CCI Retirees and COBRA

2025

Benefit Guide

Consolidated communications

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

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 pages 18 & 20 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	n/a	n/a	https://c2mb.ajg.com/cciretiree/home/	n/a
401(k) Plan	T. Rowe Price	800.922.9945	www.troweprice.com	105908
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 & Rx (CA HMO only)	Kaiser Permanente	800.464.4000	www.kp.org	001649
Medical	Collective Health	855.429.5142	www.bcbstx.collectivehealth.com	PPO Plan - 396165 HDP Plan - 396166 Indemnity Plan - 396167
Pension Plan	Consolidated Communications Pension Service Center	855.409.9592	www.eepoint.com/CCI	n/a
Prescription Drugs (Collective Health plans)	Retail: Collective Health Specialty: Payer Matrix Specialty: Accredo Pharmacy Mail Order: Express Scripts	855.429.5142 877.305.6202 833.721.1619 833.715.0942	www.bcbstx.collectivehealth.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 (Collective Health Plans)	MDLive	866.680.8646	www.mdlive.com/bcbstx	n/a
Vision	VSP	800.877.7195	www.vsp.com	30084834

Collective Health

Consolidated Communications has partnered with Collective Health to help you navigate your benefits, manage your coverage, and support you along the way! Collective Health puts your health benefits at your fingertips through a personalized online account that you can access on the Collective Health website or mobile app. When you're trying to understand your medical benefits — they've got your back! They're also here to help with your prescription benefits.

What's in Store In Your Collective Health Account

Before you enroll

Visit the Collective Health Welcome Portal at joincollectivehealth.com/consolidatedcommunications. On this site, you can learn more about Collective Health, locate in-network providers, and explore your health plan options. The Member advocate team is also available to support you during open enrollment.

Best in class network

Collective Health utilizes the nationwide BCBS PPO network, the same network you have today! Due to this unique partnership, you will receive ID cards with the Blue Cross logo and network information.

Before you make an appointment, search for in-network providers near you online (and learn why it's always important to double-check that a doctor is in network!). The search tool can be located by logging into bcbstx.collectivehealth.com. Prior to enrollment, you can access the provider search tool on the Welcome Portal at joincollectivehealth.com/consolidatedcommunications.

They're here to help

The Collective Health Member Advocate team can help you get you the answers you need. From clearing up provider billing to researching the finer details of your benefits coverage, their experts can get you what you need. Care Navigation services also help you navigate complex health care situations. Receive guidance from a care team of Social Workers, Pharmacists, Dieticians, and Nurses.

Member Advocates are here to help you:

- Understand your benefits
- Answer claims questions
- Navigate through your healthcare journey
- And more!

Collective Health Member Advocates are available Monday-Friday, 4am-6pm PT and Saturday 7am-11am PT through secure messaging and chat once you're registered, and on the phone at 855.383.5551.

See How you're covered

Look up how you're covered for different types of care, see applicable session limits, and understand what part of your bill you'll be responsible for.

You can also learn about and get connected to additional benefit offerings.

Review your claims

After you see the doctor, Collective Health will show you how our benefits applied to your care, and let you know what you can expect to pay.

My Collective and the Collective Health App

Turn to your Collective Health account (also known as My Collective) when you:

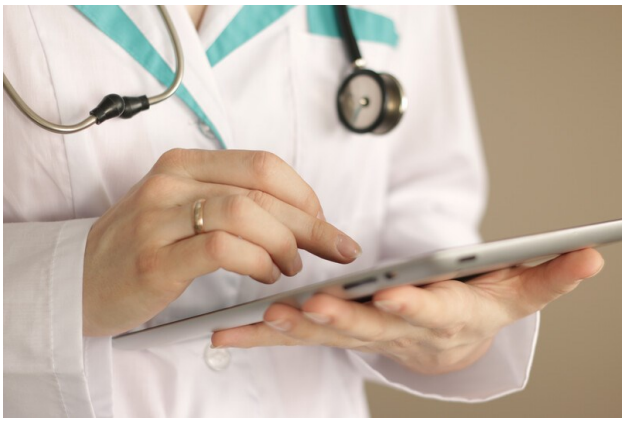
- Are looking for an in-network doctor for preventative or specialized care
- Have questions about your benefits or benefits statements
- Want to understand more about how your plan works

Access your digital medical cards, view your benefits, find a doctor and more all through My Collective (The Collective Health portal), or the app. With the Collective Health app, you can:

- Access your member cards on-the-go
- See your medical benefits
- Get your questions answered quickly by our highly trained, compassionate Member Advocates
- Find in-network doctors and specialists in your area in seconds
- View your claims, understand what you owe and why

Medical Benefits (If Applicable)

Administered by Collective Health



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

In addition to the Collective Health plans, California employees have the option to enroll in an HMO plan provided by **Kaiser Permanente.** With the HMO plan you are required to utilize only Kaiser facilities and services, and there is no out of network coverage, except in the case of a life threatening emergency.

