2023 Required Health Coverage Notices

Important: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug Program gives you more choices about your prescription drug coverage. Please see page 15 for more details.

To All Participants and Beneficiaries:

The following are some of the notices that are required to be distributed to new and/or existing enrollees in a Frontier Communications group health plan. Please share these notices with your enrolled spouse/partner.

This Required Health Coverage Notice ("Notice") is a summary of material modifications ("SMM") to all of the Frontier Communications employee welfare benefit plans (referred to singularly and collectively, as applicable, as the "Plan"). This SMM amends the Plan's Summary Plan Descriptions ("SPD"). This Notice describes only material changes in the Plan and the SPD. You should keep this SMM together with your SPD and other plan documentation. To the extent there is a conflict between your SPD, any other SMMs and this Notice, this Notice will control.

Please refer to your applicable SPD for further information regarding your health benefits, including other required notices and prior summaries of material modifications. SPDs, SMMs and other Plan notices are available online at https://frontier.mybenefitchoice.com. You also have the right to request a paper copy of your SPDs, SMMs and Plan notices. If you have any questions about these notices or would like to request a paper copy of an SPD, this SMM or any other Plan notice, please contact a representative at the Frontier Benefits Service Center at 1-866-333-2074 Option 2. Representatives are available Monday through Friday from 8:00 am to 8:00 pm, Eastern Time.

This Notice applies to benefits that are effective commencing January 1, 2023.

NOTICE OF PRIVACY PRACTICES

Revised Effective: July 1, 2021

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

Frontier Communications (including its subsidiaries and divisions), as the sponsor of various group health plans ("Plan Sponsor"), is required by law to take steps to ensure the privacy of your personally identifiable health information and to provide you with this Notice of Privacy Practices ("Privacy Notice"). This Privacy Notice is provided to you as a covered person under one of the following health plans, which are collectively referred to, in this Privacy Notice, as the "Health Plan:"

- Frontier Communications Health Care Plan, Plan 505 (medical, dental, health flexible spending account and employee assistance EAP coverage)
- Frontier Communications Vision Service Care Plan, Plan 517 (vision coverage)

- Frontier Communications Retiree Medical Plan, Plan 530 (medical coverage)
- Frontier Communications Managed Care Network and Medical Expense Plan, Plan 550 (medical, dental, vision and EAP)
- Frontier Communications Plan 552 (health flexible spending account)
- Frontier Communications Plan 554 (medical and dental)
- Frontier Communications Choices Plan, Plan 579 (health flexible spending account)
- Frontier Communications Plan for Group Insurance, Plan 580 (medical, dental, vision and EAP)
- Frontier Communications Retiree Plan for Group Insurance, Plan 581 (medical)
- Frontier Communications Retiree Welfare Plan 603 (medical)

A federal law, known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires the Health Plan to maintain the privacy of your protected health information ("PHI"). PHI encompasses substantially all "individually identifiable health information" which is transmitted or maintained by the Health Plan, regardless of its form. PHI includes medical information relating to your physical or mental health or condition, the provision of health care to you, or the payment for health care provided to you. However, PHI does not include all health information that may be maintained by Frontier Communications or its benefit plans. For example, PHI does not include health information maintained by Frontier Communications in its capacity as an employer, such as drug testing results, sick leave requests and related physician notes and medical information used for processing Family Medical Leave Act (FMLA) requests. Further, PHI does not include health information that is used or maintained by Frontier Communications' non-health benefit plans, such as workers' compensation, life insurance, accidental death and dismemberment (AD&D) and short and long term disability benefits. If health information is not PHI, then the health information is not protected by HIPAA and is not covered by this Privacy Notice.

Frontier Communications and the Health Plan understand that your PHI is personal and private, and both are committed to maintaining the privacy of your PHI. In particular, this Privacy Notice describes the ways in which the Health Plan may use or disclose your PHI. It also describes the Health Plan's obligations to you and your individual rights regarding the use and disclosure of your PHI. HIPAA requires the Health Plan to provide this Privacy Notice to you and to comply with its terms.

