CONSOLIDATED COMMUNICATIONS, INC.

MEDICAL PREMIUM REIMBURSEMENT PROGRAM
FOR
ELIGIBLE UNION RETIREES

Summary Program Description

Effective August 10, 2018

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Introduction
Consolidated Communications, Inc. (the "Company") maintains the Consolidated Communications, Inc. Medical Premium Reimbursement Program for Eligible Union Retirees (the "Program") to allow Eligible Union Retirees (as defined on page 4) to obtain reimbursement of certain substantiated medical premium expenses, up to a specified monthly limit.

About this Document
This Summary Program Description ("SPD") describes the Program as in effect as of August 10, 2018. The benefits described in this SPD are provided under the terms of the Program's formal documents (see listing of documents at page 12). Every effort has been made to ensure the accuracy of the information included in this SPD. However, in the event of any inconsistency between this SPD and the formal documents, the terms of the Program's formal documents will control.

This SPD uses a variety of terms that are defined in the *Glossary of Terms* section and in the formal Program documents. It is important that you reference these definitions when determining eligibility for coverage and for benefits.

References to "the Company" refer to Consolidated Communications, Inc. and its Participating Affiliates. References to "you" or "your" refer to the Eligible Union Retiree only.

Who is Eligible

Only Eligible Union Retirees may participate in the Program. You are an "Eligible Union Retiree" if you meet each of the following conditions:

- You are a former bargaining unit employee of Northern New England Telephone Company (or any successor thereto) (each such company, a "Participating Affiliate") who was represented by IBEW Local 2320, 2326 or 2327 while employed.
- You terminate employment with the Company and all affiliates on or after August 10, 2018 but no later than June 30, 2021.
- You are eligible for and actually commence your pension benefit under the FairPoint Communications Northern New England Pension Plan for Represented Employees immediately upon terminating employment (i.e., as of the first day of the month following the month in which you terminate employment).

IMPORTANT NOTE: No former employee of the Company or any affiliate can become an Eligible Union Retiree after June 30, 2021.

How the Program Works

As an Eligible Union Retiree, you are not entitled to any coverage under any Company retiree medical plan, whether as an employee, spouse or dependent, but you are free to obtain coverage under any other insurance plan or policy, including COBRA coverage under the union medical insurance plan that covered you while you were employed. Benefits available under the Program consist of reimbursements of the eligible medical premium expenses you have paid to obtain medical coverage for yourself, your Spouse, and your Family Members under an individual or group health insurance policy or plan.

These expenses are referenced as "Medical Premium Expenses." For purposes of the Program, Medical Premium Expenses include only premiums for medical and prescription drug coverage, and exclude premiums for dental and vision coverage.

Enrolling in the Program

As soon as practicable after the Company has verified that you meet the conditions described above under "Who Is Eligible", you will be enrolled as a Participant in the Program. The process of verifying your pension enrollment status may take up to 90 days. Reimbursement of Medical Premium Expenses shall commence once you are enrolled in medical insurance coverage, the cost of which you and/or your Spouse are required to pay in whole or in part (including coverage provided through COBRA); provided that, the Company will also reimburse you for any Medical Premium Expenses that you submit during the Company's verification process, as long as they are submitted within 45 days of the date that you are enrolled in the Program.

Eligible Medical Premium Expenses

The following are eligible for reimbursement under the Program:

- Medical Premium Expenses actually paid for your coverage while you are an Eligible Union Retiree and a Participant in the Program, and
- Medical Premium Expenses actually paid for coverage for your Spouse and your Family Members while you are an Eligible Union Retiree, provided that you are then a Participant in the Program and are submitting and being reimbursed for Medical Premium Expenses for your own coverage. If you are not submitting and being reimbursed for your own Medical Premium Expenses, any premiums for your Spouse's or Family Member's coverage are ineligible for reimbursement.

In addition, to be eligible for reimbursement under the Program, the Medical Premium Expenses cannot be reimbursable through any other source, including any other insurance or reimbursement arrangement.

Maximum Reimbursements

Once you are enrolled as a Participant in the Program and obtain eligible medical insurance, you may receive reimbursements of up to $450 per month for eligible Medical Premium Expenses for yourself, your Spouse and your Family Members. Reimbursements will be made based on the amount of premiums actually paid, subject to the above limit. If your monthly Medical Premium Expenses are less than $450, you will be reimbursed only for the amount you paid. If your monthly Medical Premium Expenses exceed the $450, you will be reimbursed only up to $450.