How the Plan Works

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

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

Pharmacy Advocate Program

Tria Health

Tria Health is a free and confidential benefit available for all members enrolled in the Collective Health 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.

Collective Health Medical Plan

	HDP Plan	PPO
	In-Network Benefits	In-Network Benefits
Calendar Year Deductible	$4.000 Individual $8,000 Family (Embedded)	$2,500 Individual $5,000 Family (Embedded)
Medical Out-of-Pocket Maximum (includes deductible)	$6,000 Individual $12,000 Family	$7,500 Individual $15,000 Family
Prescription Drug Out-of-Pocket Maximum	N/A — combined with Medical	N/A — combined with Medical
Coinsurance	80%	80%
OFFICE VISITS		
Preventive Care	100%, no deductible	100%, no deductible
Primary Care Physician or Specialist	80% after calendar year deductible	$25 or $45 copay
EMERGENCY MEDICAL SERVICES		
Urgent Care	80% after calendar year deductible	$25 copay
Emergency Room	80% after calendar year deductible	80% after calendar year deductible
INPATIENT/OUTPATIENT FACILITY EXPENSES		
Inpatient Hospital Facility Expenses	80% after calendar year deductible	80% after calendar year deductible
Outpatient Surgery and Other Services	80% after calendar year deductible	80% after calendar year deductible
PHARMACY BENEFIT - COLLECTIVE HEALTH ADMINISTERED BY PRIME THERAPEUTICS		
Tier 1 – Generics		
Retail (30 day supply)	You pay 20% once your medical deductible has been met.	You pay 10% ($50 maximum)
Retail (90 day supply at participating pharmacies)		You pay 10% ($50 maximum)
Mail Order (90 day supply)		You pay 10% ($50 maximum)
Specialty (30 day supply)		You pay 10% ($150 maximum)
Tier 2 – Preferred Brand		
Retail (30 day supply)	You pay 20% once your medical deductible has been met.	You pay 20% ($50 maximum)
Retail (90 day supply at participating pharmacies)		You pay 20% ($100 maximum)
Mail Order (90 day supply)		You pay 20% ($100 maximum)
Specialty (30 day supply)		You pay 20% ($150 maximum)
Tier 3 – Non-Preferred Brand		
Retail (30 day supply)	You pay 20% once your medical deductible has been met.	You pay 40% (no maximum)
Retail (90 day supply at participating pharmacies)		You pay 40% (no maximum)
Mail Order (90 day supply)		You pay 40% (no maximum)
Specialty (30 day supply)		You pay 40% (no maximum)

Telehealth

MDLive Virtual Visits

If you enroll in the Collective Health 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
- When accessing MDLive services, be sure to enter your member ID number from your Collective Health ID card

Collective Health Medical Plan Options Continued

	Indemnity - Medicare NNEA Retirees
	Benefits (In or Out of Network)
Calendar Year Deductible	$2,500 Individual $5,000 Family (Embedded)
Medical Out-of-Pocket Maximum (includes deductible)	$10,000 Individual $20,000 Family
Prescription Drug Out-of-Pocket Maximum	N/A — combined with Medical
Coinsurance	70%
Lifetime Benefit Maximum	$1,000,000
Preventive Care	100%, no deductible
Primary Care Physician or Specialist	70% after calendar year deductible
EMERGENCY MEDICAL SERVICES	
Urgent Care	70% after calendar year deductible
Emergency Room	70% after calendar year deductible
INPATIENT/OUTPATIENT FACILITY EXPENSES	
Inpatient Hospital Facility Expenses	70% after calendar year deductible
Outpatient Surgery and Other Services	70% after calendar year deductible
PHARMACY BENEFIT - BLUECROSS BLUESHIELD ADMINISTERED BY PRIME THERAPEUTICS	
Tier 1 – Generics	
Retail (30 day supply)	n/a - Mail Order only
Retail (90 day supply at participating pharmacies)	
Mail Order (90 day supply)	You pay 50%
Specialty (30 day supply)	
Tier 2 – Preferred Brand	
Retail (30 day supply)	n/a - Mail Order only
Retail (90 day supply at participating pharmacies)	
Mail Order (90 day supply)	You pay 50%
Specialty (30 day supply)	
Tier 3 – Non-Preferred Brand	
Retail (30 day supply)	n/a - Mail Order only
Retail (90 day supply at participating pharmacies)	
Mail Order (90 day supply)	You pay 50%
Specialty (30 day supply)	

Pharmacy Benefits

Collective Health (Administered by Prime Therapeutics)

- Visit bcbstx.collectivehealth.com to view medicines, find pharmacies and view your prescription history
- Collective Health 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.