This Privacy Notice summarizes the Health Plan's privacy practices and those of any third party that assists in the administration of the Health Plan, such as a third-party administrator that pays Health Plan claims. This Privacy Notice does not apply to any health benefit that is fully-insured with an insurer or that is provided through a health maintenance organization (HMO). You will receive a separate Notice of Privacy Practices from the insurer or HMO with respect to the privacy practices of those entities. This Privacy Notice does not apply to any health care provider.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

The following categories describe different ways that the Health Plan uses and discloses your health information. For each category, the Privacy Notice will outline the uses or disclosures included in the category, but not every use or disclosure within a category can be listed.

For Treatment. The Health Plan may use and disclose your PHI to provide, coordinate or manage your health care treatment and any related services provided to you by health care providers. This includes the coordination or management of your health care by a health care provider. For example, the Health Plan may use and disclose your PHI in order to describe or recommend treatment alternatives to you or to provide information about health-related benefits and services that may be of interest to you, such as generic prescription drug alternatives.

For Payment. The Health Plan may use and disclose your PHI to make coverage determinations and provide payment for health care services you have received. These activities include determining your eligibility for benefits under the Health Plan (including coordination of benefits or the determination of cost sharing amounts); processing your claims for benefits under the Health Plan; resolving subrogation and reimbursement rights under the Health Plan; billing, claims management and collection activities; obtaining payment under stop-loss and excess loss insurance policies; reviewing health care services you receive for Health Plan coverage, medical necessity and appropriateness; and conducting utilization review activities (including precertification, preauthorization, concurrent review and retrospective review activities). For example, the Health Plan may disclose your health information to a third party (for instance, a medical reviewer) when necessary to resolve the payment of a claim for health care services that have been provided to you.

For Health Care Operations. The Health Plan may use and disclose your PHI for administration and operations, including quality assessment and quality improvement activities; wellness and related activities; underwriting, premium rating and other activities relating to the creation, renewal or replacement of a health insurance or health benefits contract or a stop-loss or excess loss insurance contract; conducting or arranging for medical assessments, legal services and auditing functions (including fraud and abuse detection and compliance programs), and other general administrative activities such as customer service and HIPAA compliance. For example, the Health Plan may disclose your health information to potential health insurance carriers in order to obtain a premium bid from the carrier.

Notwithstanding, special protections are given to your genetic information. The Health Plan is not permitted to use or disclose your genetic information for any underwriting purpose.

Each of the Health Plans which are subject to this Privacy Notice may share health information between them to carry out Treatment, Payment or Health Care Operations.

DISCLOSURE OF YOUR HEALTH INFORMATION IN SPECIAL SITUATIONS

Outlined below are situations in which the Health Plan may disclose your PHI without your authorization. Disclosures may be performed by the Plan or any business associate or agent on behalf of the Plan.

Disclosure to You or Your Personal Representative. The Health Plan may disclose your PHI to you or your personal representative.

Disclosure to the Plan Sponsor. The Health Plan, or an insurer of benefits provided under the Health Plan, may disclose your PHI without your written authorization to the Plan Sponsor for plan administration purposes. The Plan Sponsor agrees not to use or disclose your health information other than as permitted or required by the plan document(s) for the Health Plan and by applicable law. In particular, your health information will not be used for employment decisions, and your genetic information will not be used for underwriting.

Disclosure to a Business Associate. Certain services are provided to the Health Plan by third party administrators known as “business associates.” For example, the Health Plan may pay your health care provider’s claims through an electronic claims processing system maintained by one or more of the Health Plan’s business associates. In doing so, the business associate will obtain, maintain, use and disclose your PHI so it can perform its claims payment function. However, the Health Plan will require

its business associates, through contract, to appropriately safeguard your health information as required under HIPAA.