Filing Claims for Reimbursement

To receive reimbursement of eligible Medical Premium Expenses, you must submit a written claim to the Claims Administrator **within 45 days after the date the Medical Premium Expenses were actually incurred**. Medical Premium Expenses will be considered "actually incurred" on the date you actually pay them, not on the date billed or invoiced. Your claim will be considered "submitted" on the date it is received by the Claims Administrator.

Claims must be submitted on forms provided for that purpose by the Claims Administrator. You can obtain copies of the form at the Claims Administrator's website at www.amben.com/wealthcare. Once completed, you can submit the form online and upload your receipts via the portal. Or, you can print and complete the form manually and send it with supporting documentation to the Claims Administrator via:

- **Fax:** 877-723-0147
- **Mail:** American Benefits Group
  P.O. Box 1209
  Northampton, MA 01061-1209
- **Secure Email:** claims@amben.com

Supporting Documentation

In addition to the claim form, you must provide proper supporting documentation so that your reimbursement claim can be processed. Generally, you must submit an itemized receipt, invoice or other written statement from the party to whom you paid the Medical Premium Expenses. The supporting documentation must verify payment and include:

- Name of the Eligible Union Retiree (and Spouse and Family Members, if applicable) covered by the medical insurance policy or plan for which the Medical Premium Expenses were paid.
- Name and address of the insurance carrier, plan or organization to which the Medical Premium Expenses were paid.
- Amount of Medical Premium Expenses paid.
- Date on which the Medical Premium Expenses were actually paid.
- Specific dates or period of time for which the Medical Premium Expenses were paid.
- A statement that the Medical Premium Expenses claimed have not been reimbursed and are not otherwise reimbursable through any other source.
- Any other information or documentation reasonably needed to maintain legal compliance or to effectively administer the Program, as the Claims Administrator may determine and request.

Claims will be processed as soon as administratively possible, but no later than 30 days after the Claims Administrator receives your completed claim, including all required supporting documentation. For additional information, see the *Claims and Appeals Procedures* section of this SPD.

Remember that you have 45 days after the date you pay Medical Premium Expenses to submit for reimbursement. Claims that are not timely submitted or that are not accompanied by proper supporting documentation are ineligible for reimbursement.

No Carryovers

If you do not timely submit for reimbursement of eligible Medical Premium Expenses incurred for a particular month, the amount of the reimbursement that would have been available for such month cannot be carried over to cover expenses incurred in a future month, but will be forfeited at the end of the 45th day after the Medical Premium Expenses were actually incurred.

Recovery of Overpayments

An overpayment occurs if an amount paid under the Program exceeds the total reimbursement due to you under the terms of the Program. If an overpayment occurs, you will be responsible for refunding the overpayment to the Program. The Program may recover the overpayment by stopping or reducing future reimbursements payable to you, asking for immediate refund of the overpayment from you or any other method as the Company may require.

No Guarantee of Tax Consequences

Reimbursements under the Program are intended to be pre-tax medical care benefits. However, the Company makes no commitment or guarantee that any amounts paid to or for the benefit of an Eligible Union Retiree participating under this Program will be excludable from such participant's gross income for federal, state or local income tax purposes. It will be your obligation to determine whether each payment under the Program is excludible from your gross income for tax purposes and to pay any tax that may be imposed with respect to any Program benefits.

No Assignment of Benefits

Except to the extent provided below under *Payment to Representative*, no benefit payable under this Program will be assignable, transferable or subject to any lien, in whole or in part, either directly or by operation of law.

Payment to Representative

In the event that a guardian, conservator or other legal representative has been appointed for an Eligible Union Retiree participating in the Program, any payment due to the Participant under this Program may be made to the legal representative. If a Participant dies while reimbursements under the Program remain unpaid, the Company may direct the Claims Administrator to make direct payment to the executors or administrators of the Participant's estate. Payment as described above will fully discharge all liabilities of the Program and the obligations of the Claims Administrator, the Participating Affiliates and the Company.

When Participation in the Program Ends

You cease to be an Eligible Union Retiree and a Participant and your participation in the Program will end as of the end of the calendar month in which you become age 65 or you die, whichever occurs first.

IMPORTANT NOTE: Reimbursements of Medical Premium Expenses for your Spouse and Family Members (if any) will end as of the same date you cease to be an Eligible Union Retiree. In other words, once you turn age 65 or die, whichever occurs first, premium expenses for your Spouse and Family Members are no longer reimbursable under the Program.

