hours per week, even if you remain eligible for coverage under the Group Health Plan, provided that you enroll in another plan that provides "minimum essential coverage."

All election changes must be consistent with the Change in Status Event and comply with the other conditions of the Plan and IRS regulations. That means, for example, you cannot drop coverage because you gained a new Dependent child.

You cannot change your election of coverage under the Medical Reimbursement Account Benefit during a Period of Coverage based on a change in your status as an HSA-Eligible Individual unless otherwise permitted due to a Change in Status Event.

If you believe you have a Change in Status Event and want to change your election, you must contact the Benefits Department which will provide you with a written or electronic election form for changing your benefit elections. This section provides an overview of the circumstances when a mid-year election change may be permitted under the Plan. You must refer to the actual Plan document for complete information.

Any election change made during a Period of Coverage will not be effective until the date designated by the Plan Administrator, which effective date will not be before the date that the completed and signed election change form is received and accepted by the Plan Administrator (or, if the form is electronic, posted online in accordance with the Plan's procedures). However, changes pursuant to HIPAA special enrollment rights for the acquisition of a Dependent due to birth, adoption or placement for adoption will be effective as of the date of the birth, adoption or placement. You must notify the Benefits Department of a Change in Status Event within thirty (30) days of its occurrence (or within (60) days in the case of certain HIPAA special enrollment rights related to CHIP or Medicaid).

Effective as of March 1, 2020, the timeframes set forth above for an election change under the Contribution/Premium Benefit resulting from a Change in Status Event that is a special enrollment event under HIPAA, as described in this Section, shall be tolled during the COVID Disregarded Period.

Notwithstanding the foregoing, effective as of January 1, 2020, the Plan Administrator may permit you to revoke an election, make a new election, or decrease or increase an existing election regarding a Dependent Care Reimbursement Account Benefit or a Medical Reimbursement Account Benefit on a prospective basis during the Plan Years ending on December 31, 2020 and December 31, 2021, respectively, subject to such administrative procedures as determined by the Plan Administrator. However, you may not reduce an existing election under the Dependent Care

Reimbursement Account Benefit or the Medical Reimbursement Account Benefit portion of the Plan for the remainder of the 2020 or 2021 Plan Years, respectively, below the aggregate amount that has already been reimbursed as of the effective date of the election change.

During the open enrollment period before the beginning of each Plan Year, you can change your elections for the upcoming Plan Year, even if you did not have a Change in Status Event, upon your timely submission of a written or electronic change form and its receipt and acceptance by the Benefits Department (or, if the form is electronic, posted online in accordance with the Plan's procedures).

Using All Contributions Made to Your Reimbursement Accounts

Because of IRS regulations, if there is any money left in any of your Reimbursement Accounts in excess of $550 at the end of the Plan Year after all reimbursable claims have been paid for such Plan Year, that money will be forfeited. Without exception, you will not be able to receive any unused balance left in your account. This is sometimes called the "use it or lose it rule." Notwithstanding the foregoing, for the Plan Years ending on December 31, 2020 and December 31, 2021, respectively, any amount remaining in your Medical Reimbursement Account Benefit or your Dependent Care Reimbursement Account Benefit at the end of such Plan Year will be carried over to reimburse you for benefits claims incurred under the Plan for the immediately following Period of Coverage.

Limitations that Apply to Highly Compensated and Key Employees

"Highly compensated employees" and "key employees" generally are Participants who are officers, shareholders or highly paid employees as defined in the Code. If you are within these categories, the amount of your contributions and benefits may be limited so that the Plan as a whole does not disproportionately favor such employees and their Spouses and Dependents.

Plan experience will dictate whether contribution limitations on "highly compensated employees" or "key employees" will apply. You will be notified if you are affected by these limits.

Denial of Claim for Benefits

If you have a claim for benefits under one of the Covered Benefits, you will generally proceed under the claim procedures applicable to that particular Covered Benefit. However, if you are denied a benefit under the Plan (such as the ability to pay for contributions or premiums on a pre-tax basis) due to an issue that is solely germane to your coverage under the Plan (*e.g.*, determination of a Change in Status Event), the claim procedures under the Plan will apply. You will be notified in writing by the Plan Administrator within 60 days of the date you submitted your request if the request is denied. Such notification will set out the reasons your request was denied, and advise you of the steps, if any, that you can take to validate your claim. It will further advise you of your right to request an administrative review of the claim denial; you may request a review any time within the 60-day period after you have received notice of the claim denial. You or your authorized representative will have the opportunity to review any relevant documents held by the Plan Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for a review, and you will be notified of such decision.