Public Health Activities. The Health Plan may use or disclose your PHI for public health activities. Permitted disclosures include:

- Disclosure to a person subject to the jurisdiction of the Food and Drug Administration ("FDA") in connection with activities related to the quality, safety or effectiveness of FDA-regulated products.
- Disclosure to report births and deaths.
- Disclosure to report reactions to medications, problems with health related products or to notify a person of recalls of medications or products the person may be using.
- Disclosure to a public health authority for the purpose of controlling disease or injury or to report child abuse or neglect.
- Disclosure, if authorized by law, to a person who may have been exposed to or be at risk of contracting a communicable disease.

Abuse or Neglect. The Health Plan may disclose your PHI to an appropriate government authority that is authorized by law to receive reports of child abuse, neglect or domestic violence, including a social services or protective services agency, if the Health Plan reasonably believes you to be a victim of abuse, neglect or domestic violence. However, the Health Plan will only disclose your PHI in these situations, if (1) the disclosure is required by law; (2) you agree to the disclosure; or (3) the Health Plan reasonably believes that the disclosure is necessary to prevent harm to you or other potential victims. The Health Plan will notify you of a disclosure for abuse or neglect purposes if doing so will not place you at further risk.

Health Oversight Activities. The Health Plan may disclose your PHI to a health oversight agency for certain activities authorized by law including audits; civil, administrative, or criminal investigations; inspections; licensure or other activities necessary for appropriate oversight of the health care system.

Judicial and Administrative Proceedings. In certain limited situations, the Health Plan may disclose your PHI in response to a valid court or administrative order. The Health Plan may also disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if the Health Plan receives satisfactory assurances that the party seeking the information has tried to inform you of the request or to obtain a qualifying protective order to safeguard the information requested.

Required by Law. The Health Plan will disclose your PHI where required to do so by federal, state or local law. The Health Plan may also disclose your PHI to the Department of Health and Human Services regarding HIPAA compliance matters.

Coroners, Medical Examiners and Funeral Directors. The Health Plan may disclose your PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. The Health Plan may also disclose PHI to a funeral director, as necessary to allow the funeral director to carry out his or her duties.

Organ and Tissue Donation. If you are an organ donor, the Health Plan may disclose your PHI as necessary to facilitate organ or tissue donation, including transplantation.

Research. The Health Plan may disclose your PHI to researchers without your authorization if their research has been approved by an institutional review board or privacy board that has reviewed the

research proposal and established protocols to ensure the privacy of your PHI and the researchers have provided certain necessary representations regarding the research.

Serious Threat to Health or Safety. The Health Plan may disclose your PHI, consistent with applicable law and standards of ethical conduct, if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public in general or, in certain cases, when the information is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security. When the appropriate conditions apply and if you are a member of the Armed Forces, the Health Plan may disclose your PHI (1) for activities deemed necessary by appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to a foreign military authority if you are a member of that foreign military service. The Health Plan may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities for the conduct of lawful intelligence, counter-intelligence and national security activities. The Health Plan may also disclose PHI to authorized federal officials for the provision of protective services to the President or others that are authorized by law.

Inmates. If you are an inmate of a correctional institution or in the custody of a law enforcement official, the Health Plan may disclose your PHI to the institution or official if the information is necessary for (1) the provision of health care to you, (2) your health and safety or the health and safety of other inmates, the officers, employees, or others at the correctional institution, (3) law enforcement on the premises of the correctional institution, or (4) the safety and security of the correctional institution.

Workers' Compensation. The Health Plan may disclose your PHI as necessary to comply with workers' compensation laws and other similar legally established programs that provide benefits for work-related injuries or illness without regard to fault.

Law Enforcement Purposes. The Health Plan may disclose your PHI, in certain situations, to law enforcement officials, including: (1) when directed by a court order, subpoena, warrant, summons or similar process; (2) if necessary to identify or locate a suspect, fugitive, material witness or missing person; and (3) if necessary to report information about the victim of a crime in limited circumstances where the victim is unable to provide consent.