After you cease to be a Participant, you can submit for reimbursement for eligible Medical Premium Expenses as long as they were incurred (i.e., you paid them) **before** the date your Program participation ended and you submit a claim for reimbursement within no more than 45 days after the date you actually paid such Medical Premium Expenses.

Your Rights Under ERISA

As a participant in the Program you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Program participants are entitled to:

Receive Information About Your Program Benefits

- Examine, without charge, at the Company's office and at other specified locations, such as worksites and union halls, all documents governing the Program, including collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed for the Program 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 Company, copies of documents governing the Program, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated SPD. The Company may require a reasonable charge for the copies.
- Receive a summary of the Program's annual financial report. The Company is required by law to furnish each person covered under the Program with a copy of this summary financial report.
- Continue healthcare coverage for yourself or your Spouse or Family Members if there is a loss of coverage under the Program as a result of a qualifying event. You or your Spouse or Family Members will have to pay for such coverage. Review this SPD and the documents governing the Program on the rules governing your federal continuation coverage rights.

Prudent Actions by Program Fiduciaries

In addition to creating rights for Program participants, ERISA imposes duties upon the people responsible for the operation of the Program. The people who operate the Program, called "fiduciaries" of the Program, have a duty to do so prudently and in the interest of you and other Program participants and beneficiaries. No one may discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored, 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.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Program documents or the latest annual report from the Program 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 Company 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 Company. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that the fiduciaries misuse the Program'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 Program, you should contact the Company. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Company, 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.

Claims and Appeals Procedures

Claims

There are two categories of claims: (1) eligibility claims, and (2) claims for benefits.

- **Eligibility Claims:** All claims relating to eligibility to participate in the Program are eligibility claims.
- **Claims for Benefits:** A "claim for benefits" is a request for reimbursement under the Program. Eligibility claims and inquiries and casual inquiries are **not** claims for benefits.

Eligibility Claims

The Company has the authority to determine and to decide, in its sole discretion, all questions relating to eligibility to participate in the Program. All claims relating to eligibility to participate in the Program must be submitted in writing to the Company at the following address:

Consolidated Communications, Inc.
121 South 17th Street
Mattoon, IL 61938

If the Company denies your claim in whole or in part, you will receive a written explanation of the Company's determination within 30 days of the Company's receipt of your written claim. The Company may extend the time period during which it provides a written explanation for an additional 15 days if (1) the extension is necessary for circumstances beyond the Company's control, and (2) written notice of the extension is provided to the claimant prior to the expiration of the initial 30-day period. If your claim is denied in whole or in part, you may appeal the Company's determination. Your appeal must be made in writing to the Appeals Committee within 180 days of the date of your denial notice at the following address:

Consolidated Communications, Inc.
Appeals Committee
121 South 17th Street
Mattoon, IL 61938

If the Appeals Committee denies your appeal in whole or part, you will receive a written explanation of the Appeals Committee's determination within 30 days of the Appeals Committee's receipt of your written claim. The Appeals Committee may extend the time period during which it provides a written explanation for an additional 30 days if (1) the extension is necessary for circumstances beyond the Appeals Committee's control, and (2) written notice of the extension is provided to you prior to the expiration of the initial 30-day period. The eligibility review process does not permit you, your beneficiary or authorized representative the opportunity to appear in person before, or meet with, the committees or any representative of the committees.

Claims for Benefits

The Company has appointed American Benefits Group as Claims Administrator for the Program. The Committee also has delegated full discretionary authority to the Claims Administrator to decide initial claims for reimbursement and to review and resolve first level appeals.

To file an initial claim, follow the procedures outlined previously in the *Filing Claims for Reimbursement under the Program* section. Remember that you must provide proper supporting documentation so that your claim for reimbursement can be processed.

Response to Initial Claims

You generally will receive a written decision on an initial claim for reimbursement within 30 days of the date the Claims Administrator receives your completed claim. This period may be extended for up to 15 days if the Claims Administrator determines that such extension is necessary due to matters beyond the Program's control and notifies you, prior to the expiration of the 30-day response period of the circumstances requiring the extension and the date by which the decision is expected.

If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe any missing information, and you will have 45 days from receipt of the notice to provide the required additional information. The determination period will be suspended on the date the Claims Administrator sends the notice of missing information, and resume on the date you respond or the end of the 45-day period, whichever occurs first. If you fail to provide the required information, the claim may be decided based on the information originally provided.

