Final

Plan Document and Summary Plan Description for

Consolidated Communications, Inc. (f/k/a Enventis Corporation) Retiree Health Reimbursement Arrangement

(Amended and Restated Effective as of January 1, 2016)

TABLE OF CONTENTS

INTRODUCTION 2

PART I GENERAL PLAN INFORMATION 3

PART II TERMS USED IN THIS PLAN DOCUMENT 5

PART III ELIGIBILITY, COVERAGE & EXPENSES 8

PART IV CLAIMS PROCEDURES 14

PART V ERISA RIGHTS 17

PART VI COBRA AND SPECIAL RULES FOR GROUP HEALTH PLANS 19

PART VII MISCELLANEOUS LAW PROVISIONS 20

PART VIII AMENDMENT & TERMINATION 21

PART IX ALIENATION OF BENEFITS 22

APPENDIX A HIPAA PRIVACY 24

INTRODUCTION

Enventis Corporation (the "Enventis") previously established the "Enventis Corporation Retiree Health Reimbursement Arrangement" as of January 1, 2014 for the benefit of its designated retirees and the designated retirees of its participating affiliates. Effective as of January 1, 2016, the Enventis Corporation Retiree Health Reimbursement Arrangement has been renamed the "Consolidated Communications, Inc. Retiree Health Reimbursement Arrangement" (the "Plan"). Also effective as of January 1, 2016, sponsorship of the Plan has been transferred to Consolidated Communications Holdings, Inc. (the "Plan Sponsor"). The Plan has been amended and restated effective as of January 1, 2016 under the form of this combination Plan and Summary Plan Description document.

The purpose of the Plan is to reimburse Eligible Retirees and if applicable, their Eligible Spouses for certain medical expenses which are not otherwise reimbursed. The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended ("Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. The Plan is a group health plan for purposes of HIPAA and ERISA. The Plan does not cover any active employees of the Plan Sponsor or any other Employer, and thus it is not subject to part A of Title XXVII of the Public Health Service Act, relating to group health plans, as amended by the Affordable Care Act. The Plan is to be interpreted, and shall be administered, in a manner consistent with the foregoing.

For convenience of reference, this combination Plan and Summary Plan Description document may be referred to herein as the Plan or the SPD.

Note that capitalized terms used in this SPD are defined in Part II of this document. Please note that "you," "your" and "my" when used in this SPD refer to you, the Eligible Retiree.

PART I
GENERAL PLAN INFORMATION

Name of Plan:	Consolidated Communications, Inc. Retiree Health Reimbursement Arrangement
Original Effective Date:	January 1, 2014
Name, address, and telephone number of the Plan Sponsor:	Consolidated Communications Holdings, Inc. Attn: Human Resources 121 South 17th Street Mattoon, Illinois 61938-3987 (936) 788-7847
Name, address, and telephone number of the Plan Administrator: As described more fully herein, Consolidated Communications, Inc. (as Plan Administrator) has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan. Consolidated Communications, Inc. may delegate one or more of its responsibilities to one or more individuals or committees.	Consolidated Communications, Inc. Attn: Human Resources 350 South Loop 336 W Conroe, TX 77304 (507) 387-1841
Agent for Service of Legal Process:	The Plan Administrator at the address listed above.
Sponsor's federal tax identification	02-0636095
Plan Number:	530
Plan Year:	January 1 – December 31
COBRA Administrator:	*Prior to January 1, 2018* Conexis P.O. Box 226101 Dallas, TX 75222 *On and after January 1, 2018* Infinisource

Third Party Administrator:	Willis Towers Watson 10975 South Sterling View Drive, Suite A-1 South Jordan, UT 84905 1-855-801-9767 https://my.viabenefits.com/consolidated
Claims Submission Agent: All reimbursement forms, and supporting documentation, must be provided to the Claims Submission Agent.	Via Benefits P.O. Box 981156 El Paso, TX 79998-1156 Fax: 1-866-886-0878 https://my.viabenefits.com/consolidated
Funding:	Benefits are paid from the Employer's general assets. There is no trust or other fund from which benefits are paid.

PART II
TERMS USED IN THIS PLAN DOCUMENT

Affiliate. A corporation or other entity which is controlled by the Plan Sponsor, or under common control with the Plan Sponsor, as determined by the Plan Sponsor after taking into consideration the common control rules under Section 3(40)(B) of ERISA (*i.e.*, for multiple employer welfare associations).

Benefit Credits. Benefit Credits are the dollar amount of the annual contributions made to an HRA Account for an Eligible Retiree and/or Eligible Spouse.

Code. The Internal Revenue Code of 1986, as amended, and the implementing regulations and other authority issued thereunder by the appropriate governmental authority. References herein to any section of the Code will also refer to any successor provision thereof.