Marketing Activities. The Health Plan must have your authorization before it can use or disclose your PHI in connection with most marketing activities. Notwithstanding, some marketing activities are permitted. For example, the Health Plan may send you a communication (without your authorization) that encourages you to purchase or use a health related product or service that is provided by the Health Plan or that relates to your treatment.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

In order to use or disclose your PHI for any reason other than those otherwise allowed by HIPAA, the Health Plan must obtain your written authorization. Specifically, the Health Plan must obtain your written authorization (1) in certain situations to use or disclose psychotherapy notes about you, (2) to market (or allow other parties to market) products or services to you, unless an exception applies (e.g., the product or service is one that is covered by the Health Plan), and (3) to sell your PHI to a third party in exchange for remuneration (except in cases of mergers or acquisitions). If you sign an authorization form, you may revoke your authorization by submitting a request in writing. If you revoke your authorization, the Health Plan will no longer use or disclose your PHI for the reasons covered by the

authorization. However, the Health Plan is unable to retract or invalidate any uses or disclosures that were already made with your permission prior to your revocation of the authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have several important rights with regard to your PHI, which are summarized below. In most circumstances, the Health Plan's business associates (otherwise referred to as third-party administrators, claims processors, and/or carriers) have contracted with the Health Plan to respond to and fulfill your individual rights requests. Therefore, please contact the applicable business associate directly to exercise any of these rights. This can be done using the contact information on your health benefit identification card. If you prefer, you may also contact the Privacy Official.

Right to Inspect and Copy. With certain exceptions described below, you have the right to inspect and copy your PHI if it is part of a "designated record set" or "DRS." The DRS is the group of records maintained by or on behalf of the Health Plan and contained in the enrollment, payment, claims adjudication, and case or medical management record systems of the Health Plan, and any other records which are used by the Health Plan to make decisions about individuals. This right does not extend to psychotherapy notes, information gathered for certain civil, criminal or administrative proceedings, and information maintained by the Plan Sponsor that duplicates information maintained by a Health Plan third-party administrator in its DRS.

The Health Plan must provide you with access to the PHI contained in a DRS in the form and format requested by you. However, if the PHI is not readily producible in such form or format, it must be produced in a readable hard copy form or such other form as agreed to by the Health Plan and you. Further, if the PHI is maintained in an electronic DRS, you may request an electronic copy of the PHI in an electronic form or format. However, if the PHI is not readily producible in a specific electronic form and format requested by you, the Health Plan and you must agree on the electronic form or format in which it will be produced.

If you request a copy of your PHI contained in a DRS, the Health Plan may charge you a reasonable, cost-based fee for the expense of copying, mailing and/or other supplies associated with your request. To inspect and obtain a copy of your PHI that is part of a DRS, you must submit your request in writing. In most cases, you must use a specific form, which you can request directly from the health carrier or vendor.

If you exercise your right to access your PHI, the Health Plan will respond to your request within 30 days, subject to a one-time 30-day extension by providing you with a written explanation for the delay and the date by which it will respond to your request.

The Health Plan may deny your request to inspect and copy your PHI in certain limited situations. If you are denied access to your PHI, you will be notified in writing. The notice of denial will include the basis for the denial, and a description of any appeal rights you may have and the right to file a complaint with the Health Plan or with the Department of Health and Human Services. If the Health Plan does not maintain the PHI that you are seeking but knows where it is maintained, the Health Plan will notify you of where to direct your request.

Right to Amend. If you believe that your PHI in a Designated Record Set is incorrect or incomplete, you may request that the Health Plan amend the PHI. Any such request must be made in writing and must include a reason that supports your requested amendment. In most cases, you must use a specific form, which you can request directly from the health carrier or vendor. The Health Plan must respond to your

request within 60 days. If the Health Plan is not able to respond within this 60-day period, it may have a one-time 30-day extension by providing you with a written explanation for the delay and the date by which it will respond to your request.