If your claim is denied, in whole or in part, written notice of the adverse benefit determination will be provided, including:

- The specific reason or reasons for the denial;
- The Program provision on which the denial is based;
- A description of any additional information needed for you to complete the claim and an explanation of why such information is necessary;
- A description of the Program's appeal procedures.

Appeals

If the Claims Administrator denies your claim for reimbursement, in whole or in part, you have the right to two levels of appeal.

You must submit your first level appeal to:

American Benefits Group
P.O. Box 1209
Northampton, MA 01061-1209

To file a second level appeal if your first level appeal was denied, you must write or fax your appeal to:

Consolidated Communications, Inc.
Appeals Committee
121 South 17th Street
Mattoon, IL 61938
Fax number: (802) 658-2822

Upon your written request, the Claims Administrator or the Appeals Committee, whichever applies, will provide, free of charge, copies of documents, records and other information relevant to your appeal. As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

Response to Appeals

If you submit an appeal, whether first level or second level, no deference will be given to the preceding benefit determination, and the appeal will be reviewed by someone other than the individual(s) who made the prior determination or a subordinate of such individual(s).

The Claims Administrator or the Appeals Committee, whichever applies, will notify you of its appeal decision within a reasonable period of time, but no later than 30 days after its receipt of your written request for appeal. If you did not submit sufficient information, you will be notified of the additional information required and will have 45 days to submit the requested information. The appeal determination period will be suspended on the date the notice of missing information is sent to you and will resume on the date you respond or the end of the 45-day determination period, whichever occurs first. If you fail to provide the required information, the appeal may be decided based on the information originally provided.

If your first level appeal is denied, the Claims Administrator will notify you in writing, advising you of your right to file a second level appeal. If your second level appeal is denied, the Appeals Committee will notify you in writing of the final decision on your appeal. If a first or second level appeal is denied, the notification will include:

- The specific reason or reasons for the denial;
- The Program provisions on which the denial is based;

- A statement of your right to bring an action under section 502(a) of ERISA.

Legal Action

Before you can bring any action at law or equity to recover Program reimbursements to which you believe you are entitled, you must exhaust the administrative claims and appeals processes described above.

COBRA Continuation Coverage

After your Program participation ends, you or your Spouse or Family Members may be eligible to continue coverage under COBRA provided you (or your Spouse or Family Members, whichever applies) pay the required COBRA premium, which is 102% of the total cost of coverage to the Program.

How Much Will You Pay for COBRA Continuation Coverage?

To receive COBRA coverage, you must pay a monthly COBRA premium. The COBRA premium will equal the cost to the Program of providing reimbursements, plus 2%.

> **EXAMPLE:** Joe Smith, an Eligible Union Retiree, dies at age 60. Joe was receiving reimbursements of $450 for himself and his Spouse at the time of his death. Joe's Spouse wants to elect COBRA continuation coverage for herself. The cost to the Program of reimbursing her premium expenses is $450 per month. Therefore, Joe's Spouse would have to pay a monthly COBRA premium of $459 ($450 x 102%) in order to continue receiving monthly reimbursements during the COBRA continuation period.

IMPORTANT NOTE: **Even though COBRA continuation coverage is available as required by federal law, the cost of COBRA premiums will exceed the reimbursement amount you would receive under the Program. If you have any questions, you should consult your financial advisor to review whether electing COBRA is in your financial best interest.**

COBRA qualified beneficiaries have 45 days from the date they elect continuation coverage to make the first COBRA premium payment. The initial payment must cover premiums for the entire period from the date of the qualifying event to the date of election. Thereafter, COBRA premiums are due monthly on the first day of each calendar month.

When is COBRA Continuation Coverage Available?

COBRA coverage is only available if you or your Spouse or Family Members lose Program coverage due to any of the following "qualifying events":

- **For you**:
  - becoming entitled to Medicare
  - bankruptcy proceedings being filed with respect to the Company
- **For your Spouse and Family Members**:
  - your death
  - divorce or legal separation from you
  - you becoming entitled to Medicare
  - bankruptcy proceedings being filed with respect to the Company
  - loss of status as a dependent child (not applicable to Spouses)

You or your Spouse must notify the Company by calling HR Services at (833) 224-1300 within 60 days after a divorce or legal separation. If the required notice for these qualifying events is not provided, your Spouse will lose the right to COBRA continuation coverage. The Company will process and administer other qualifying events.

How Do You Elect COBRA Continuation Coverage?