Eligible Dependent. A (1) legal spouse of an Eligible Retiree, or (2) child (as defined in Code Section 152(f)(1) of the Eligible Retiree or Eligible Spouse until the end of the month in which occurs the child's 26th birthday or if 26 or older must be a qualified disabled child for federal income tax purposes. An Eligible Dependent is not a "participant" in the Plan and may not submit claims under the Plan on his or her own behalf; however, an Eligible Retiree (or, if applicable, an Eligible Spouse) is entitled to obtain reimbursement from the HRA Account for Eligible Medical Expenses incurred by or on behalf of an Eligible Dependent.

Eligible Retiree. A current or future retiree eligible to receive benefits under this Plan. Only a limited group of employees hired before January 1, 2007 and who worked for Enventis (including certain former Enventis employees who became employees of an Employer pursuant to the October 16, 2014 merger of Enventis with Consolidated Communications, Inc.) are eligible for the Plan. The Plan Administrator maintains a list of Eligible Retirees. Please contact the Plan Administrator if you have any questions about your eligibility for the Plan.

Individuals not on the list maintained by the Plan Administrator are not eligible. For example, the following groups of individuals are ineligible for the Plan:

- Employees hired on or after January 1, 2007.
- Leased employees.
- Independent contractors.
- Any individual not classified by the Plan Administrator as eligible, even if the individual is later determined by a court or governmental agency to be or to have been a former common law employee of Enventis or an Employer.

If you became an employee of Consolidated Communications, Inc. (or an Affiliate) pursuant to the October 16, 2014 merger of Enventis with Consolidated Communications, Inc., then you will only be included on the Plan Administrator's list of Eligible Retirees if you met the eligibility requirements to be "grandfathered" into the Enventis retiree medical benefits (*i.e.*, you attained (or will attain) age 55 or older with at least 15 years of service on or before October 16, 2017).

In addition to the foregoing, in order to become covered under the Plan, an Eligible Retiree must remain properly enrolled in a major medical plan sponsored by the Plan Sponsor up to the first day of the first month of such individual's eligibility for Medicare.

Any requests for eligibility determinations under the Plan must be submitted to the Plan Administrator no later than 60 days after your date of retirement. The Plan Administrator's determination of who is eligible is final.

Eligible Spouse. The legal spouse of an Eligible Retiree as of the date of the Eligible Retiree's retirement from Enventis or an Employer. An individual must be eligible for Medicare in order to be considered an "Eligible Spouse" for purposes of the Plan. In addition to the foregoing, in order to be considered an "Eligible Spouse" for purposes of the Plan, an individual must remain properly enrolled in a major medical plan sponsored by the Plan Sponsor up to the first day of the first month of such individual's eligibility for Medicare.

Eligible Medical Expense. An expense incurred by an Eligible Retiree, Eligible Spouse or an Eligible Dependent for medical care as defined in Code Section 213(d) and the rules, regulations and Internal Revenue Service interpretations thereunder, including premiums for health care insurance coverage. Notwithstanding the foregoing, "Eligible Medical Expenses" shall not include:

- Expenses or premiums reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance arrangement or any amount claimed as a deduction on the federal income tax return.
- A medicine or drug that is not prescribed.
- Additional items as noted in this document.

An Eligible Medical Expense is incurred when the medical care is provided, not when the expense is formally billed, charged, or paid.

Employer. The Plan Sponsor or any Affiliate which is part of a controlled group of entities, as defined in Code Section 414(b) or (c), that includes the Plan Sponsor. In addition, any other Affiliate not described in the preceding sentence may adopt the Plan with the consent of the Plan Sponsor.

ERISA. The Employee Retirement Income Security Act of 1974, as amended, and regulations and other authority issued thereunder by the appropriate governmental authority. References herein to any section of ERISA or such regulations shall include references to any successor section or provision of ERISA or such regulations, as applicable.

HRA Account. A Health Reimbursement Arrangement (HRA) Account is a notional, recordkeeping account established for an Eligible Retiree and/or his or her Eligible Spouse to reimburse Eligible Medical Expenses. If both the Eligible Retiree and his or her Eligible Spouse have satisfied the eligibility and enrollment requirements specified in Q-4 below, the HRA Account will be a joint HRA Account for the Eligible Retiree and his or her Eligible Spouse. All Benefit Credits for which an Eligible Retiree and/or his or her Eligible Spouse are eligible under the terms of the Plan will be credited to the HRA Account. Unless otherwise specified in an agreement with an Eligible Retiree, the following fixed annual amount will be credited to an HRA Account:

- $3,500 per calendar year for an Eligible Retiree.
- $2,750 per calendar year for the Eligible Spouse of an Eligible Retiree.

Plan Administrator. The person or entity which has the authority and responsibility to manage and direct the operation of the Plan in its discretion. However, the Plan Administrator may assign or delegate duties to third parties, such as the Claims Submission Agent, under the terms of either the Plan or any Welfare Program, or by means of a separate written agreement. The Plan Administrator is the

"plan administrator" for purposes of Section 3(16)(A) of ERISA. The Plan Administrator will be Consolidated Communications, Inc.