In limited situations, the Health Plan may deny your request to amend your PHI. For example, the Health Plan may deny your request if (1) the PHI was not created by the Health Plan (unless the person who created the information is no longer available to make the amendment); (2) the Health Plan determines the information to be accurate or complete; (3) the information is not part of the DRS; or (4) the information is not part of the information which you would be permitted to inspect and copy, such as psychotherapy notes. If your request is denied, you will be notified in writing. The notice of denial will include the basis for the denial, and a description of your right to submit a statement of disagreement and the right to file a complaint with the Health Plan or with the Department of Health and Human Services.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain types of disclosures of your PHI made by the Health Plan during a specified period of time. You do not have the right to request an accounting of all disclosures of your PHI. For example, you do not have the right to receive an accounting of (1) disclosures for purposes of Treatment, Payment or Health Care Operations; (2) disclosures to you or your personal representative regarding your own PHI; (3) disclosures pursuant to an authorization; or (4) disclosures prior to six years from the date of your accounting request.

Your request must indicate the time period for which you are seeking the accounting, such as a single month, six months or two calendar years. The Health Plan must respond to your request within 60 days. If the Health Plan is not able to respond within this 60-day period, it may have a one-time 30-day extension by providing you with a written explanation for the delay and the date by which it will respond to your request.

The Health Plan will provide the first accounting you request in any 12-month period free of charge. The Health Plan may impose a reasonable, cost-based fee for each subsequent accounting request within the 12-month period. The Health Plan will notify you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI that the Health Plan uses or discloses about you in certain situations. However, the Health Plan is not required to agree to your request. The Health Plan has determined that approving these requests would generally interfere with the resolution of benefit claims and, therefore, a restriction request will only be approved in special and compelling circumstances in the sole discretion of the Health Plan.

With respect to a health care provider, you have a right to request that a health care provider restrict disclosure of your PHI and not disclose such PHI and related claim information to the Plan, if the PHI pertains solely to a health care item or service for which you or another person on your behalf has paid the health care provider in full outside of the Plan.

Right to Request Confidential Communications. You have the right to request that the Health Plan communicate with you about health matters in a specific manner or specific location. To request confidential communications, you must make your request in writing and must specify how and/or where you wish to be contacted, for example, by mailings to a post office box. In most cases, you must use a specific form, which you can request directly from the vendor. The Health Plan will consider and attempt to meet reasonable requests.

Right to a Paper Copy of this Notice. You have the right to request a paper copy of this Privacy Notice,

even if you previously received this Privacy Notice electronically. Any such request should be submitted to the HIPAA Communications Official. You may also view this Privacy Notice on the benefits website at https://frontier.mybenefitchoice.com.

Personal Representatives. You may exercise your HIPAA rights though a personal representative. The representative must produce appropriate evidence of his or her authority to act on your behalf. Examples of acceptable authority include (1) a power of attorney, notarized by a notary public, (2) a court order of appointment as conservator or guardian and (3) a parent of an unemancipated minor. The Health Plan may deny access to PHI to a personal representative, including a parent of an unemancipated minor, if the denial is in the best interest of the individual.

NOTICE OF BREACHES OF UNSECURED PHI

Under HIPAA, the Health Plan and its business associates are required to maintain the privacy and security of your PHI. The goal of the Health Plan and its business associates is to not allow any unauthorized uses or disclosures of your PHI. However, regrettably, sometimes an unauthorized use or disclosure of your PHI occurs. These incidents are referred to as "breaches." If a breach affects you and is related to unencrypted PHI, the Health Plan or its applicable business associate will notify you of the breach and the actions taken by the Health Plan or the business associate to mitigate or eliminate the exposure to you.

CHANGES TO THIS PRIVACY NOTICE

The Health Plan reserves the right to change, at any time, its privacy practices and this Privacy Notice. If this Privacy Notice is materially revised, a revised copy of the Privacy Notice will be provided within 60 days. Unless otherwise set forth in the revised Privacy Notice, the revised Privacy Notice will be effective for all PHI that the Health Plan maintains at the time of the revision as well as PHI the Health Plan receives in the future.

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a complaint to the Health Plan or the Secretary of the Department of Health and Human Services. Frontier Communications will not retaliate against you for filing a complaint with the Health Plan or with the Department of Health and Human Services.

The business associates (i.e., third party administrators and/or carriers) for the health coverage in which you are enrolled must also protect the privacy and security of your PHI. If you believe your privacy rights have been violated by a business associate, you may submit a complaint directly to the business associate or, if you prefer, you may contact the Health Plan.