Denial of Claim for Benefits Under the Medical Reimbursement Account Benefit

A description of the procedures governing the denial and appeal of a claim for benefits under the Medical Reimbursement Account Benefit is contained in the attached "Claims Procedures for Medical Reimbursement Account Benefit Appendix". Please note that different time limitations apply for making claims for benefits and appealing denied claims under the Medical Reimbursement Account.

COBRA Continuation Coverage

Federal law requires most employers sponsoring group health plans to offer employees and their covered Dependents the opportunity for a temporary extension of health care coverage (called "COBRA continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the Medical Reimbursement Account Benefit (and any other Group Health Plans offered as Covered Benefits under the Plan).

The rules regarding COBRA coverage which apply to the Medical Reimbursement Account Benefit are described in the following sections. The Group Health Plans offered as Covered Benefits under the Plan maintain separate COBRA coverage provisions. References to "Plan" in the following sections regarding COBRA coverage mean the Medical Reimbursement Account Benefit.

Eligibility

Subject to the other rules regarding COBRA coverage below, a Participant (and/or his Spouse and Dependents) is eligible for COBRA coverage under the Plan only if, as of the date of his Qualifying Event, the maximum remaining reimbursement amount that is available to the Participant in his Medical Reimbursement Account or Limited Purpose Medical Reimbursement Account exceeds the COBRA contribution payments that would be paid by the Participant to maintain COBRA coverage under the Plan for the remainder of the Plan Year. In that case, the Participant (and or/his Spouse and Dependents) who is a Qualified Beneficiary (defined below) may elect COBRA coverage under the Medical Reimbursement Account Benefit only through the last day of the Plan Year in which his Qualifying Event occurred, except as otherwise required with respect to amounts carried over (up to $550) to a subsequent year under the Carryover Rule described above.

If you are a Participant in the Medical Reimbursement Account Benefit and you are eligible for COBRA coverage, then you have a right to choose continuation coverage under the Medical Reimbursement Account Benefit if you lose your coverage because of:

- A reduction in your hours of employment;
- A voluntary or involuntary termination of your employment (for reasons other than gross misconduct);
- A military leave of absence that lasts thirty-one (31) days or longer (in accordance with USERRA, as discussed below); or
- Your failure to return from FMLA leave.

If you are the Spouse of a Participant who is eligible for COBRA coverage, then you have the right to choose continuation coverage for yourself if you lose coverage for any of the following reasons:

- Death of the Participant;
- The Participant becomes entitled to Medicare benefits (under Part A, Part B, or both);
- Voluntary or involuntary termination of the Participant's employment (for reasons other than gross misconduct) or reduction in the Participant's hours of employment;
- Divorce or legal separation from the Participant; or
- Failure of the Participant to return from FMLA leave.

In the case of a Dependent child of a Participant who is eligible for COBRA coverage, he or she has the right to choose continuation coverage if coverage is lost for any of the following reasons:

- Death of the parent-Employee;
- Voluntary or involuntary termination of the parent-Employee's employment (for reasons other than gross misconduct) or reduction in the Employee's hours of employment;
- His or her parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- His or her parents' divorce or legal separation; or
- He or she ceases to be an eligible Dependent child under the provisions of the Plan; or
- Failure of his or her parent-Employee to return from FMLA leave.

A Dependent child who is born to, or placed for adoption with, the Employee during a period of continuation coverage is also entitled to continuation coverage under COBRA. Those who are entitled to COBRA continuation coverage are called "Qualified Beneficiaries".