Prior Authorization

Collective Health

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

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

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

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

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

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

Kaiser Permanente Medical Plan Option (California Employees)

	HMO Plan
	In-Network Benefits Only
Calendar Year Deductible	$2,500 Individual $5,000 Family (Embedded)
Medical Out-of-Pocket Maximum (includes deductible)	$5,000 Individual $10,000 Family
Prescription Drug Out-of-Pocket Maximum	N/A — combined with Medical
Coinsurance	80%
OFFICE VISITS	
Preventive Care	100%, no deductible
Primary Care Physician	$30 copay
Specialist	$40 copay
EMERGENCY MEDICAL SERVICES	
Urgent Care	$30 copay
Emergency Room	80% after calendar year deductible
OUTPATIENT SURGERY	
Outpatient Surgery	80% after calendar year deductible
INPATIENT FACILITY EXPENSES	
Hospital Facility Expenses Room and Board	80% after calendar year deductible
PHARMACY BENEFIT	
Generics	
Retail (30 day supply)	You pay $10
Mail Order (100 day supply)	You pay $20
Specialty (30 day supply)	You pay 20% to $250 max
Brand Name Drugs	
Retail (30 day supply)	You pay $30
Mail Order (100 day supply)	You pay $60
Specialty (30 day supply)	You pay 20% to $250 max

Kaiser Permanente members can access urgent care at a CVS MinuteClinic. Members pay only their standard copay or coinsurance at the time of service. After the visit, members will be charged for any additional cost they may owe, depending on their specific plan. If members get urgent care at a CVS MinuteClinic within a state that does not have Kaiser Permanente providers, they'll be asked to pay upfront for services and will need to file a claim for reimbursement.

To find a participating CVS MinuteClinic, contact Member Services at 1-888-901-4636.

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:

2025 IRS Limits	
Single (employee only) coverage	$4,300
Family (employee plus one or more) coverage	$8,550
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 (If Applicable)

Administered by Cigna

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

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

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

Vision Benefits (If Applicable)

Insured by VSP

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

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

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

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

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

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

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

HIPAA Privacy Notice

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

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.

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. Health Benefits Plan are equal to the lifetime maximum and annual maximum dollar limits for medical and surgical benefits under this plan.

Availability of Summary Health Information

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

Disclaimer

This 2025 Benefits Summary highlights recent plan design changes and is intended to fully comply with the requirements under the Employee Retirement Income Security Act (ERISA) as a Summary Material Modification (SMM) and should be kept with your most recent Summary Plan Description (SPD). This document does not guarantee any benefits.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US 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/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	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 and CHIP
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.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, 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

This Notice Applies to the following health plan options:

Consolidated Communications Holdings, Inc. Retiree Health Benefits Plan—PPO, HDP, and Kaiser HMO options

Consolidated Communications, Inc. Texas Bargaining Retiree Health Benefits Plan (all options)

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

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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

Contact HR Services 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, 2024

Name of Entity/Sender: Consolidated Communications, Inc.

Contact: HR Services

Address: 508 Old Magnolia
Conroe, TX 77304

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

Medicare Part D Notice

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

This notice applies only to the Retiree Indemnity Plan option under the Consolidated Communications, Inc. Health Benefits Plan.

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 Holdings, 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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 Holdings, Inc. has determined that the prescription drug coverage offered by the Consolidated Communications, Inc. Health Benefits Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Consolidated Communications, Inc. Health Benefits Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Consolidated Communications Holdings, Inc. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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 15th through December 7th.

However, if you decide to drop your current coverage with Consolidated Communications Holdings, Inc., since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under Consolidated Communications, Inc. Health Benefits Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under the Consolidated Communications, Inc. Health Benefits Plan is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 Holdings, Inc. coverage will not be affected.

If you are an eligible Medicare Part D beneficiary you have the following options available to you:

1. you can retain your existing Consolidated Communications Holdings, Inc. coverage and choose not to enroll in a Medicare Part D plan; or

2. you can enroll in a Medicare Part D plan as a supplement to the Consolidated Communications Holdings, Inc. coverage; and

3. your current Consolidated Communications Holdings, Inc. coverage pays for other medical expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current medical and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan. However, if you choose to drop your prescription coverage through Consolidated Communications Holdings, Inc. you will also lose your medical coverage through Consolidated Communications Holdings, Inc.

If you do decide to join a Medicare drug plan and drop your current Consolidated Communications Holdings, Inc. coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Holdings, 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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 1-800-772-1213 (TTY 1-800-325-0778).

Date:	October 15, 2024
Name of Entity/Sender:	Consolidated Communications, Inc.
Contact:	HR Services
Address:	508 Old Magnolia Conroe, TX 77304

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 January 1, 2024, 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: Director – Employee Benefits, at 508 Old Magnolia, Conroe, TX 77304, telephone #: 217-235-3373 and Complaint Official for the Plan: Chief Legal Officer at 508 Old Magnolia, Conroe TX 77304, telephone #: 936-521-0027.

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This benefits guide prepared by

Gallagher

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