To submit a complaint to the Health Plan, you must submit the complaint in writing to the HIPAA Communications Official. To submit a complaint to the Department of Health and Human Services, you must contact the Office for Civil Rights of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201. Further information is also available on the Office's website at https://www.hhs.gov/hipaa/filing-a-complaint/index.html.

If you have a complaint against the Health Plan or a business associate, you are encouraged (but not required) to notify the Health Plan before contacting the federal government. The Health Plan will make every effort to address your complaint in a prompt and satisfactory manner.

CONTACT INFORMATION

If you have any questions about this Privacy Notice or would like to submit a complaint to the Health Plan, please contact the HIPAA Communications Official as follows:

Frontier Benefits Service Center
https://frontier.mybenefitchoice.com
1-866-333-2074 Option 2 (Monday-Friday, 8:00 am to 8:00 pm, Eastern Time)

If you would like to exercise any of your rights concerning your health information (such as your right to request access to your health information), you should contact the business associate directly. This can be done by using the contact information on your applicable Health Plan identification card. You may also obtain the contact information for your health carrier or vendor by contacting the HIPAA Communications Official as listed above.

Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA is a federal law prohibiting discrimination against an Employee, Retiree, Dependent or Spouse on the basis of an individual's genetic information. Genetic information is defined as information about an individual's genetics based on genetic tests of an individual's family members or information about the manifestation of a disease or disorder within an individual's family. Genetic information includes any request for or receipt of genetic services (including genetic testing, counseling or education), or participation in clinical research that includes such services, by the individual or family member.

In general, this Plan is not permitted to:

- Use genetic information to discriminate with respect to premiums or contributions;
- Request or require Participants and/or their Dependents to undergo genetic testing (except in specifically permitted situations);
- Collect genetic information for underwriting purposes or prior to enrollment under the Plan;
- Use genetic information to determine eligibility for coverage.

Federal guidelines related to GINA are constantly evolving, however, the Plan is making a good faith effort to comply with current guidelines as we understand them. If you have any questions with respect to the use of your genetic information or GINA, you should contact The Frontier Benefits Service Center at **https://frontier.mybenefitchoice.com/**

CONTINUATION COVERAGE RIGHTS UNDER COBRA

For the Frontier Communications Corporate Retiree Welfare Plan 603, the Frontier Communications Corporate Services Retiree Plan for Group Insurance, the Frontier Communications Corporation Retiree Medical Plan, and the Frontier Communications Corporate Services Plan 554

You are receiving this notice because you recently gained coverage under one of the above-named Frontier Communications group health plans (collectively, the "Plan"). Alternatively, you may be

receiving this notice as part of the health care notices which are provided annually to participants. This notice applies to the extent that you are eligible for and enrolled in a health benefit offered under the respective Plan. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. If you become eligible for COBRA continuation coverage, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. There may also be special rules that apply with respect to additional continuation coverage offered to individuals who participate in HMO or insured coverage options. For additional information, please contact the Frontier Employee Service Center.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the COBRA Administrator. The COBRA Administrator may be contacted at:

Frontier Benefits Service Center
https://frontier.mybenefitchoice.com
1-866-333-2074 Option 2 (Monday-Friday, 8:00 am to 8:00 pm, Eastern Time)

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Additional information is provided below.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Covered Retirees. If you are a covered retiree, you'll become a qualified beneficiary if you lose your coverage under the Plan because Frontier Communications commences Chapter 11 bankruptcy proceedings.

Spouse of a Covered Retiree. If you are the covered spouse of a retiree, you'll become a qualified beneficiary if you lose your coverage under the Plan because of one of the following qualifying events:

(1) Your spouse dies.
(2) You become divorced or legally separated from your spouse.
(3) Frontier Communications commences Chapter 11 bankruptcy proceedings.
(4) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).