Notice of Qualifying Event

The Plan will offer COBRA coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a qualifying event as described above ("**Qualifying Event**") has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event within thirty (30) days after it occurs. For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within a maximum of sixty (60) days after the latest of (a) the Qualifying Event, (b) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event, or (c) the date on which you are informed, including through this Summary or a COBRA general notice, of your responsibility to provide a Qualifying Event notice as described in this section and the Plan's procedures for providing such notice. You must provide this notice to the Plan's COBRA Administrator, as designated below in the section of this Summary entitled "Questions and Other Information Regarding COBRA Coverage". This notice must be in writing and must contain the name of the Qualified Beneficiary, the name of the Plan to which the notice applies, a description of the Qualifying Event, and the date on which the Qualifying Event occurred. If you mail the notice, it must be postmarked no later than the last day of the applicable

notice period described above. Failure to make timely notification will result in a termination of the Qualified Beneficiary's rights to COBRA coverage under the Plan.

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active Employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan during your COBRA coverage period upon the occurrence of any event that permits a similarly situated active Employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Medical Reimbursement Account Benefit will end with the date you would otherwise lose coverage.

Birth, Adoption or Placement for Adoption of a Child

A Qualified Beneficiary must notify the Plan Administrator in writing of the birth to, adoption by or placement for adoption of a child with a Participant receiving COBRA coverage. This notice must contain (a) the name of the Participant, (b) the name of the Plan to which the notice applies, (c) the reason for the notice (*i.e.*, the birth, adoption or placement for adoption of a child, as applicable), and (d) the date of such child's birth, adoption or placement for adoption.

Electing COBRA Continuation Coverage

Each Qualified Beneficiary is entitled to make a separate election for continuation coverage under the Plan. In order to elect continuation coverage, you must complete the election form(s) provided to you by the Plan Administrator. You have a maximum of sixty (60) days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later, to provide your completed election form to the Plan Administrator indicating that you wish to continue coverage. Failure to return the election form within the maximum 60-day period will be considered a waiver, and you will not be allowed to elect continuation coverage.

Contributions

You will have to pay the entire cost of your continuation coverage. Payments for continuation coverage are payable on an after-tax basis only. The cost of your continuation coverage will not exceed 102% of the applicable cost for the period of continuation coverage. The first contribution payment after electing continuation coverage will be due forty-five (45) days after making your election. Subsequent contributions must be paid within a 30-day grace period following the due date. Failure to pay contributions within this time period will result in termination of your continuation coverage. Claims incurred during any period will not be paid until your contribution payment is received for that period. If you timely elect continuation coverage and pay the applicable contribution, however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

Duration of COBRA Continuation Coverage

The maximum period for which coverage may be continued under the Medical Reimbursement Account Benefit will be until the end of the Plan Year in which the Qualifying Event occurs. You will be notified of the duration of continuation coverage when you have a Qualifying Event. However, continuation coverage may end earlier for any of the following reasons:

- The contribution for your continuation coverage is not paid on time or it is insufficient (Note: If your payment is insufficient by the lesser of 10% of the required COBRA contribution, or $50, you will be given thirty (30) days to cure the shortfall);

- The date that you first become covered under another group health plan under which you are not subject to a pre-existing condition exclusion limitation, after you elect continuation coverage;

- The date that you first become entitled to Medicare, after you elect continuation coverage; or

- The date the Employer ceases to maintain a group health plan within its controlled group.

Questions and Other Information Regarding COBRA Coverage

It is your responsibility to keep the Plan Administrator informed of any changes in the address of you, your Spouse and your Dependents. You should also keep a copy for your records of any notices you send to the Plan Administrator. Questions concerning your COBRA coverage rights should be directed to the third party administrator responsible for administering COBRA on behalf of the Plan Administrator, as follows:

UnifyHR
105 Decker Ct., Suite 310
Irving, TX 75062
(800) 519-8366

If the Company changes COBRA administrators or you are unable to reach the above-referenced COBRA administrator, you should direct your questions to the Plan Administrator at the address and telephone number listed in the section of this Summary entitled "General Plan Information".

Tolling of Certain COBRA Deadlines Due to the COVID National Emergency

Notwithstanding the foregoing, effective as of March 1, 2020, the following COBRA-related Compliance Timeframes (as such term is defined in the definition of COVID Disregarded Period in the section above entitled "Important Terms") shall be tolled during the COVID Disregarded Period:

(a) The timeframe within which the Plan Administrator (or its designee) must provide a COBRA election notice under ERISA Section 606(c) and Code Section 4980B(f)(6)(D);

(b) The 60-day election timeframe for COBRA continuation coverage under ERISA Section 605 and Code Section 4980B(f)(5);

(c) The 45-day timeframe (for initial premiums) or 30-day timeframe (for monthly premiums) within which COBRA qualified beneficiaries must make COBRA premium payments pursuant to ERISA Section 602(2)(C) and (3) and Code Section 4980B(f)(2)(B)(iii) and (C); and

(d) The timeframe within which individuals must notify the Plan Administrator (or its designee) of a COBRA qualifying event or determination of disability under ERISA Section 606(a)(3) and Code Section 4980B(f)(6)(C).

