SUMMARY PLAN DESCRIPTION

OF THE

CONSOLIDATED COMMUNICATIONS, INC.
ILLINOIS BARGAINING
LIFE, ACCIDENT AND LONG TERM DISABILITY BENEFITS PLAN

(Effective as of January 1, 2007)

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Consolidated Communications Holdings, Inc. (the "**Plan Sponsor**") previously established welfare benefit plans to provide life, accidental death and dismemberment ("**AD&D**"), and long term disability insurance benefits to eligible employees ("**Prior Plans**"). Effective as of January 1, 2007, the Plan Sponsor hereby (i) separates from those Prior Plans, for administrative purposes, the life, AD&D and long term disability insurance benefits provided to eligible employees who are employed in Illinois and covered by a collective bargaining agreement and (ii) continues such benefits coverage under this "Consolidated Communications, Inc. Illinois Bargaining Life, Accident and Long Term Disability Benefits Plan" effective as of January 1, 2007 (the "**Plan**").

The establishment of the Plan does not affect the rights and duties of any person or entity under the Prior Plans and their operative contracts pursuant to which benefits were provided. All benefits which were paid (or reimbursed) to or on behalf of a Participant under the Prior Plans will be included and counted, without a gap or lapse in coverage, towards any applicable Plan maximums and other benefit limits in the Welfare Program(s) hereunder as of and subsequent to January 1, 2007.

The Plan is an "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**"). The Plan provides benefits to Participants in accordance with the terms, conditions and limitations of the Plan. Rules pertaining to eligibility, coverage, exclusions and limitations on coverage, and other rules pertaining to the benefits available under the Plan are set forth in the Welfare Program Documents, which are incorporated into this Summary Plan Description of the Plan (the "**SPD**") in their entirety by reference and attached hereto as Appendix C.

Please review this SPD carefully, including the Welfare Program Documents, paying particular attention to the provisions in this SPD and the Welfare Program Documents concerning exclusions and limitations on coverage.

The masculine gender of words used in this document include the feminine gender, and words used in the singular include the plural, and vice-versa, when applicable. Terms with initial capital letters used in this SPD are defined in Article I.

FOREWORD

The benefits provided under the Plan are for the exclusive benefit of the eligible Employees (and their eligible Dependents) of the Plan Sponsor and the other adopting Employers of the Plan. These benefits are intended to be continued indefinitely, however, the Plan Sponsor reserves the unilateral right to make any changes, without advance notice, to the Plan which it deems to be necessary or appropriate, in its discretion, to comply with applicable law, regulation or other authority issued by a governmental entity. The Plan Sponsor also reserves the unilateral right to amend, modify, or terminate, without advance notice, all or any part of the Plan and to make any other changes that it deems necessary or appropriate in its discretion. Changes in the Plan may occur in any or all parts of the Plan, including benefit coverage, exclusions, limitations, definitions, eligibility and the like, under any or all of the Welfare Programs identified in Appendix B. You should not, therefore, assume that the benefits which are provided under the Plan will continue to be available and remain unchanged, and you should disregard any information or communication (written or oral) that would seem to limit the Plan Sponsor's absolute right and discretion to terminate, suspend, discontinue or amend such benefits. Furthermore, the Plan Administrator and the Claims Fiduciary each reserve the right to interpret, construe, construct and administer the terms and provisions of the Plan in their discretion. Decisions made by the Claims Fiduciary regarding benefits will be final and binding on all interested persons subject only to the claims appeal procedures of the Plan.

ARTICLE I
DEFINITIONS

The following terms, where capitalized, shall have the meanings set forth below when used in this SPD and thus supersede any other meanings for the same terms set forth in the Welfare Programs, unless a different meaning is plainly required by the context:

1.1 Affiliate means 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 (multiple employer welfare associations).

1.2 Beneficiary means a Beneficiary under the Plan as defined under the terms of the respective Welfare Program.

1.3 Board of Directors means the Board of Directors of the Plan Sponsor.

1.4 CEO means the then current Chief Executive Officer of the Plan Sponsor.

1.5 Claims Administrator means the insurance company or other entity, as set forth in Appendix D, designated by the Plan Administrator to determine eligibility for benefits, process claims and perform other administrative duties under the Plan or a Welfare Program.

1.6 Claims Fiduciary means the person or entity that serves as the named claims fiduciary with respect to reviewing and making final decisions regarding claims under a Welfare Program.