Dependent children. Your covered dependent children will become qualified beneficiaries if they lose coverage under the Plan because of one of the following qualifying events:

(1) The parent-retiree dies.
(2) The parents become divorced or legally separated.
(3) The child loses eligibility for coverage as a "dependent child" under the Plan.
(4) Frontier Communications commences Chapter 11 bankruptcy proceedings.
(5) The parent-retiree becomes entitled to Medicare benefits (under Part A, Part B, or both).

A child born to or placed for adoption with a covered retiree during the continuation coverage period may also elect continuation coverage. The coverage period will be determined according to the date of the qualifying event that gave rise to the covered retiree's COBRA coverage.

Covered Domestic Partners and their Dependent Children. Federal COBRA laws do not cover domestic partners and their dependent children, unless they are your legal spouse (both opposite sex and same sex spouses) or your tax dependent for federal tax purposes. Therefore, this notice and the COBRA continuation rights provided by this notice do not apply to any domestic partners and their dependent children who may have coverage under the Plan. Once Plan coverage terminates for a domestic partner and a partner's dependent children, Plan coverage cannot be continued.

You Must Give Notice of Certain Qualifying Events

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan has been notified that a qualifying event has occurred.

For the qualifying events of:

(1) A divorce or legal separation of the retiree and spouse, or
(2) A dependent child (of the retiree) losing eligibility for coverage as a "dependent child" (including expiration of the continued coverage for full-time students who lose eligibility as a result of a serious illness or injury),

You must contact the COBRA Administrator (listed in the first page of this COBRA notice) within 60 days after the qualifying event occurs. When you contact the COBRA Administrator, you will be asked to provide certain information about the qualifying event and the qualifying beneficiaries. Therefore, you should have this information available when you call. In certain situations, the COBRA Administrator may request that you provide additional information regarding the qualifying event or certain written documentation, including a copy of the decree of divorce or legal separation (if the qualifying event is a divorce or legal separation). If any additional information or written materials are requested, you must timely provide the information or the written materials. If the above notification is not made within 60 days after the applicable qualifying event occurs or if you do not timely provide the additional documentation or information (if requested), your notification will be rejected and COBRA continuation coverage will not be offered.

For all other qualifying events, such as the death of the retiree, you are not required to notify the Plan of these events. Rather, your employer is responsible for notifying the Plan of these qualifying events.

Election Period

Once the Plan receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage for 60 days from the later of the date coverage is lost under the Plan or the date of notification to elect continuation coverage. If a qualified beneficiary does not elect continuation coverage within this period, your rights to COBRA continuation coverage will terminate. Covered retirees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. If a covered retiree or a covered retiree's spouse elects COBRA continuation coverage without specifying whether the election is for self-only coverage, the election will be considered to be made on behalf of all other qualified beneficiaries with respect to that qualifying event.

If COBRA continuation coverage is elected, the coverage previously in effect will generally be continued. From time to time, some changes in coverage are possible. For example, benefits and cost will be modified as regular changes are made to the Plan. Once you make your election, you will have up to 45 days to pay your first COBRA premium, which will include any make-up premiums you missed. COBRA coverage will be effective the day after the qualifying event. Premiums will be equal to the entire cost of the coverage, with an additional 2 percent to cover administrative expenses.

When making the decision of whether to elect COBRA continuation coverage, you should keep in mind that you may have other options. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov or by calling 1-800-318-2596.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible. When you lose job-based health coverage, it is important that you choose carefully between COBRA continuation coverage and other coverage options, because once you have made your choice, it can be difficult or impossible to switch to another coverage option.

Length of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is:

- The death of the covered retiree.
- Your divorce.
- A dependent child losing eligibility as a dependent child.

In the case of a bankruptcy proceeding, COBRA continuation coverage generally lasts for the covered retiree until the date of the covered retiree's death. For a spouse, surviving spouse or dependent child, COBRA continuation coverage ends on the earlier of:

- The date of the spouse's, surviving spouse's or dependent child's death; or

- 36 months after the date of the covered retiree's death.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will terminate before the end of the indicated time period if:

- You or any of your covered dependents become covered under another medical plan not offered by Frontier Communications provided that the plan does not have a legally valid pre-existing condition exclusion or limitation affecting the qualified beneficiary.
- Your spouse or a dependent child becomes entitled to Medicare after electing COBRA continuation coverage.
- The first required premium is not paid within 45 days or any subsequent premium is not paid within 30 days of the due date.
- All health plans for retirees are terminated by Frontier Communications.

