



Lufkin / Conroe Bargaining Retirees and COBRA



2024 Benefit Guide

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**Benefit eligibility determined at the time you left the company.
Refer to your enrollment form for benefits available to you.**

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal Law gives you choices about your prescription drug coverage. Please see page 14 for more details.



Contact Information

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

Benefit	Administrator	Phone	Website/Email	Group or Policy #
Benefits Plan Info and Forms	n/a	n/a	https://c2mb.ajg.com/cciretree/home/	n/a
401(k) Plan	T. Rowe Price	800.922.9945	www.rps.troweprice.com	105908
Benefits Value Advisor with Member Rewards	BlueCross BlueShield	800.521.2227	www.bcbstx.com	PPO Plan – 048598 HDP Plan – 048599
COBRA & Direct Bill	UnifyHR	800.519.8366	www.unifyhr.com	n/a
Dental	Cigna	800.CIGNA24	www.mycigna.com	3328447
Health Savings Accounts	Optum Financial	844.881.4439	www.optum.com	n/a
Life Insurance	Voya	800.955.7736	www.voya.com	706515
Medical	BlueCross BlueShield	800.521.2227	www.bcbstx.com	PPO Plan – 048598 HDP Plan – 048599
Pension	Consolidated Communications Pension Service Center	855.409.9592	www.eepoint.com/CCI	n/a
Prescription Drugs (BlueCross plans)	Retail: BlueCross BlueShield Specialty: Payer Matrix Specialty: Accredo Pharmacy Mail Order: Express Scripts	800.521.2227 877.305.6202 833.721.1619 833.715.0942	www.bcbstx.com www.payermatrix.com www.accredo.com www.express-scripts.com/rx	n/a
Pharmacy Advocate Program	Tria Health	888.799.8742	https://myportal.triahealth.com/Account/Login	n/a
Telemedicine (BlueCross Plans)	MDLive	866.680.8646	www.mdlive.com/bcbstx	n/a
Vision	VSP	800.877.7195	www.vsp.com	30084834

Administered by BlueCross BlueShield of Texas (BCBSTX)

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

Provider Finder® Supports Choice and Access

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

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

Go to www.bcbstx.com and click on Find Care from the home page. Open the link beside Doctors & Hospitals.

Either download the BCBS TX app, or go to www.bcbstx.com and click on Find Care and then open the link beside Doctors & Hospitals. Register or log in to Blue Access for Members to stay connected to claims, your ID card, coverage, prescription reminders and health tips via text messages.

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

Tria Health

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

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

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



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



BCBSTX Medical Plan Options

	PPO (Standard) Plan	High Deductible Plan
	In-Network Benefits	In-Network Benefits
Calendar Year Deductible	\$1,300 Individual \$2,400 Family	\$3,200 Single \$6,200 Family
Medical Out-of-Pocket Maximum (includes deductible)*	\$3,200 Individual \$6,200 Family	\$3,200 Single \$6,200 Family
Prescription Drug Out-of-Pocket Maximum*	\$2,000 Individual \$6,000 Family	N/A - combined with Medical
Coinsurance	80%	100%
OFFICE VISITS		
Preventive Care	100%, no deductible	100%, no deductible
Primary Care Physician or Specialist	\$35 copay then the plan pays 100%	100% after calendar year deductible
MDLive Telehealth Visit	\$10 copay	100% after calendar year deductible
EMERGENCY MEDICAL SERVICES		
Urgent Care	\$35 copay	100% after calendar year deductible
Emergency Room	80% after calendar year deductible	100% after calendar year deductible
INPATIENT/OUTPATIENT FACILITY EXPENSES		
Inpatient Hospital Facility Expenses	80% after calendar year deductible	100% after calendar year deductible
Outpatient Surgery and Other Services	80% after calendar year deductible	100% after calendar year deductible
PHARMACY BENEFIT - BLUECROSS BLUESHIELD ADMINISTERED BY PRIME THERAPEUTICS		
Tier 1 – Generics		
Retail (30 day supply)	You pay 10% (\$25 maximum)	You pay \$0 once your medical deductible has been met.
Retail (90 day supply at participating pharmacies)	\$15 copay	
Mail Order (90 day supply)	\$15 copay	
Tier 2 – Preferred Brand		
Retail (30 day supply)	You pay 20% (\$50 maximum)	You pay \$0 once your medical deductible has been met.
Retail (90 day supply at participating pharmacies)	\$50 copay	
Mail Order (90 day supply)	\$50 copay	
Tier 3 – Non-Preferred Brand		
Retail (30 day supply)	You pay 40% (no maximum)	You pay \$0 once your medical deductible has been met.
Retail (90 day supply at participating pharmacies)	\$100 copay	
Mail Order (90 day supply)	\$100 copay	

Telehealth

MDLive Virtual Visits

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

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

Pharmacy Benefits

BlueCross BlueShield (Administered by Prime Therapeutics)

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

Mail Order and Specialty Medications

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

Specialty Medications

Payer Matrix

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

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

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

Oncology Navigator

BlueCross BlueShield

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

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

Benefits Value Advisor with Member Rewards

BlueCross BlueShield of Texas (BCBSTX)

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

Benefits Value Advisor can:

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

Member Rewards

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

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

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



A Closer Look at the Health Savings Account (HSA)

Administered by Optum Financial

If you enroll in the High Deductible Plan (HDP), you will have access to the HSA - a tax-advantaged savings account. Only participants in the HDP medical plan can open this account. You own the account, and the money can be used today or for future expenses.