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

1.8 Dependent means a covered Dependent under the Plan as defined under the terms of the respective Welfare Program.

1.9 Effective Date means the effective date of the Plan, *i.e.*, January 1, 2007.

1.10 Employee means, unless otherwise specified in a Welfare Program, any individual who is considered to be in an employer-employee relationship with the Employer on the payroll records of the Employer for purposes of federal income tax withholding. Except as otherwise specified in a Welfare Program, the term "Employee" shall not include any person during any period that such person was classified on the Employer's records as other than an Employee. For example, "Employee" shall not include anyone classified on the Employer's records as an independent contractor, agent, leased employee, contract employee, temporary employee or similar classification, regardless of a determination by a governmental agency that any such person is or was a common law employee of an Employer. For purposes of this definition, (a) a "leased employee" means any person, regardless of whether or not he is a "leased employee" as defined in Section 414(n)(2) of the Code, whose services are supplied by an employment,

leasing, or temporary service agency and who is paid by or through an agency or third-party; and (b) an "independent contractor" means any person rendering service to the Employer and whom the Employer treats as an independent contractor by reporting payments for the person's services on Internal Revenue Service Form 1099, regardless of whether any agency (governmental or otherwise) or court concludes that the person is, or was, a common law employee of the Employer.

Furthermore, employees who are non-resident aliens and who receive no earned income (within the meaning of Code Section 911(d)(2)) from an Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)) shall not be considered Employees for purposes of the Plan.

1.11 Employer means 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 and, in such event, any such other adopting Employer of the Plan will be listed in Appendix A (attached hereto), as such Appendix may be revised from time to time by the Plan Sponsor without the need for a formal amendment to the Plan.

1.12 ERISA means the Employee Retirement Income Security Act of 1974, as amended.

1.13 Former Employee means any person formerly employed as an Employee of the Employer.

1.14 Participant means an Employee or Former Employee of the Employer who meets the requirements for eligibility as set forth in Article III and who properly enrolls for coverage under the Plan. The term "Participant" also includes any Dependent of a person specified in the previous sentence who is properly enrolled for coverage under the Plan. A person shall cease to be a Participant when he no longer meets the requirements for eligibility as set forth in applicable provisions of the Plan.

1.15 Participant Contribution means the pre-tax or after-tax contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term "Participant Contribution" thus includes, but is not limited to, contributions used to purchase coverage under insurance contracts or policies.

1.16 Payee means a Beneficiary, assignee, or other person or entity, including the Participant's estate, who is entitled to a benefit under the Plan pursuant to the terms of a Welfare Program.

1.17 Plan means the "Consolidated Communications, Inc. Illinois Bargaining Life, Accident and Long Term Disability Benefits Plan", which consists of the Plan document (including any appendices attached thereto), this SPD (including any appendices attached hereto), and each Welfare Program incorporated hereunder by reference, as amended from time to time.

1.18 Plan Administrator means 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 Administrator or

the Claims Fiduciary, under the terms of either the Plan or any Welfare Program, or by means of a separate written agreement. The Plan Administrator will be Consolidated Communications, Inc.

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

1.20 Plan Year means each twelve (12) month calendar year commencing January 1st and ending on December 31st.

1.21 SPD means this Summary Plan Description, including any appendices attached hereto, and each Welfare Program Document incorporated hereunder by reference, as amended from time to time, and incorporated into the Plan by reference.

1.22 Spouse a person of the opposite sex to whom an Employee is lawfully married, which marriage was solemnized, authenticated and recorded as required by the state in which the marriage took place, to the extent such state law requirements are consistent with the federal Defense of Marriage Act, P.L. 104-199, but shall not include an individual separated from the Employee under a legal separation or divorce decree. The term "Spouse" shall also include a common law spouse if the Employee resides in a state which recognizes common law marriages and meets the requirements for common law marriage in that state. The Employee must provide proof of a common law marriage as reasonably required by the Plan Administrator such as, for example, an affidavit of common law marriage issued by the applicable state.

1.23 Welfare Program means a program of benefits that is offered by the Plan Sponsor (and/or another Employer) under the Plan to provide certain employee welfare benefits coverage to eligible individuals which would be an "employee welfare benefit plan" under Section 3(1) of ERISA if offered separately. The Welfare Programs are incorporated into this SPD, which is, in turn, incorporated into the Plan. Each Welfare Program under the Plan is identified in Appendix B of this SPD.