Coverage While on Duty in the Uniformed Service

Your right to continued participation in the health benefits under the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("**USERRA**"). Accordingly, if you are absent from work due to a period of active duty in the Uniformed Services for less than thirty-one (31) days, your participation in the health benefits under the Plan will not be interrupted and you will not be required to pay more than the Employee share for such coverage.

Thereafter, you may elect to continue such health benefits coverage under the Plan for you and your family members for up to twenty-four (24) months. You will be required to pay up to 102% of the applicable cost for any portion of your absence that exceeds thirty-one (31) days. You must pay the contributions with after-tax funds, subject to the rules that are set out in the Group Health Plans. Your coverage under this section will run concurrently with COBRA Continuation Coverage described above in this Summary. However, continuation coverage extended under USERRA is not subject to the early termination provisions of COBRA or the provisions of COBRA allowing for an extension due to a subsequent Qualifying Event.

The "Uniformed Services" are the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

Family and Medical Leave

If you are absent from work on a leave of absence covered by the Family and Medical Leave Act ("**FMLA**"), you are entitled to maintain the coverage you have under the Plan during your absence. You must pay the contributions for the coverage during your absence using one of the following alternative methods:

- *Prepayment*. Under the prepayment option, you may (at your option) increase your salary reduction in an amount sufficient to cover the premiums that will come due during the FMLA leave.

- *Pay-as-you-go*. With the pay-as-you-go option, you continue to pay contributions on a regular basis throughout the FMLA leave. If your FMLA leave is paid, your contributions will be paid with pre-tax money as if you had not taken the leave. On the other hand, if your FMLA leave is unpaid and you choose this option, you must pay the contributions directly during the course of your leave, on an after-tax basis, with your contributions being due for each month of coverage on the first day of each month.

- *Agreement with Employer*. You may pay your contributions by any other method that is voluntarily agreed to between you and your Employer.

If your Employer pays a portion of your contributions for such coverage, it must continue those payments during your FMLA leave. However, if you do not return from FMLA leave, you

may be required to repay the Employer-paid portion of the health contributions. Please refer to your Employer's FMLA Policy for additional information.

XII. Conclusion

The Plan offers a unique and efficient way of saving money on taxes. Through convenient payroll redirection, you can save money on your share of the contributions for the plans listed in the Covered Benefits Appendix. You may also save money by paying for out-of-pocket medical and dependent care expenses through the Reimbursement Account Benefits offered under the Plan or by contributing to your HSA. In addition, through proper planning, you can be better prepared for the predictable medical and dependent care expenses that affect you and your family.

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities, and save for the future. The Plan will help you keep more of your income by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your money.

The Company is pleased to continue to sponsor the Plan for the benefit of our Employees. We value your efforts and hope that your participation will enable you to look with continued confidence to your future with us.

Consolidated Communications Holdings, Inc.

XIII. General Plan Information

Plan Name:	Consolidated Communications, Inc. Flexible Employee Benefits Plan
Plan Sponsor:	Consolidated Communications Holdings, Inc. Attn: Human Resources 2116 S. 17th Street Mattoon, Illinois 61938-3987 (833) 224-1300
Plan Number:	508
Employer Identification No.:	02-0636095
Plan Administrator:	Consolidated Communications, Inc. Attn: Human Resources 508 Old Magnolia Road Conroe, TX 77304 (833) 224-1300
Claims Administrator:	Wex Health, Inc. 4321 20th Avenue S. Fargo, ND 58103 (866) 451-3399
HSA Custodian:	BenefitWallet P.O. Box 1584 Secaucus, NJ 07094
HSA Trustee:	Bank of New York Mellon
Funding Medium:	Employer contributions and employee covered benefits contributions
Agent for Service of Legal Process:	Service of legal process may be made to the Plan Administrator c/o Human Resources Department
Amendment and Termination:	The Company intends to continue the Plan indefinitely, but reserves the right to amend or terminate the Plan at any time for any reason pursuant to the procedures described in the Plan. This Summary is intended to be brief; consequently, in the case of any conflict between the terms and provisions of the Plan (including each Covered Benefit available under the Plan), and the terms and provisions of this Summary, the Plan will control and govern.
Covered Benefits:	See attached Covered Benefits Appendix.