Plan Sponsor. Consolidated Communications Holdings, Inc. or its successor in interest.

PART III
ELIGIBILITY, COVERAGE & EXPENSES

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to reimburse Eligible Retirees and Eligible Spouses for Eligible Medical Expenses which are not otherwise reimbursed by any other plan or program.

Q-2. Who can participate in the Plan?

Eligible Retirees and Eligible Spouses who have satisfied all applicable eligibility and enrollment requirements may participate in the Plan.

Q-3. Can my dependents participate in the Plan?

Eligible Spouses who have satisfied all applicable eligibility and enrollment requirements may participate in the Plan, and may submit claims for reimbursement of Eligible Medical Expenses. Other Eligible Dependents are not eligible to participate in the Plan; however, you (or, if applicable, your Eligible Spouse) are entitled to obtain reimbursement from the HRA Account for Eligible Medical Expenses incurred by or on behalf of an Eligible Dependent. This is explained more in Q-6 below.

You are required to provide proof of an Eligible Dependent's status upon request by the Plan Administrator (or its designee). Failure to provide such proof may result in a delay or denial of benefits provided under the Plan. In addition, the Plan will allow reimbursement of Eligible Medical Expenses for a child of yours in accordance with a Qualified Medical Child Support Order ("QMCSO") to the extent the QMCSO does not require coverage not otherwise offered under this Plan. The Plan Administrator will make a determination as to whether the order is a QMCSO in accordance with the Plan's QMCSO procedures. The Plan Administrator will notify both you and the affected child once a determination has been made. You may request a copy of the Plan's QMCSO procedures, free of charge, by contacting the Plan Administrator.

Q-4. When do I actually start receiving Benefit Credits to my HRA Account in the Plan?

An Eligible Retiree becomes eligible to receive Benefit Credits to an HRA Account (which may be a joint HRA Account) on the later of:

- The first day of the month following the Eligible Retiree's date of retirement;
- The first day of the month in which the Eligible Retiree attains age 65; and
- The date on which he or she has completed any enrollment forms or procedures required by the Plan Administrator.

An Eligible Spouse becomes eligible to receive Benefit Credits to an HRA Account (which may be a joint HRA Account) on the later of:

- The first day of the month following the Eligible Retiree's date of retirement;
- The first day of the month in which the Eligible Spouse attains age 65; and
- The date on which he or she has completed any enrollment forms or procedures required by the Plan Administrator.

Q-5. How does the Plan work?

One HRA Account will be established as of the date that either you or your Eligible Spouse becomes eligible to receive Benefit Credits pursuant to Q-4 above. If an HRA Account is established for your Eligible Spouse prior to the date that you become eligible to receive Benefit Credits pursuant to Q-4 above , then only your Eligible Spouse will be permitted to submit claims for reimbursement of Eligible Medical Expenses from the HRA Account until you become eligible to participate in the Plan. If both you and your Eligible Spouse are eligible to receive Benefit Credits pursuant to Q-4 above, the HRA Account will be a joint HRA Account covering both you and your Eligible Spouse. The HRA Account may be used to reimburse Eligible Medical Expenses, as described in Q-6 below. These reimbursements will reduce the amount in the HRA Account. After participation in the Plan begins, you or your Eligible Spouse, as applicable, may receive reimbursement for Eligible Medical Expenses up to the amount in the HRA Account. Note that the law does not permit you or your Eligible Spouse to make contributions to the HRA Account; only the Plan Sponsor can make contributions to the HRA Account.

An HRA Account is merely a bookkeeping account on the Plan Sponsor's records; it is not funded and does not bear interest or accrue earnings of any kind. All benefits under the Plan are paid entirely from the Plan Sponsor's general assets.

Q-6. What is an "Eligible Medical Expense"?

An Eligible Medical Expense is an expense incurred by you, your Eligible Spouse or any other Eligible Dependent for medical care, as that term is defined in Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease). Some common examples of Eligible Medical Expenses include:

- Medications (in reasonable quantities) (**NOTE**: Medications are considered Eligible Medical Expenses only if they are prescribed by a doctor (without regard to whether the medication is available without a prescription) or if the medication is insulin);
- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Chiropractor treatments;
- Hearing aids;
- Wheelchairs;
- Premiums for medical, prescription drug, dental, or vision insurance, to the extent such insurance covers medical care, as that term is defined in Code Section 213(d); and
- Premiums for any qualified long-term care insurance contract (as defined in Code Section 7702B(b)).

Some examples of common items that are <u>not</u> Eligible Medical Expenses include:

- Baby-sitting and child care;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues; and

- Cosmetics, toiletries, toothpaste, etc.

If you need more information regarding whether an expense is an Eligible Medical Expense under the Plan, contact the Third Party Administrator as provided in Part 1.