Here are some key features of the HSA:

- All money in the account is tax-free (including interest and investment earnings) when used to pay eligible healthcare expenses
- The money is yours to keep in your HSA until you need it
- If you don't spend your full HSA balance during the current year, the unused money rolls forward to each following year

HSA Contribution Limits:

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

HSA: Things You Should Know

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



Dental Benefits

Administered by Cigna

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



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

Dental coverage is provided automatically with your BlueCross medical plan election.

	PPO NETWORK
	In-Network
Annual Deductible	\$25 individual /\$75 family
Annual Maximum Benefit	\$1,500
Preventive Services (2 cleanings per year)	100% (deductible waived)
Basic Services (fillings, extractions, periodontal treatment)	80%
Root Canals	80%
Oral Surgery	Covered under the medical plan
Major Services (dentures, bridges, crowns)	50%
Orthodontia Services Dependent Children up to age 26	50% \$1,500 lifetime maximum per child
Percentile R&C	90th

Vision Benefits

Insured by VSP

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

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

Vision coverage is provided automatically with your BlueCross medical plan election.

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





401(k) Plan

T. Rowe Price

As a retiree, your 401(k) account can remain in the CCI 401(k) Plan. You can enjoy the same discounted costs, expenses and trust accounts as active participants. Visit www.rps.troweprice.com or call 800.922.9945 for more information.



Pension

For retirees with monthly annuity payments from Northern Trust:

- For changes to direct deposit, income tax withholding, or address, please contact Northern Trust at 866.252.5395 or www.northerntrust.com/bppweb.
- For questions about your pension benefit, eligible employees should contact the Consolidated Communications Pension Service Center at 855.409.9592 or visit www.eepoint.com/CCI

Life Insurance (if Applicable)

Insured by Voya

Life insurance provides financial security for the people who depend on you. If you have a retiree life insurance policy through Consolidated Communications, your beneficiaries will receive a lump sum payment upon your death.

The company provided basic life insurance is insured by Voya. Refer to your retirement letter for your benefit amount (if applicable). Contact HR Services with any questions.

Funeral Planning

Provided by Voya

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

- 24/7 Advisor Planning Assistance from highly trained advisors
- PriceFinder Research Reports
- Online Funeral Planning Tools
- Family Assistance and Plan Implementation
- Negotiation Assistance
- Visit join.empathy.com/voya



Travel Assistance

Insured by Voya

Assistance available when traveling more than 100 miles from home:

- Pre-trip information
- Emergency personal services
- Medical assistance services
- Emergency transportation services

Visit <https://imglobal.com/member>. The referral code is VOYATRAVEL

For any questions, call (317) 659-5841 or email assist@imglobal.com

Legal Updates

HIPAA Special Enrollment Rights

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

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

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

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

- 1. TERMINATION OF MEDICAID OR CHIP COVERAGE** - If the employee or dependent is covered under a Medicaid plan or under a State child health plan and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.
- 2. ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP** - If the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than provide direct enrollment in a state Medicaid program.

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

HIPAA Privacy Notice

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

Newborns' and Mothers' Health Protection Act

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

Mental Health Parity Act

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

Pretax Contributions

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

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

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

Women's Health and Cancer Rights Act

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

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

In addition, the plan may not:

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

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

Availability of Summary Health Information

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



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

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

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

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

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

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

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

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



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

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

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

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

Paperwork Reduction Act Statement

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

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

Medicare Part D

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

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Consolidated Communications, Inc. has determined that the prescription drug coverage offered by the Consolidated Communications, Inc. Texas Bargaining Retiree Health Benefits Plan and the Texas Bargaining Health Benefits Plan are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: October 15, 2023

Name of Entity/Sender: Consolidated Communications, Inc.

Contact: HR Services

Address: 350 South Loop 336W
Conroe, TX 77304

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



Notice of Privacy Practices

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

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

Consolidated Communications, Inc. Health Benefits Plan

Consolidated Communications, Inc. Employee Assistance Program

Consolidated Communications, Inc. Flexible Employee Benefits Plan

Consolidated Communications, Inc. Texas Bargaining Health Benefits Plan

Consolidated Communications, Inc. Retiree Health Benefits Plan

Consolidated Communications, Inc. Texas Bargaining Retiree Health Benefits Plan

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

Consolidated Communications, Inc. Retiree Health Reimbursement Arrangement

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

How the Plan Will Use or Disclose Your PHI

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

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

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to HHS;
- uses or disclosures that are required by law;
- uses or disclosures that are required for the Plan's compliance with legal regulations; and
- uses and disclosures made pursuant to a valid authorization.

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

Your Privacy Rights With Respect to PHI

Right to Request Restrictions on PHI Uses and Disclosures

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

Right to Inspect and Copy PHI

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

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

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

Right to Amend

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

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

Right to Receive an Accounting of PHI Disclosures

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

Right to Receive Confidential Communications

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

Right to Receive a Paper Copy of This Notice Upon Request

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

A Note About Personal Representatives

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

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

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



The Plan's Duties With Respect to Your PHI

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

Your Right to File a Complaint

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

Contact Information

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

Disclaimer

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