Adopting Employers: See attached Adopting Employers Appendix.

XIV. Your Rights Under ERISA

Although the Consolidated Communications, Inc. Flexible Employee Benefits Plan itself is not an "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act of 1974 (ERISA), certain Covered Benefits, such as the Medical Reimbursement Account Benefit and the Company's Group Health Plans (collectively referred to in this Article XIII as the "**ERISA Plan**"), are governed by ERISA. With respect to any of those benefits which are subject to ERISA, you, as a Plan Participant, are entitled to certain rights and protections under ERISA, as follows:

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description of the ERISA Plan. The administrator may make a reasonable charge for the copies.

Receive a summary of the ERISA Plan's annual financial report. The ERISA Plan administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the ERISA Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Summary and the documents governing the ERISA Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of ERISA Plan documents or the latest annual report from the ERISA Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the ERISA Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you disagree with that denial, you must file an appeal of that denial in accordance with the claims procedures described in this Summary, including any Appendices hereto, or in the other applicable ERISA Plan documents. If your appeal is denied, and you have exhausted the administrative remedies provided to you under the applicable claims procedures, you may file suit in a state or Federal court. In addition, if you disagree with the ERISA Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that ERISA Plan fiduciaries misuse the ERISA Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

SUMMARY OF THE
CONSOLIDATED COMMUNICATIONS, INC.
FLEXIBLE EMPLOYEE BENEFITS PLAN

COVERED BENEFITS APPENDIX

As of January 1, 2021, the Covered Benefits, other than cash, offered pursuant to the Plan are coverages under the following employee welfare benefit plans and programs maintained by the Plan Sponsor or the designated labor union:

- Consolidated Communications, Inc. Health Benefits Plan;
- Consolidated Communications, Inc. Texas Bargaining Health Benefits Plan;
- NECA/IBEW Family Medical Care Plan;
- Line Construction Benefit Fund Plan of Benefits ("**Lineco Benefit Plan**");
- Dependent Care Reimbursement Account Benefit;
- Medical Reimbursement Account Benefit, which includes:
    - Medical Reimbursement Account; and
    - Limited Purpose Medical Reimbursement Account;
- Health Savings Account Funding Benefit;
- United Furniture Workers Insurance Fund; and
- IBEW 236 Health Fund.

The operative plan and other documents evidencing the actual terms and provisions of the Covered Benefits are hereby incorporated herein by reference, including any exhibits, amendments or modifications to such documents as in effect from time to time.

SUMMARY OF THE
CONSOLIDATED COMMUNICATIONS, INC.
FLEXIBLE EMPLOYEE BENEFITS PLAN

CLAIMS PROCEDURES FOR
MEDICAL REIMBURSEMENT ACCOUNT BENEFIT APPENDIX

Background

The procedures set forth in this Claims Procedures For Medical Reimbursement Account Benefit Appendix apply only to claims submitted under the Medical Reimbursement Account Benefit. The reimbursement of expenses covered under the Employer's group health or other welfare benefit plans, as set out in the Covered Benefits Appendix, are governed by separate claims provisions set forth in such other plans.

Claims Procedure

You must submit a claim for benefits under the Medical Reimbursement Account Benefit within the timeframe specified in Article IV of this Summary. Furthermore, a submitted claim is not treated as filed until all information necessary to process the claim is submitted. If your claim, as originally submitted, is not complete, you will be notified and then have the responsibility for providing the missing information.

Initial Claim Process

The Claims Administrator is responsible for processing all benefit claims under the Medical Reimbursement Account Benefit. Accordingly, to obtain benefits, you must complete, sign, and submit a written claim on the request form. This request, along with all related bills, must be submitted to the Claims Administrator at the address listed in Article XII. Alternatively, you may submit a Card Claim, as described above. A claim for benefits may also be submitted by your personal representative.