Only Eligible Medical Expenses incurred while you are an Eligible Retiree covered under the Plan may be reimbursed from the HRA Account. Similarly, only Eligible Medical Expenses incurred while an Eligible Spouse is similarly covered under the Plan may be reimbursed from the HRA Account. Note that, even though your Eligible Dependent is not a "participant" in the Plan, you (or, if applicable, your Eligible Spouse) are entitled to obtain reimbursement from the HRA Account for Eligible Medical Expenses incurred by or on behalf of an Eligible Dependent. Eligible Medical Expenses are "incurred" when the medical care is provided, not when you or your Eligible Dependent is billed, charged or pay for the expense. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may <u>not</u> be reimbursed from an HRA Account:

- expenses incurred for qualified long term care services;
- expenses incurred by you or your Eligible Spouse or Eligible Dependents *prior to the date* that an HRA Account had been established for you or your Eligible Spouse;
- expenses incurred by you or your Eligible Spouse or Eligible Dependents *after the date* that you cease to participate in the Plan (except to the extent that your Eligible Spouse continues to participate in the Plan after your death, as provided in Q-11 below), subject to the "spend-down" provision described in Q-7 below;
- expenses incurred by an Eligible Spouse *after the date* that the Eligible Spouse ceases to participate in the Plan;
- expenses that have been reimbursed by another plan (including Medicare) or for which you or your Eligible Spouse may seek reimbursement under another health plan (including Medicare);
- premiums which are paid by an individual on a pre-tax basis, through a cafeteria plan under Section 125 of the Code or otherwise; and
- any other expenses specifically identified as excluded in this document.

Q-7. When do I cease participation in the Plan?

If you are an Eligible Retiree, you will cease participation in the Plan on the earlier of:

- the date you cease to be an Eligible Retiree for any reason;
- the date you are rehired as an active employee of the Employer in a position that provides access to and you participate in the active health care benefit;
- the date you cease to be eligible for Medicare;
- your date of death;
- the effective date of any amendment terminating your eligibility under the Plan; or
- the date the Plan is terminated.

An Eligible Spouse will cease participation in the Plan on the earlier of:

- the date that the individual ceases to be an Eligible Spouse for any reason;
- the date that the individual is hired as an active employee of an Employer in a position that provides access to the active health care benefit, and the individual participates in the active health care benefit;
- the date that the individual ceases to be eligible for Medicare;

- the date that the individual divorces the Eligible Retiree;
- twelve (12) months after the date of the Eligible Retiree's death;
- the date of the individual's death;
- the effective date of any amendment terminating the individual's eligibility under the Plan; or
- the date the Plan is terminated.

You will not be eligible for any additional Benefit Credits to the HRA Account after the date your participation in the Plan ceases. However, if your participation ceases for any reason other than termination of the Plan, you may continue to submit expenses for reimbursement until the HRA Account balance is depleted, or in the event of your death, as provided in Q-11.

An Eligible Spouse will not be eligible for any additional Benefit Credits after the date the Eligible Spouse's participation in the Plan ceases. Except as provided in Q-11, an Eligible Spouse may not submit expenses for reimbursement from an HRA Account after his or her participation in the Plan ceases.

Q-8. What happens if I do not use all of the credits allocated to my HRA Account during the Plan Year?

If you or your Eligible Spouse do not use all of the amounts credited to the HRA Account during a Plan Year, those amounts will be carried over to subsequent Plan Years.

Q-9. How do I receive reimbursement under the Plan?

You must complete a reimbursement form and mail, electronically scan or fax it to the Claims Submission Agent indicated in the General Plan Information section, along with a copy of your insurance premium bill, an "explanation of benefits" or "EOB," or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment; and (d) the amount incurred. You can obtain a reimbursement form from the Third Party Administrator identified in the General Plan Information section. Your claim is deemed filed when it is received by the Claims Submission Agent.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Submission Agent.

Q-10. What happens if my claim for benefits is denied?

See the Claims Procedures description in Part IV.

Q-11 What happens upon death?

<u>Death of Eligible Retiree</u>
If the Eligible Retiree dies with no Eligible Spouse, his or her HRA Account is immediately forfeited upon death, but the deceased Eligible Retiree's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Eligible Retiree and his or her Eligible Dependents before his or her death. Claims must be submitted within 180 days of his or her death. No additional Benefit Credits will be contributed to the HRA Account for the Eligible Retiree after his or her death.

If the Eligible Retiree dies with an Eligible Spouse, the balance remaining in the joint HRA Account shall transition to the Eligible Spouse who can continue to submit Eligible Medical Expenses for reimbursement until the HRA Account is depleted or until the surviving Eligible Spouse's death. Benefit Credits will continue to be made for the benefit of such Eligible Spouse for up to twelve (12) months after the Eligible Retiree's death. However, if the surviving Eligible Spouse dies in the same calendar year as the Eligible Retiree, no additional Benefit Credits will be made for the following calendar year.

Death of Eligible Spouse

If an Eligible Spouse dies and there is a surviving Eligible Retiree, the balance remaining in the joint HRA account shall transition to the Eligible Retiree who can continue to submit Eligible Medical Expenses for reimbursement until the HRA Account is depleted or until the surviving Eligible Retiree's death. No additional Benefit Credits will be contributed to the HRA Account for the Eligible Spouse after his or her death.