1.24 Welfare Program Document means a written arrangement, including (a) a benefits booklet or summary plan description, including any amendments, riders or attachments thereto, or (b) a certificate of insurance, schedule of benefits, notice or other instrument, or (c) a group insurance policy issued by the insurance carrier to the Plan Sponsor (or other Employer), including any amendments, endorsements or riders thereto, under which a Welfare Program is established and operated. Each of the documents referenced in items (a), (b) and (c) (above) is attached to the SPD as part of Appendix C. A Welfare Program Document (or any portion thereof) shall not, in and of itself, constitute either the written "Plan document" or the "summary plan description" of the Plan, as required by ERISA, notwithstanding any references in any Welfare Program Document to the contrary.

ARTICLE II
INTERPRETATION

Notwithstanding any reference in a Welfare Program Document that such Welfare Program Document, in and of itself (or any portion thereof), constitutes a "summary plan description", the SPD, as required by ERISA, consists of this document and the Welfare Program

Documents for the Welfare Programs as identified in Appendix B. If a term or provision of the SPD directly conflicts with a term or provision of a Welfare Program Document, the term or provision of the Welfare Program Document shall control unless specifically stated otherwise herein. Further, if a term or provision of the SPD directly conflicts with any term or provision of the Plan document, then the term or provision of the SPD shall control.

Notwithstanding the foregoing, if there is a conflict between a term or provision of the Plan document, a Welfare Program Document or the SPD, and such conflict involves a term or provision required by ERISA, the Code or other controlling law, on the one hand, and a term or provision not so required on the other, the term or provision required by controlling law shall control. This determination shall be made by the Plan Administrator. The terms and provisions of this SPD shall not enlarge the rights of a Participant or Beneficiary to any benefits available under a Welfare Program.

ARTICLE III
ELIGIBILITY AND PARTICIPATION

3.1 Eligibility.

An Employee or Former Employee shall be eligible to participate in the Plan only if and to the extent such person is eligible with respect to the particular benefit in question under a Welfare Program specified in Appendix B. A Welfare Program also (a) designates the Dependents or Beneficiaries of an Employee or Former Employee who are eligible to receive benefits under the Plan and (b) sets forth the criteria for coverage thereunder.

The Plan excludes all Employees except Employees who are both (i) employed by the Employer at an Illinois location and (ii) subject to a collective bargaining agreement between the Employer and one or more of the unions that are specified in Appendix E.

3.2 Enrollment.

The Plan Administrator may establish procedures in accordance with the Welfare Programs for the enrollment of Employees and Former Employees (and/or their Dependents) under the Plan. The Plan Administrator shall provide enrollment forms that must be completed by the prescribed deadline prior to commencement of coverage under the Plan.

3.3 Termination of Participation.

A Participant will cease being a Participant in the Plan and coverage under the Plan for the Participant and his or her Dependents and Beneficiaries shall terminate in accordance with the provisions of the specific Welfare Program.

3.4 Leave of Absence Under the Family and Medical Leave Act.

An Employee Participant shall be entitled to benefits under the Plan during a period of leave pursuant to the federal Family and Medical Leave Act of 1993, as amended ("**FMLA**"), at a minimum, to the same extent that similarly-situated Employees on other forms of leave (paid or

unpaid, as appropriate) are entitled to benefits under the Plan during such other forms of leave, as determined by the Employer's established leave of absence policy.

At the end of an Employee's FMLA leave, benefits under the Plan shall be resumed in the same manner and at the same levels as provided to the Employee when the leave began, and subject to any changes in benefit levels that may have taken place during the period of FMLA leave affecting all Participants, unless otherwise elected by the Employee. Upon return from FMLA leave, an Employee shall not be required to re-qualify for any Plan benefits the Employee was entitled to receive as a Participant before his FMLA leave began.

3.5 Leave of Absence Under the Uniformed Services Employment and Reemployment Rights Act.

The Plan shall comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("**USERRA**") with regard to continuation rights during an approved military leave of absence and reenrollment rights on return from such military leave of absence.

During a period of duty in the Uniformed Services (as defined in USERRA), the Employee shall be deemed to be "on furlough" or "leave of absence" from the Employer. The Employee shall be entitled to benefits under the Plan in accordance with the Employer's administrative policies and procedures regarding leaves of absence for military service under USERRA, but at a minimum, to the same extent as similarly-situated Employees who are on non-USERRA leave of absence from the Employer. If Plan benefits to which Employees on non-USERRA leave of absence are entitled vary according to the type of leave, the Employee on leave under USERRA must be given at least the most favorable benefits under the Plan accorded to any comparable form of leave.