Applicable Time Limitations For Initial Benefit Decision

The following time limitations apply to claims submitted under the Medical Reimbursement Account Benefit:

You will be notified of the benefit determination by the Claims Administrator, regardless of whether the determination is adverse or not, no later than thirty (30) days after your claim for benefits is filed. If the Claims Administrator requires additional time to make a benefit determination for matters beyond the control of the Plan, the time period for making the initial benefit determination may be extended for up to fifteen (15) additional days. If such extension is required, the Claims Administrator will notify you within the initial thirty (30) day period of the circumstances requiring the extension and the date by which a Plan expects to render a benefit decision.

If additional time is required to render a benefit decision because of your failure to submit the information necessary to decide the claim (for example, you fail to submit copies of all bills related to the claim), the notice informing you of the extended period of time required to render a benefit determination shall also include a specific description of the information necessary to decide the

claim. You will then have at least 45 days from the day that you receive the notice to provide the specified information.

Notice of Adverse Benefit Determination

The Claims Administrator will provide written or electronic notification of any adverse benefit determination. The notice will set forth the following:

- The specific reason(s) for the adverse determination;
- Reference to the specific Plan provision(s) on which the determination was based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures, as well as a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review, and any other statement required by law; and
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

For the purposes of the foregoing notice, a document, record, or other information will be considered "relevant" to a claimant's claim if such document, record, or other information:

- was relied upon in making the adverse benefit determination;
- was submitted, considered, or generated in the course of making the adverse benefit determination, without regard to whether such document, record, or other information was relied upon in making the adverse benefit determination;
- demonstrates compliance with any administrative processes and safeguards in making the adverse benefit determination; or
- constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the adverse benefit determination.

In addition, if the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

If the adverse benefit determination is based on the fact that the treatment was not medically necessary or the experimental/investigational exclusion or similar exclusion or limit was applied, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeal of Adverse Benefit Determination.

If you receive an adverse benefit determination under the Medical Reimbursement Account Benefit, you will have 180 days following your receipt of the notification of the initial benefit determination in which to appeal the decision to the Plan Administrator. You may submit written comments, documents, records, and other information relating to the claim. Upon request, you will

be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The appeal will take into account all comments, documents, records, and other information that you submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The appeal will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the initial adverse determination or any subordinate of that person.

If the adverse determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary will consult with a health care professional who was not involved in the initial benefit determination and is not the subordinate of any health care professional that was involved in the initial benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additional medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

Applicable Time Limitations For Appeal of Adverse Benefit Decision

The following time limitations will apply for an appeal of an adverse benefit decision under the Medical Reimbursement Account Benefit.

The Plan Administrator will notify you of its benefit determination on appeal no later than sixty (60) days after the Plan Administrator receives your request for review.

Notice of Adverse Determination on Appeal

The Plan Administrator will provide written or electronic notification of an adverse benefit determination on appeal. The appeal will set forth the following:

- The specific reason(s) for the adverse determination;
- A reference to the specific Plan provision(s) upon which the determination was based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- A statement of the claimant's right to bring an action under Section 502(a) of ERISA;
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency"; and
- Any other information required by law.

For the purposes of the foregoing notice, a document, record, or other information will be considered "relevant" to a claimant's claim if such document, record, or other information:

- was relied upon in making the adverse benefit determination;

- was submitted, considered, or generated in the course of making the adverse benefit determination, without regard to whether such document, record, or other information was relied upon in making the adverse benefit determination;
- demonstrates compliance with any administrative processes and safeguards in making the adverse benefit determination; or
- constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the adverse benefit determination.

In addition, if the determination was based upon an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or other similar criterion will be provided free of charge. If this is not practical, a statement will be included in the notice of adverse determination that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and a copy will be provided free of charge, upon request.

If the adverse determination was based on a medical necessity, or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge, upon request, will be included in the notice of adverse determination.

Tolling of Certain Claims Appeal Deadlines Due to the COVID National Emergency

Notwithstanding the foregoing, effective as of March 1, 2020, the timeframe within which claimants are permitted to file an appeal of a claim denial under the claim and appeal procedures of the Medical Reimbursement Account Benefit (*i.e.*, a Compliance Timeframe) shall be tolled during the COVID Disregarded Period.