Upon the Eligible Spouse's death with no surviving Eligible Retiree, the HRA Account is immediately forfeited upon death, but the deceased Eligible Spouse's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Eligible Spouse and his or her Eligible Dependents before his or her death. Claims must be submitted within 180 days of his or her death. No additional Benefit Credits will be contributed to the HRA Account for the Eligible Spouse after his/her death.

Q-12. Are my benefits taxable?

The Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive under the Plan generally are not taxable to you. Neither the Plan Sponsor, nor the Plan Administrator makes any commitment or guarantee that any amounts paid to you, your Eligible Spouse, or for the benefit of you, your Eligible Spouse or your Eligible Dependent under the Plan will be excludable from gross income for federal or state income and employment tax purposes, or that any other federal or state tax treatment will apply to or be available. It is your obligation to determine whether each payment under the Plan is excludable from your gross income for federal and state income and employment tax purposes and to notify the Plan Administrator if there is any reason to believe that any such payment is not excludable.

Q-13. What happens if I receive an overpayment under the Plan or a reimbursement is made in error from my HRA Account?

If it is later determined that you or your Eligible Spouse received an overpayment or a payment was made in error (e.g., you were reimbursed from the HRA Account for an expense that is later paid by another medical plan), you or your Eligible Spouse will be required to refund the overpayment or erroneous reimbursement to the Plan.

If you or your Eligible Spouse do not refund the erroneous payment within a reasonable time period as determined by the Plan Administrator, the erroneous payment will be (a) charged directly to you or your Eligible Spouse as a reduction of the amount of future benefits otherwise payable to or on behalf of an you, your Eligible Spouse or an Eligible Dependent, or (b) recouped by any other method which the Plan Administrator deems appropriate in its discretion.

Q-14. How long will the Plan remain in effect?

Although the Plan Sponsor expects to maintain the Plan indefinitely, it has the right to amend, modify, or terminate the program at any time for any reason by action of the Plan Sponsor's Board of Directors (or a committee of the Board of Directors), the CEO, and any other officer of the Plan Sponsor who is duly authorized by the Board of Directors (or such committee) or the CEO for this purpose. Additionally, the Sr. Director – Compensation & Benefits and the Vice President – Human Resources of the Plan Sponsor each have the right, authority and power to make, at any time, any amendment to the Plan as he or she may deem necessary or desirable to ensure the Plan's continued compliance with applicable law and authoritative guidance thereunder.

Q-15. How does the Plan interact with other medical plans?

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). If an Eligible Medical Expense is eligible for reimbursement under any other plan or plans (including Medicare) covering you, your Eligible Spouse or your Eligible Dependent, you must first submit any claims for such Eligible Medical Expense to the other plan or plans before submitting the expenses to this Plan for reimbursement.

If you are also a participant in a health flexible spending account, the expenses covered both by this Plan and the health flexible spending account must be submitted first to the health flexible spending account. Such expenses will not be considered Eligible Medical Expenses until after amounts available for reimbursement under the health flexible spending account have been exhausted.

Q-16. Who do I contact if I have questions about the Plan?

If you have any questions about the Plan, you should contact the Third Party Administrator or the Plan Administrator. Contact information for the Third Party Administrator and the Plan Administrator is provided in Part I.

PART IV
CLAIMS PROCEDURES

The claims provisions of this Part IV describe the procedures that apply to the Claims Submission Agent's review and determination regarding claims for benefits under the Plan, including the timeframes for making such determinations. The timeframes do not refer to the period in which payments for claims that are determined to be payable will be made by the Claims Submission Agent. Instead, the Claims Submission Agent will issue payments on claims finally determined to be payable as soon as reasonably practicable following such determination. Benefits under the Plan will be paid only if the Claims Submission Agent determines in its discretion that the claimant is entitled to them. Notwithstanding anything to the contrary herein, when used in this Part IV, the terms "you" and "your" refer to any Eligible Retiree or Eligible Spouse who is eligible to submit claims for reimbursement from an HRA Account under this Plan.

Requests for eligibility or coverage determinations which are not associated with a claim for benefits under the Plan shall not constitute a claim for benefits under ERISA or the Plan. In order for such an inquiry or request to constitute a claim for benefits or an appeal of an adverse benefit determination, it must be associated with a claim for benefits that is made by a claimant in accordance with the claim procedures set forth in this Part IV.

In General. The Plan Administrator reserves the right to delegate its authority to make decisions. The Plan Administrator may hold hearings. The Plan Administrator and Claims Submission Agent may rely on any applicable statute of limitations as a basis to deny a claim. The Plan Administrator' and Claims Submission Agent's decisions are conclusive and binding on all parties. You may, at your own expense, have a representative act on your behalf, but the Plan Administrator reserves the right to require a written authorization from you before permitting a person to act on your behalf.

Claims Submission Process.