Special rules may apply if the qualifying event is a Chapter 11 bankruptcy filing by Frontier Communications. For additional information, please contact the Frontier Employee Service Center.

Continuation coverage also may be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Health Insurance Marketplace and Other Coverage

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace, you will also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.healthcare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days, your special enrollment period will end and you may not be able to enroll until annual enrollment, so you should take action right away if you think that you may want Marketplace coverage. In addition, you may also enroll in Marketplace coverage annually during what is called an "open enrollment" period. The open enrollment period is the time during which anyone can purchase coverage through the Marketplace. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.healthcare.gov.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." If, however, you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait to enroll in

Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if you enroll outside of the Marketplace open enrollment.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you are eligible, you will have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

When considering your options for health coverage, you may want to think about:

- *Premiums:* You can be charged up to 102% of total plan premiums for COBRA coverage (more if you qualify for an extension of coverage on account of a disability). Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

- *Provider Networks:* If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.

- *Drug Formularies:* If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

- *Service Areas:* Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

- *Other Cost-Sharing:* In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

If You Have Questions

If you have questions concerning the Plan or your COBRA continuation coverage rights, you should contact the COBRA Administrator. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at https://www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and

District EBSA Offices are available through EBSA's website.) For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, you should keep the Plan informed of any changes in the addresses of family members by contacting the COBRA Administrator. You should also keep a copy, for your records, of any notices or documentation you send to the Plan or COBRA Administrator.

Plan Contact Information

For additional information about the Plan or COBRA continuation coverage, you may contact Jo Ann Farrall, VP, Retirement Benefits, 401 Merritt 7, Norwalk, CT 06851, phone: 203-614-5723.

IMPORTANT NOTICE FROM FRONTIER COMMUNICATIONS ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under a Frontier Communications health plan (the "Plan") 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 Frontier Communications' prescription drug coverage and Medicare's prescription drug coverage:

1. **You can get Medicare Prescription Drug 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. **Frontier Communications has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as the 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 (i.e., 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 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a 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?

When you are eligible to elect a Medicare prescription drug plan (generally when you reach age 65), and if you are eligible for and enrolled in a medical option under a Frontier Communications retiree medical plan, you should keep in mind the following important information:

- Your Frontier Communications retiree medical and prescription drug coverage will be cancelled for you and your covered spouse/partner and dependents, if you or your covered spouse/partner enroll in a Medicare prescription drug plan. This means that Medicare will be the only source of medical and prescription drug coverage for you and your spouse/partner and dependents.

- If you or your covered spouse/partner do enroll in a Medicare prescription drug plan and your Frontier Communications retiree medical and prescription drug coverage is cancelled, you will not be able to re-enroll in the Frontier Communications retiree medical and prescription drug coverage. This means that you will permanently lose retiree medical and prescription drug coverage through Frontier Communications if you or your covered spouse/partner enroll in a Medicare prescription drug 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 Frontier Communications 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 October to join.

For More Information about this Notice or your Current Prescription Drug Coverage…

Contact the person listed below for further information. You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if this coverage through Frontier Communications 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. If you are Medicare-eligible or close to becoming Medicare-eligible, you will receive 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 http://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 http://www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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).

Date:	October 1, 2022
Name of Entity/Sender:	Frontier Communications Health Plans
Contact--Position/Office:	Frontier Benefits Service Center https://frontier.mybenefitchoice.com 1-866-333-2074 Option 2 (Monday-Friday, 8:00 am to 8:00 pm, Eastern Time)

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

This notice applies to services provided on or after January 1, 2023.

This notice does not apply to separate dental and vision coverages.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments,

coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact your health plan using the contact information on the back of your health ID card. The federal phone number for information and complaints is 1-800-985-3059. You may also contact the Employee Benefits Security Administration as follows:

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