SUMMARY OF THE
CONSOLIDATED COMMUNICATIONS, INC.
FLEXIBLE EMPLOYEE BENEFITS PLAN

HIPAA MEDICAL PRIVACY AND SECURITY APPENDIX

Background

This HIPAA Medical Privacy and Security Appendix ("**HIPAA Appendix**") is intended to comply with the requirements under HIPAA, the Privacy Standards, the Security Standards, the HIPAA Enforcement Rule at 45 CFR part 160, subparts C through E ("**Enforcement Rules**") and the "**Breach Notification Rules**" issued under the Health Information Technology for Economic and Clinical Health Act ("**HITECH**"), as each of the foregoing were amended by the regulations issued on January 25, 2013 ("**HIPAA Omnibus Rules**"). References to any section of the Privacy Standards, the Security Standards, the Enforcement Rules or the Breach Notification Rules shall include any amendments or successor provisions thereto, including the HIPAA Omnibus Rules.

For purposes of this HIPAA Appendix, "Protected Health Information" ("**PHI**") means information, including genetic information, that is created or received in connection with the Health Care Component (as defined below) Plan which (a) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, (b) identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual, and (c) is transmitted or maintained in any form or medium. "Electronic Protected Health Information" ("**ePHI**") means individually identifiable health information that is created or received by the Health Care Component and transmitted by or maintained in electronic media.

Designation of Health Care Components and Safeguard

To the extent the Plan is a hybrid entity (as defined by 45 CFR § 164.103 of the Privacy Standards), the provisions of this HIPAA Appendix will only apply to the health care component of the Plan (referred to as the "**Health Care Component**"), as set forth below in this HIPAA Appendix. All references to Protected Health Information (PHI) or Electronic Protected Health Information (ePHI) in this HIPAA Appendix refer to PHI or ePHI that is created or received by or on behalf of the Health Care Component. The Health Care Component will thus comply with the following requirements:

- The Health Care Component will not disclose PHI to another component of the Plan in circumstances in which the Privacy Standards would prohibit such disclosure if the Health Care Component and the other component were separate and distinct legal entities; and

- If an employee of the Plan Sponsor performs duties for both the Health Care Component and for another component of the Plan, such employee will not use or disclose PHI created or received in the course of, or incident to, the employee's work for the Health Care Component in a way prohibited by the Privacy Standards.

For purposes of this HIPAA Appendix, the Health Care Component of the Plan is the Medical Reimbursement Account Benefit. The Group Health Plans identified in the attached Covered Benefits Appendix maintain separate HIPAA privacy and security provisions.

Use and Disclosure of PHI

The Plan Sponsor may only use and disclose PHI that it receives from the Health Care Component, which is considered a "group health plan" as defined by the Privacy Standards, as permitted and/or required by, and consistent with, the Privacy Standards. This includes, but is not limited to, the right to use and disclose a Participant's PHI in connection with payment, treatment, and health care operations, or as otherwise permitted or required by law. The Plan shall not use or disclose PHI that is genetic information for underwriting purposes.

Payment includes activities undertaken by the Health Care Component to obtain contributions, premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and copayments as determined for an individual's claim);
- Coordination of benefits or non-duplication of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including precertification, preauthorization, concurrent review and retrospective review;
- Disclosure to consumer reporting agencies related to the collection of contributions, premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- Obtaining reimbursements due to the Plan.

Health Care Operations include, but are not limited to, the following activities:

- Quality assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
- Enrollment, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies; and
- Business management and general administrative activities of the Plan, including, but not limited to:

(a) Management activities relating to the implementation of, and compliance with, HIPAA's administrative simplification requirements;
(b) Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
(c) Resolution of internal grievances; and
(d) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

Certification of Amendment of Plan Documents by the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions set forth in this HIPAA Appendix.

Plan Sponsor Agrees to Certain Conditions for PHI

The Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and

- Establish separation between the Plan and the Plan Sponsor in accordance with 45 CFR § 164.504(f)(2)(iii).

With respect to ePHI, the Plan Sponsor agrees, on behalf of the Plan, to:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) under the Privacy Standards is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides this information or who receives this information on behalf of the Plan agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident of which it becomes aware, in accordance with the administrative procedures adopted by the Plan for compliance with the Security Standards.