- **Filing a Reimbursement Claim**. No benefit will be paid unless a claim for benefits has been filed with the Claims Submission Agent. When you submit a request for reimbursement, you are filing a reimbursement claim. You must file a written claim with the Claims Submission Agent (reference Q-9 for details). A submitted claim is not treated as filed until all information necessary to process the claim is submitted. If the claim, as originally submitted, is not complete, you will be notified and will then be responsible for providing the missing information.

- **Response**. Within 30 days of the date the Claims Submission Agent receives your claim, you will receive either a written or electronic notice of the Claims Submission Agent's decision or a notice describing the need for additional time (up to 15 additional days) to reach a decision. If the Claims Submission Agent notifies you that it needs additional time, the notice will describe the special circumstances requiring the extension and the date by which it expects to reach a decision.

  If additional time is required to render a benefit decision because of your failure to submit the information necessary to decide the claim (for example, you fail to submit copies of all bills related to the claim), the notice informing the you of the extended period of time required to render a benefit determination will also include a specific description of the information necessary to decide the claim. You will have at least forty-five (45) days from the date you receive the notice to provide the specified information.

- **Notice of Adverse Benefit Determination**. If the Claims Submission Agent denies your claim, in whole or in part, you will receive a notice specifying the specific reasons for the denial, the Plan provisions on which the denial is based, a description of any additional material or information (if any) needed to perfect the claim and an explanation of why such material or information is necessary, an explanation of your right to request a review, and a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Appeal of Adverse Benefit Determination.

- **In General**. If the Claims Submission Agent denies your claim, you must file a written request to have the denial reviewed.

- **Filing an Appeal**. Your request should state the facts and make the arguments that you want considered in the review. You may submit written comments, documents, records, and other information relating to your claim. Upon request you are entitled to receive, without charge, reasonable access to, and copy of, the documents, records, and other information relevant to your claim.

- **Time for Filing Appeals of a Denied Claim**. If your claim is denied, you may request a review of your claim. The Claims Submission Agent must receive actual delivery of your written request within 180 days following your receipt of the notification of the adverse benefit determination in order to submit an appeal of the decision to the Claims Submission Agent.

- **The Appeal**. The appeal will take into account all comments, documents, records, and other information that you submit relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The appeal will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the initial adverse determination or any subordinate of that person. If the adverse determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Claims Submission Agent will consult with a health care professional who was not involved in the initial benefit determination and is not the subordinate of any health care professional that was involved in the initial benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additional medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

- **Response on Appeal**. Within 60 days after the date the Claims Submission Agent receives your request for review, you will receive either a written or electronic notice of the decision or a notice describing the need for additional time (up to 60 additional days) to reach a decision. If the Claims Submission Agent notifies you that it needs additional time, the notice will describe the special circumstances requiring the extension and the date by which it expects to reach a decision. If the Claims Submission Agent affirms the denial of your claim, in whole or in part, you will receive a notice containing the following information: the reasons for the denial, the Plan provisions on which the denial is based, and notice that, upon request, you are entitled to receive, free of charge, reasonable access to, and copies of, the relevant documents, records, and information used in the claims process.

Limitations Period. If you file your claim within the required time, complete the entire claim procedures, and your claim is denied after you request a review, you may file a lawsuit over your claim (unless you have executed a release on your claim). You must begin this lawsuit within six (6) months after the claim process is completed. Regardless of when you file your claim, you may not, under any circumstances, begin a lawsuit more than thirty (30) months after you knew or should have known of facts supporting your claim.

Exhaustion of Administrative Remedies. No action at law or in equity may be brought to recover under the Plan until all administrative remedies have been exhausted (including two appeals of an adverse benefit determination). If you fail to file a timely claim, or if you fail to request a review in accordance with the Plan's claim procedures outlined herein, you will have no right of review and will have no right to bring any action in any court. The denial of the claim will become final and binding on all persons for all purposes.

Unclaimed Benefits. If, within twelve months after any amount becomes payable hereunder, and the same will not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care will have been exercised in attempting to make such payments, the amount thereof will be forfeited and will cease to be a liability of the Plan.

Knowledge of Fact by Participant Imputed to Beneficiary. For the purpose of applying the deadlines to file a claim or a legal action, knowledge of all facts that you knew or reasonably should have known shall be imputed to every claimant who is or claims to be your beneficiary or otherwise claims to derive an entitlement by reference to you for the purpose of applying the deadlines set forth above.

Choice of Law. Except to the extent that federal law is controlling, the Plan shall be construed and enforced in accordance with the laws of the State of Minnesota (except that the state law will be applied without regard to any choice of law provisions).

PART V
ERISA RIGHTS

This Plan is an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that you will be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Plan Coverage. Continue Plan coverage for your Eligible Spouse or Eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. However, such spouse or dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing COBRA continuation coverage rights.