ARTICLE IV
FUNDING

Notwithstanding anything to the contrary contained herein, participation in the Plan by a Participant and the payment of Plan benefits attributable to Employer contributions shall be conditioned on such Participant Contributions towards the cost of coverage under the Plan at such time and in such amounts as the Plan Administrator shall establish from time to time, in accordance with the terms of the Welfare Programs. The Plan Administrator may require that any Participant Contributions be made by payroll deduction. Nothing herein requires an Employer or the Plan Administrator to contribute to or under the Plan, or to maintain any fund or segregate any amount for the benefit of any Participant or Payee, except to the extent specifically required under the terms of a Welfare Program. No Participant, Employee or Payee shall have any right to, or interest in, the assets of any Employer or the Plan until actually paid.

Benefits or premiums for the Plan shall be funded through insurance contracts in accordance with the terms of the relevant Welfare Program. To the extent that the Plan is funded through an Employer's purchase of insurance, payment of any benefits under such Welfare Program shall be the sole responsibility of the insurer, and the Employer shall have no responsibility for such payment.

ARTICLE V
BENEFITS

The actual terms and conditions of eligibility, coverage, exclusions and limitations on coverage, and the additional rules pertaining to the benefits of Participants under the Plan, are set forth in the Welfare Program Documents, as they may be amended from time to time. The Welfare Program Documents, as then currently in effect, are incorporated in their entirety by reference into this SPD which, in turn, is incorporated by reference into the Plan.

Notwithstanding anything to the contrary contained herein, benefits will be paid solely in the form and amount specified in the relevant Welfare Program and pursuant to the terms and conditions of such Welfare Program, except as otherwise required by ERISA, the Code or other applicable law, regulation, or other authority issued by a governmental entity.

ARTICLE VI
CLAIMS PROCEDURES

6.1 General.

(a) Except as provided in subsection (b) (below), a claim for benefits under a Welfare Program shall be submitted in accordance with, and to the party designated under, the terms of such Welfare Program. Notwithstanding the foregoing, unless a Welfare Program specifically provides otherwise, a claim for benefits must be submitted not later than twelve (12) months after the date that the claim is incurred. In the event that a claim, as originally submitted, is not complete, the Claimant shall be notified and the Claimant shall then have the responsibility for providing the missing information within the timeframe stated in such notification.

(b) To the extent that a Welfare Program does not prescribe a claims procedure for Disability Claims or Non-Health Claims that satisfies the requirements of Section 503 of ERISA and the regulations promulgated thereunder, as determined by the Plan Administrator, the claims procedures set out below in Sections 6.2 through 6.8 shall apply to a Disability Claim or a Non-Health Claim, as such terms are defined in Section 6.2, below.

(c) The claims procedures applicable to claims made for benefits under the Plan do not include casual or general inquiries regarding eligibility or particular Welfare Program benefits that may be provided under the Plan. In order for an "inquiry" to constitute a claim for benefits or an appeal of an Adverse Benefit Determination, a Participant must follow the claim procedures under the applicable Welfare Program, or, if such procedures are not contained in such Welfare Program, then according to the claims procedures set forth in this Article VI.

6.2 Definitions.

(a) *Adverse Benefit Determination* means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit under the Plan, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan.

(b) *Adverse Benefit Determination on Review* means the upholding or affirmation of an appealed Adverse Benefit Determination.

(c) *Benefit Determination* means a determination by the Claims Fiduciary on a claim for benefits under the Plan, whether or not an Adverse Benefit Determination.

(d) *Benefit Determination on Review* means a determination by the Claims Fiduciary on an appeal of an Adverse Benefit Determination, whether or not an Adverse Benefit Determination on Review.

(e) C*laimant* means a Participant or Payee under the Plan, or his authorized representative, who is designated by the Participant or Payee to act on his behalf.

(f) *Disability Claim* means a claim for benefits under a Welfare Program that is conditioned upon a showing of "disability" by the Claimant.

(g) *Health Care Professional* means a physician or other health care service provider who is licensed, accredited, or certified to perform the specified health services consistent with state law.