Within 14 days of being notified of a qualifying event, the Company (or its designee) will advise eligible individuals of their right to continued coverage under the Program. Eligible individuals, known as "COBRA qualified beneficiaries," must elect COBRA continuation coverage within 60 days of:

- The date the individual would lose coverage because of the qualifying event, or
- If later, the date the eligible individual is notified of the right to continue coverage under COBRA.

How Long Will COBRA Continuation Coverage Be Available?

COBRA continuation coverage is available for a maximum of 36 months from the date of the qualifying events listed above.

When Does COBRA Continuation Coverage End?

If a COBRA qualified beneficiary elects COBRA, coverage will end on the earliest of the following to occur:

- The end of the maximum COBRA continuation period of 36 months,
- The date the COBRA qualified beneficiary fails to pay a COBRA required premium within 30 days of its due date, or
- The date the COBRA qualified beneficiary becomes entitled to Medicare.

General Program Information

Program Name:

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

Program Sponsor:

Consolidated Communications, Inc.
121 South 17th Street
Mattoon, IL 61938
(833) 224-1300

Employer Identification Number (EIN):

02-0636095

Agent for Service of Legal Process:

Consolidated Communications, Inc.
121 South 17th Street
Mattoon, IL 61938
(833) 224-1300

Claims Administrator:

American Benefits Group
P.O. Box 1209
Northampton, MA 01061-1209

Plan Number:

525 (the Program is a component plan in the Consolidated Communications, Inc. Retiree Health Benefits Plan)

Plan Year:

The calendar year.

Type of Program/Benefits:

Welfare benefits plan; provides reimbursement of eligible medical premium expenses.

Program Documents:

The Program's formal documents are the documents entitled "Consolidated Communications, Inc. Health Benefits Plan," of which this Program is a component plan, and "Consolidated Communications, Inc. Medical Premium Reimbursement Program."

Program Administration

The Company has full discretionary authority to interpret the terms of the Program, to determine your eligibility for benefits under the Program and to make claims and appeals determinations. The Company has appointed American Benefits Group as the Claims Administrator responsible for administering claims and reimbursements under the Program.

Future of the Program

The Program was established with the intent of providing Program reimbursements to Eligible Union Retirees. No former employee can become an Eligible Union Retiree or a Participant in this Program after June 30, 2021. The Program will automatically terminate when all Eligible Union Retirees have become ineligible for participation due to attainment of age 65 or death, whichever occurs first. After the Program terminates automatically, the Company and the Participating Affiliates shall have no liability for or obligation to make any reimbursements under the Program.

The Company reserves the right to amend or modify the Program in any way at any time prior to its termination, provided that any such amendment or modification shall not adversely affect the payment of reimbursements already due to Eligible Union Retirees under the terms of the Program as in effect on August 10, 2018.

Glossary of Terms

Appeals Committee

The Appeals Committee is a committee of the Company that is responsible for reviewing appeals under the Program.

Claims Administrator

American Benefits Group is the Claims Administrator. The Company has appointed and delegated to the Claims Administrator the responsibility and full discretionary authority to administer claims for reimbursement and initial appeals under the Program.

Company

Consolidated Communications, Inc.

Eligible Union Retiree

Eligible Union Retiree means a former bargaining unit employee of a Participating Affiliate who was represented by IBEW Local 2320, 2326 or 2327 while employed and who satisfies each of the following conditions:

- Terminated employment with the Company and all affiliates on or after August 10, 2018 but no later than June 30, 2021; and
- Was eligible for and actually commenced receiving his/her pension benefit under the FairPoint Communications Northern New England Pension Plan for Represented Employees immediately upon terminating employment (i.e., as of the first day of the month following the month in which employment terminated).

Family Member

Family Member means an individual who would be eligible to be covered as an Eligible Union Retiree's dependent under the Consolidated Communications, Inc. Health Benefits Plan, if such Eligible Union Retiree were a covered participant in that plan.

Medical Premium Expenses

Medical Premium Expenses means insurance premiums paid by an Eligible Union Retiree for coverage under an individual or group health care insurance policy or plan for the Eligible Union Retiree, his/her Spouse and his/her Family Members . For purposes of this Program, Medical Premium Expenses include premiums for medical and prescription drug coverage, and exclude premiums for dental and vision coverage.

Participant

Participant means an Eligible Union Retiree who has enrolled in the Program and for whom coverage is in effect under the Program.

Program

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

Spouse

Spouse means your lawful Spouse. For this purpose, "lawful spouse" is the person to whom you are legally married under the laws of any state, territory or possession of the United States or of any foreign country (excluding civil union, registered domestic partnership or other similar formal relationships that are not designated as a marriage under such laws).