Adequate Separation Between the Plan and the Plan Sponsor

In accordance with the Privacy Standards, only employees or classes of employees designated in the HIPAA Privacy Employee Designation Appendix may be given access to PHI.

Limitations of PHI Access and Disclosure

The persons described in the HIPAA Privacy Employee Designation Appendix may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

Noncompliance Issues

If the persons described in the HIPAA Privacy Employee Designation Appendix do not comply with the Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Other Medical Privacy Laws

The Plan will comply with the Privacy Standards and the Security Standards, as well as with any applicable federal, state and local laws governing confidentiality of health information, to the extent such laws are not preempted by HIPAA or ERISA.

Additional Requirements Imposed by the Health Information Technology for Economic and Clinical Health Act ("HITECH")

In accordance with, to the extent required by, and as of the effective dates specified therein, HITECH and the regulations and other authority promulgated thereunder by the appropriate governmental authority, the Plan will (a) comply with notification requirements when unsecured PHI has been accessed, acquired, or disclosed as a result of a breach, (b) comply with an individual's request to restrict disclosure of PHI, (c) limit disclosures of PHI to a limited data set or the minimum necessary, (d) provide an accounting of disclosures, and (e) provide access to PHI in electronic format.

Limitation on the Use and Disclosure of Genetic Information

Notwithstanding anything herein to the contrary, no "genetic information" (as defined by Section 105 of the Genetic Information Nondiscrimination Act of 2008) shall be used or disclosed for underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, or ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance).

Notification in Case of a Breach of Unsecured PHI

In the event of the acquisition, access, use, or disclosure of PHI in a manner not permitted by the Privacy Standards that constitutes a "Breach," as such term is defined in 45 CFR 164.402, the Plan, or its designee, shall notify each individual whose PHI has been, or is reasonably believed to have been, accessed, acquired, used or disclosed as a result of the Breach no later than 60 days after the Plan, or its designee, discovers the Breach, unless notification may be delayed as permitted by 45 CFR 164.412 because such notice would impede a criminal investigation or damage national security. The Plan, or its designee, will mail individual notifications by first-class mail to the individual's last known address or by electronic mail, provided that electronic disclosure is permitted by the applicable regulations. The individual notification will include the following information:

- A brief description of what happened, including the date of the Breach and the date of its discovery, if known;

- A description of the type of PHI involved, such as name, social security number, date of birth, address, account number, diagnosis, disability code, or other type of information involved;

- Any steps the individual should take to protect himself from potential harm resulting from the Breach;

- A brief description of what the Plan or its business associate is doing to investigate the Breach, mitigate harm to individuals, and to protect against further Breaches; and

- Contact procedures for individuals to ask questions or learn additional information, including a toll-free telephone number, e-mail address, web site, or postal address.

If the Breach involves more than 500 residents of a state or jurisdiction, the Plan, or its designee, will also notify prominent media outlets that service the state or jurisdiction of the Breach. Additionally, the Plan will notify the Secretary of the Department of Health and Human Services of the Breach as required by 45 CFR 164.408.

SUMMARY OF THE
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HIPAA PRIVACY EMPLOYEE DESIGNATION APPENDIX

The following job classifications of employees (or classes of employees) are hereby designated as being entitled to receive Protected Health Information subject to HIPAA under the Medical Reimbursement Account Benefit:

- HIPAA Privacy Official;
- HIPAA Complaint Official;
- Benefits Analyst;
- Sr. Benefits Analyst;
- Vice President – Compensation & Benefits;
- Chief Legal Officer;
- Senior Director;
- HR Generalist and Staff Specialist and HR Managers, to the extent these persons have access to PHI when working with the Benefits Staff with respect to the Plan;
- Retirement Specialist;
- Software Engineers; and
- Manager – Employee Benefits.

SUMMARY OF THE
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FLEXIBLE EMPLOYEE BENEFITS PLAN

ADOPTING EMPLOYERS APPENDIX

As of January 1, 2021, other than as specified in the definition of "Employer" in the Plan, there are no additional adopting Employers of the Plan.

A complete listing of the Employers that have adopted the Plan may be obtained by a Participant upon written request to the Plan Administrator at the address listed in Article XIII. Such listing is also available for examination by a Participant by contacting the Plan Administrator at the address or telephone number listed in Article XIII.