(h) *Non-Health Claim* means a claim other than (i) a Disability Claim or (ii) a claim for medical care benefits under a Welfare Program.

6.3 Initial Claim Procedure and Time Limits.

(a) *Initial Claim Process*.

A claim and all required documentation shall be filed in writing with the applicable Claims Fiduciary and decided within the applicable timeframe under federal law, regardless of whether all information required to perfect the claim is included. The timeframe for decision begins upon receipt by the Claims Fiduciary of a claim filed by the Claimant in accordance with the Plan's claims procedures, and is contingent upon the type of claim that is submitted, whether the claim submitted is a complete claim or incomplete claim, whether additional information is required and whether an extension is required to make a decision on the claim.

(b) *Non-Health Claims*.

(i) If a Non-Health Claim is submitted, the Claims Fiduciary will render a Benefit Determination and provide notice to the Claimant of any denial, in whole or in part, of such Non-Health Claim within a reasonable period of time, but not later than ninety (90) days after receipt of the Non-Health Claim, unless the Claims Fiduciary determines that special circumstances require an extension of time for processing the Non-Health Claim. If the Claims Fiduciary determines that an extension of time for processing is required, written notice of the extension will be furnished to the Claimant prior to the termination of the initial ninety (90) day period. In no event shall such extension exceed a period of ninety (90) days from the end of such initial period. The extension notice will indicate the special

circumstances requiring an extension of time and the date by which the Plan expects to render the Benefit Determination.

(ii) Notification of any Adverse Benefit Determination with respect to a Non-Health Claim shall be made in accordance with Section 6.4 (below).

(c) *Disability Claims.*

(i) If a Disability Claim is submitted, the Claims Fiduciary will render a Benefit Determination and provide notice to the Claimant of any such Adverse Benefit Determination within a reasonable period of time, but not later than forty-five (45) days after receipt of the Disability Claim (the "**Initial Period**"). The Initial Period may be extended by the Plan for up to thirty (30) days (the "**First Extension**"), provided that the Claims Fiduciary both (A) determines that such an extension is necessary due to matters beyond the control of the Plan, and (B) notifies the Claimant, prior to the expiration of the Initial Period, of the circumstances requiring the First Extension and the date by which the Plan expects to render a decision.

(ii) If, prior to the end of the First Extension, the Claims Fiduciary determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within the First Extension, the period for making the determination may be extended for up to an additional thirty (30) days (the "**Second Extension**"), provided that the Claims Fiduciary notifies the Claimant, prior to the expiration of the First Extension, of the circumstances requiring the Second Extension and the date as of which the Plan expects to render a decision.

(iii) In the case of any extension under this subsection (c), the notice of extension shall specifically explain (A) the standards on which entitlement to a benefit is based, (B) the unresolved issues that prevent a decision on the claim, and (C) the additional information needed to resolve those issues, and the Claimant shall be afforded at least forty-five (45) days within which to provide the specified information.

(iv) Notification of any Adverse Benefit Determination with respect to a Disability Claim shall be made in accordance with Section 6.4 (below).

6.4 Notification of Benefit Determination.

The Claims Fiduciary shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth in a manner calculated to be understood by the Claimant:

(a) the specific reason or reasons for the Adverse Benefit Determination;

(b) reference to the specific Plan provisions upon which the determination is based;

(c) a description of additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) a description of the Plan's appeal procedures and time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on Review (or, with respect to a Disability Claim under a Welfare Program that requires two levels of appeal, following an Adverse Benefit Determination on Review with respect to the second appeal); and

(e) in the case of an Adverse Benefit Determination under a Welfare Program regarding a Disability Claim, if the Adverse Benefit Determination is based upon:

(i) an internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or

(ii) a medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

6.5 Appeal Procedures.

(a) *General Appeal Procedures.*

(i) Each Claimant shall have a reasonable opportunity to appeal an Adverse Benefit Determination to the Claims Fiduciary as set forth hereafter.

(ii) Each Claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the claim appealed.

(iii) Each Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits under the Plan. Whether a document, record, or other information is "relevant" to a claim for benefits under the Plan shall be determined by reference to Section 6.8 (below).

(iv) The appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial Benefit Determination.

(v) The Claimant shall have sixty (60) days (one-hundred eighty (180) days in the case of a Disability Claim) following receipt of notification of an Adverse Benefit Determination within which to appeal said Determination.

(b) *Disability Claims Appeal Procedures*.