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

Enforcement of Your Rights. If your claim for a welfare benefit under an ERISA-covered plan is denied or ignored in whole or in part, you must receive a written explanation of the reason for the denial, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, and you disagree with that denial, you must file an appeal of that denial in accordance with the Claim Procedures described in this SPD. If your appeal is denied in accordance with the Claims Procedures herein, and you have exhausted the administrative remedies provided to you under the Plan, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek

assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (*e.g.*, if it finds your claim is frivolous).

Assistance with Your Questions. If you have any questions about the Plan, you should contact the Plan Administrator at (507) 387-1841. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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

PART VI
COBRA AND SPECIAL RULES FOR GROUP HEALTH PLANS

Under a federal law called "COBRA," an Eligible Spouse under the Plan may elect to continue coverage under the Plan for a limited time after the date they would otherwise lose coverage because of a divorce from the Eligible Employee. Note that an Eligible Spouse is required to notify the Plan Administrator in writing of a divorce within sixty (60) days of the event or they will lose the right to continue coverage under the Plan.

If an Eligible Spouse elects to continue coverage, he or she is entitled to the level of coverage under the Plan in effect immediately preceding the qualifying event. He or she may also be entitled to an increase in his or her HRA Account equal to the amounts credited to the HRA Accounts of similarly situated participants (subject to any restrictions applicable to similarly situated participants) so long as he or she continues to pay the applicable premium.

In order to continue coverage, the Eligible Spouse must pay a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event.

Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the Eligible Spouse's HRA Account is exhausted;
- The date the Eligible Spouse notifies the Plan Administrator that he or she wishes to discontinue coverage;
- Any required monthly premium is not paid when due or during the applicable grace period;
- The date, after the date of the Eligible Spouse's election to continue coverage, that he or she becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary; or
- The Plan Sponsor ceases to provide this Plan.

PART VII
MISCELLANEOUS LAW PROVISIONS

Newborns' and Mothers' Health Protection Act

The Plan will comply with the applicable requirements of the Newborns' and Mothers' Health Protection Act ("**NMHPA**"). To the extent required by the NMPHA, the Plan generally will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Women's Health and Cancer Rights Act of 1998

The Plan will comply with the Women's Health and Cancer Rights Act requirement that group health plans providing coverage for mastectomies also provide certain mastectomy-related benefits or services. Under federal law, the Plan must provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance; and
- Prostheses; and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The same deductibles and co-insurance limitations apply to these procedures as apply to any other illness.

Other Laws

The Plan shall be construed to comply with ERISA and comply with all other applicable laws to the extent not preempted by ERISA or other controlling federal law.

PART VIII
AMENDMENT & TERMINATION

The Plan Sponsor reserves the right to, at any time (including after you retire), amend or terminate the Plan for any reason and in its sole discretion. The right to amend or terminate the Plan includes, but is not limited to, changes in the eligibility requirements, HRA Account contributions, benefits provided and termination of all or a portion of the coverage provided under the Plan. If the Plan is amended or terminated, you, your Eligible Spouse and any Eligible Dependents will be subject to all of the changes effective as a result of such amendment or termination. Neither you, your Eligible Spouse, nor any Eligible Dependent has ongoing rights to any Plan benefit. The Plan does not provide any vested benefits.

PART IX
PLAN ADMINISTRATION AND MISCELLANEOUS PROVISIONS

Alienation of Benefits
No benefit, right or interest under this Plan may be voluntarily or involuntarily assigned or alienated and any attempt to do so shall be void and unenforceable. Neither the Plan Sponsor nor any other Employer shall be in any manner liable for or subject to the debts, contracts, liabilities, engagements or torts of any individual entitled to benefits hereunder.

Facility of Payment
If the Plan Administrator deems any person incapable of receiving benefits to which he or she is entitled by reason of minority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Plan Administrator to disburse it, whose receipt shall be complete aquittance therefor. Such payments shall, to the extent thereof, discharge all liability of the Plan Sponsor and Plan Administrator.

Lost Distributees
Any benefit payable hereunder shall be deemed forfeited if, after reasonable efforts, the Plan Administrator is unable to locate the participant to whom payment is due.

QMCSOs
In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA Section 609(a)(2)(B)), the Plan Administrator shall notify you and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a QMCSO (within the meaning of ERISA Section 609(a)(2)(A)). Within a reasonable period, the Plan Administrator shall determine whether the order is a QMCSO and shall notify you and alternate recipient of such determination. A copy of the Plan's QMCSO procedures is available upon request.

HIPAA Notice of Privacy Practices
A copy of the HIPAA Notice of Privacy Practices will be distributed to you in accordance with applicable law and is also available upon request.

Severability
If any provision of the Plan is held invalid, unenforceable, or inconsistent with any law, regulation, or requirement for a reimbursement, its invalidity, unenforceability or inconsistency shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision were not a part of the Plan.

Construction of Terms
Words of gender shall include persons and entities of any gender, the plural shall include the singular, and the singular shall include the plural. Section headings exist for reference purposes only and shall not be construed as part of the Plan.