The following appeal procedures, in addition to those set forth in subsection (a) (above), shall apply to Disability Claims:

(i) The appeal shall not afford deference to the initial Adverse Benefit Determination and shall be conducted by a decision maker who is neither the individual who made the Adverse Benefit Determination that is on appeal, nor the subordinate of such decision maker.

(ii) In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, the decision maker shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involving the medical judgment.

(iii) All medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination on appeal shall be identified without regard to whether the advice was relied upon in making the Adverse Benefit Determination.

(iv) All Health Care Professionals engaged for purposes of consultation under Section 6.5(b)(ii) (above) shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is on appeal, nor the subordinate of such individual.

(v) A Claimant shall not be required to file more than two appeals of an Adverse Benefit Determination prior to bringing a civil action under Section 502(a) of ERISA. To the extent that the claims procedures set forth in any Welfare Program provide for more than two levels of appeal of an Adverse Benefit Determination, any level of appeal beyond the second level of appeal shall be "voluntary".

(vi) To the extent that any Welfare Program offers a voluntary level of appeal ("**Voluntary Appeal**") (except to the extent the Plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, and notwithstanding anything in such Welfare Program to the contrary:

(A) The Plan waives any right to assert that a Claimant has failed to exhaust administrative remedies because the Claimant did not elect to submit a benefit dispute to a Voluntary Appeal;

(B) Any statute of limitations or other defense based on timeliness is tolled during the time that a Voluntary Appeal is pending;

(C) A Claimant may elect to submit a benefit dispute to a Voluntary Appeal only after exhaustion of the appeals permitted by the Welfare Program under which the benefit dispute arose, subject to Section 6.5(b)(v);

(D) A Claimant will be provided, upon request, sufficient information relating to the Voluntary Appeal to enable the Claimant to make an informed judgment about whether to submit a benefit dispute to Voluntary Appeal, including a statement that the decision of a Claimant as to whether or not to submit a benefit dispute to Voluntary Appeal will have no effect on the Claimant's rights to any other benefits under the Plan, and information about the applicable rules, the Claimant's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(E) No fees or costs will be imposed on the Claimant as part of the Voluntary Appeal.

(vii) Notwithstanding anything in a Welfare Program to the contrary, a Claimant shall not be subject to mandatory arbitration of an Adverse Benefit Determination, except to the extent that:

(A) The arbitration is counted as one of the two appeals described in Section 6.5(b)(v) and is conducted in accordance with the requirements applicable to such appeals; and

(B) The Claimant is not precluded from challenging the decision resulting from such arbitration under section 502(a) of ERISA or other applicable law.

6.6 Benefit Determination on Review.

(a) *Timing of Notification.*

(i) *Disability Claims*. In the case of a Disability Claim, the Claims Fiduciary shall notify the Claimant in accordance with Section 6.6(b) (below) of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than forty-five (45) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the Claims Fiduciary determines that special circumstances require an extension of time for processing the claim. If the Claims Fiduciary determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial forty-five (45) day period. In no event shall such extension exceed a period of forty-five (45) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

(ii) *Non-Health Claims*. In the case of a Non-Health Claim, the Claims Fiduciary shall notify the Claimant in accordance with Section 6.6(b) (below) of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than sixty (60) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the Claims Fiduciary determines that special circumstances require an extension of time for processing the claim. If the Claims Fiduciary determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial sixty (60) day period. In no event shall such extension exceed a period of sixty (60) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

(iii) In the case of an Adverse Benefit Determination on Review, the Claims Fiduciary shall provide access to, and copies of, documents, records, and other information described in Sections 6.6(b)(iii) through (vi) (below), as appropriate.

(b) *Manner and Content of Notification of Benefit Determination on Review*.

The Claims Fiduciary shall provide a Claimant with written or electronic notification of the Plan's Benefit Determination on Review. In the case of an Adverse Benefit Determination on Review, the notification shall set forth in a manner calculated to be understood by the Claimant:

(i) The specific reason or reasons for the Adverse Benefit Determination on Review;

(ii) Reference to the specific Plan provisions upon which the Adverse Benefit Determination on Review is based;

(iii) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits under the Plan. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to Section 6.8 (below);

(iv) A statement describing any Voluntary Appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures described in Section 6.5(b)(vi)(D) (above);

(v) A statement of the Claimant's right to bring an action under Section 502(a) of ERISA (or, with respect to a Disability Claim under a Welfare Program that requires two levels of appeal, the Claimant's right to bring an action under Section 502(a) of ERISA following an Adverse Benefit Determination on Review with respect to the second appeal); and

(vi) in the case of an Adverse Benefit Determination on Review under a Welfare Program regarding a Disability Claim:

(A) if the Adverse Benefit Determination on Review is based upon an internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination on Review and that a copy of the rule, guideline, protocol, or other similar criterion will be provided, free of charge, to the Claimant upon request;

(B) if the Adverse Benefit Determination on Review is based upon a medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided, free of charge, upon request; and

(C) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

6.7 Calculating Time Periods.

For the purposes of Sections 6.3 and 6.6(a) (above), the period of time within which a Benefit Determination or a Benefit Determination on Review is required to be made, shall begin at the time a claim or appeal, as the case may be, is filed in accordance with the procedures of the Plan, without regard to whether all information necessary to make a Benefit Determination or a Benefit Determination on Review, as the case may be, accompanies the filing. In the event that a period of time is extended as permitted under Section 6.3 or 6.6(a) due to a Claimant's failure to submit information necessary to decide a claim or the appeal, the period for making the Benefit Determination or the Benefit Determination on Review shall be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

6.8 Relevance to Claim.

For the purposes of Sections 6.5(a)(iii) and 6.6(b)(iii) (above), a document, record, or other information shall be considered "relevant" to a Claimant's claim if such document, record, or other information:

(a) was relied upon in making the Benefit Determination;

(b) was submitted, considered, or generated in the course of making the Benefit Determination, without regard to whether such document, record, or other information was relied upon in making the Benefit Determination;

(c) demonstrates compliance with any administrative processes and safeguards in making the Benefit Determination; or

(d) in the case of a Disability Claim, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the Benefit Determination.

6.9 Exhaustion of Administrative Remedies.

Notwithstanding anything to the contrary in a Welfare Program, 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 required by the applicable Welfare Program). If a Claimant fails to file a timely claim, or if the Claimant fails to request a review in accordance with the Plan's claim procedures, such Claimant shall have no right of review and shall have no right to bring any action in any court. The denial of the claim shall become final and binding on all persons for all purposes.

6.10 Action for Recovery.

Unless stated otherwise in a Welfare Program, and subject to Section 6.9, no action at law or in equity may be brought for recovery under the Plan sooner than sixty (60) days or later than one (1) year from the time written proof of a claim is required to be furnished. If the particular Welfare Program expressly states a limitations period for bringing an action thereunder, then the Welfare Program will control.

6.11 Participant's Responsibilities.

Each Participant shall be responsible for providing the Claims Fiduciary, the Plan Administrator and/or the Employer with the Participant's and each Beneficiary's current U.S. mailing address and electronic address, as specified in the Welfare Programs. Any notices required or permitted to be given hereunder shall be deemed given if directed to such address furnished by the Participant and mailed by regular United States mail or by electronic means as specified in Section 2520.104b-l(c) of ERISA. The Claims Fiduciary, Plan Administrator and the Employer shall not have any obligation or duty to locate a Participant or Beneficiary.

In the event that a Participant or Beneficiary becomes entitled to a payment under the Plan, the amount of such payment, if and when made, shall be determined under the provisions of the applicable Welfare Program.

ARTICLE VII
AMENDMENT OR TERMINATION

The provisions of this Article VII shall govern and control Plan amendment and termination under the Plan and shall supersede any conflicting or inconsistent provisions set forth in a Welfare Program Document.

7.1 Right to Amend.

The Board of Directors (or a committee of the Board of Directors) or the CEO, or an officer of the Plan Sponsor who is duly authorized by the Board of Directors (or such committee)

or the CEO for this purpose, shall each have the right, authority and power to make, at any time, and from time to time, any amendment to the Plan; provided, however, no amendment shall prejudice any claim under the Plan that was incurred but not paid prior to the amendment date, unless the person or entity as responsible above for the amendment, as applicable, determines such amendment is necessary to comply with applicable law or is required under the particular Welfare Program.