Plan Administration
The Plan Administrator has discretionary authority to grant or deny eligibility under the Plan and has the sole discretion, authority, and responsibility (unless delegated) to interpret and construe the Plan, and to determine all factual and legal questions under the Plan, including but not limited to the entitlement of all persons to benefits and the amount of their benefits. The Plan Administrator shall make such

determinations as may be required from time to time in the administration of the Plan. The Plan Administrator may delegate any and all authority and responsibility to any third party administrator or claims administrator, committee or other person or persons. In addition, the Plan Administrator may adopt any rule that (i) is not in conflict with the Plan, (ii) is necessary for administering the Plan, or (iii) carries out the provisions of the Plan.

Named Fiduciary
The Plan Administrator shall be the "named fiduciary" for purposes of ERISA Section 402(a)(1). Subject to the following subsection entitled "Delegation by the Plan Administrator," the "named fiduciary" has the authority to control and manage the operation and administration of the Plan and to review and make final decisions regarding claim determinations and appeals under the Plan and will be responsible for complying with all of the reporting and disclosure requirements of Part 1 of Subtitle B of Title I of ERISA.

Delegation by the Plan Administrator
The Plan Administrator may delegate to other persons or entities any of the administrative functions relating to the Plan, together with all powers necessary to enable its designee(s) to properly carry out such duties hereunder, including, without limitation, delegation to the Claims Submission Agent. The Plan Administrator may employ such counsel, accountants, claims administrators, claims fiduciaries, consultants, actuaries and such other persons or entities as it deems advisable in its discretion. The Plan Administrator, as well as any person to whom any duty or power in connection with the operation of the Plan is delegated, may rely upon all valuations, reports, and opinions furnished by any accountant, consultant, third-party administration service provider, legal counsel, or other specialist. Moreover, the Plan Administrator or such delegate who is also an employee of an Employer will be fully protected in respect to any action taken or permitted in good faith in reliance on such information.

Expenses
All reasonable expenses incurred in administering the Plan are paid by the Employer.

APPENDIX A
HIPAA PRIVACY

1.1 HIPAA Privacy and Security in General. This Appendix A is intended to comply with the requirements under the Health Insurance Portability and Accountability Act of 1996, as amended ("**HIPAA**"), the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E, as promulgated under HIPAA ("**Privacy Standards**"), the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR part 160 and part 164, subpart C, as promulgated under HIPAA ("**Security Standards**"), the HIPAA Enforcement Rule at 45 CFR part 160, subparts C through E ("**Enforcement Rules**") and the "**Breach Notification Rules**" issued under the Health Information Technology for Economic and Clinical Health Act ("**HITECH**"), as each of the foregoing were amended, generally effective as of September 23, 2013, by the regulations issued on January 25, 2013 ("**HIPAA Omnibus Rules**"). References to any section of the Privacy Standards, the Security Standards, the Enforcement Rules or the Breach Notification Rules shall include any amendments or successor provisions thereto, including the HIPAA Omnibus Rules.

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

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

Payment is as defined under 45 CFR § 160.501 and includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided.

Health Care Operations is as defined under 45 CFR § 160.501.

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

1.4 Plan Sponsor Agrees to Certain Conditions for PHI. The Plan Sponsor agrees to:

(a) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the

Plan Sponsor with respect to such PHI;

(c) Not use or disclose PHI for employment-related actions and decisions unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;

(d) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;

(e) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make PHI available to an individual in accordance with HIPAA's access requirements;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) Make available the information required to provide an accounting of disclosures;

(i) Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;

(j) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and

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

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

(a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) under the Privacy Standards is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides this information or who receives this information on behalf of the Plan agrees to implement reasonable and appropriate security measures to protect the information; and

(d) Report to the Plan any security incident of which it becomes aware, in accordance with the administrative procedures adopted by the Plan for compliance with the Security Standards.

1.5 Adequate Separation Between the Plan and the Plan Sponsor. In accordance with the

Privacy Standards, only the following employees or classes of employees may be given access to PHI:

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

1.6 Limitations of PHI Access and Disclosure. The persons described in Section 1.5 of this Appendix A may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

1.7 Noncompliance Issues. If the persons described in Section 1.5 of this Appendix A do not comply with the Plan document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

1.8 Additional Requirements Imposed by HITECH. The provisions of this Section will apply to the Plan to the extent the Plan is a "covered entity" as defined in 45 CFR § 160.103. In accordance with, and to the extent required by, HITECH and the regulations and other authority promulgated thereunder by the appropriate governmental authority, the Plan will (a) comply with notification requirements when unsecured PHI has been accessed, acquired, or disclosed as a result of a breach, (b) comply with an individual's request to restrict disclosure of PHI, (c) limit disclosures of PHI to a limited data set or the minimum necessary, (d) provide an accounting of disclosures, and (e) provide access to PHI in electronic format.

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

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

- A brief description of what happened, including the date of the Breach and the date of its

discovery, if known;

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

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

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

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

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

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