7.2 Right to Terminate.

The Board of Directors (or a committee of the Board of Directors) or the CEO shall each have the right, authority and power to terminate the Plan at any time, in whole or in part, without prior notice, to the extent deemed advisable in its or his discretion; provided, however, such termination shall not prejudice any claim under the Plan that was incurred but not paid prior to the termination date unless the Board of Directors (or such committee) or CEO, as applicable, determines it is necessary to comply with applicable law. An Employer, by action of its board of directors (or equivalent governing body) or chief executive officer, may terminate the Plan with respect to its Employees only, at any time with at least thirty (30) days prior notice to the Plan Administrator; provided, however, the Plan Administrator, in its discretion, may limit such termination to the end of a Plan Year.

ARTICLE VIII
ADMINISTRATION

8.1 Allocation of Authority.

The Plan Administrator shall control and manage the operation and administration of the Plan, except to the extent such duties have been delegated to other persons or entities as provided in this SPD. Any decisions made by the Claims Fiduciary (or any other person or entity delegated authority by the Claims Fiduciary to determine benefits in accordance with the applicable Welfare Program) shall be final and conclusive on all Participants, Payees and all other persons and entities, subject only to the claims appeal provisions of the Plan. Neither the Plan Administrator or any Employee shall receive any compensation with respect to services provided under the Plan, except as an Employee may be entitled to benefits hereunder.

8.2 Powers and Duties of Plan Administrator.

The Plan Administrator and the Claims Fiduciary shall have such duties and powers as may be necessary to discharge their duties under the Plan and the Welfare Programs.

All decisions, interpretations and other determinations by the Plan Administrator and the Claims Fiduciary, as applicable, under the Plan and the Welfare Programs shall be final and conclusive on all persons and entities subject only to the claims appeal provisions of the Plan, and there shall be no de novo review of any such determination by any court. Any review of such determination shall be limited to determining whether the determination was so arbitrary and capricious as to be an abuse of discretion under ERISA standards. Benefits under the Plan will be paid only if the Claims Fiduciary decides in its discretion that the Participant is entitled to them.

The Plan Administrator shall have the authority and power to appoint persons or entities to assist in the administration of the Plan as it deems advisable, and the Plan Administrator may delegate thereto any power or duty imposed upon or granted to it under the Plan. Neither the Plan Administrator nor the Employer makes any guarantee to any Employee in any manner for any loss because of the Employee's participation in the Plan.

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

8.3 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 Administrator and the Claims Fiduciary. 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 shall be fully protected in respect to any action taken or permitted in good faith in reliance on such information.

8.4 Rules and Decisions.

The Plan Administrator may adopt such rules and procedures, as it deems necessary or appropriate for the proper administration of the Plan. The Plan Administrator shall be entitled to rely upon information furnished to it which appears proper without the necessity of any independent verification or investigation.

8.5 Applicable Laws.

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

ARTICLE IX
IMPORTANT ERISA INFORMATION

Name of Plan: Consolidated Communications, Inc. Illinois Bargaining Life, Accident and Long Term Disability Benefits Plan.

Plan Sponsor: Consolidated Communications Holdings, Inc., 121 South 17th Street, Mattoon, Illinois 61938-3987.

Plan Administrator: Consolidated Communications, Inc., 121 South 17th Street, Mattoon, Illinois 61938-3987.

Plan Sponsor's and Plan Administrator's Telephone Number: (217) 258-9507.

Employer Identification Number: 02-0636095.

Plan Number: 515.

Type of Plan: The Plan is a fully-insured "employee welfare benefit plan" subject to ERISA which provides (1) basic and voluntary employee life insurance benefits, (2) voluntary spouse and dependent child life insurance benefits, (3) basic employee accidental death and dismemberment ("**AD&D**") insurance benefits, and (4) basic long-term disability ("**LTD**") insurance benefits, through insurance contracts purchased by the Plan Sponsor.

Type of Administration: The Plan is administered by the Plan Administrator, with benefits being provided in accordance with the terms, limits and conditions of the Plan. The Plan Administrator has engaged the Claims Administrator, as set forth in Appendix D, to determine eligibility for benefits, process claims and perform other administrative duties under the Plan.

Agent for Service of Legal Process: The Plan Administrator at the address listed above.

Plan Year: The Plan and its records are kept on a Plan Year basis. The Plan Year is the 12-month calendar year beginning each January 1st and ending on December 31st.

Sources of Contributions: The adopting Employers pay the costs for basic employee life insurance benefits coverage, basic employee AD&D insurance benefits coverage, and basic LTD insurance benefits coverage. The Participants pay the costs for voluntary employee life insurance benefits coverage and voluntary spouse/dependent child life insurance benefits coverage.

Collective Bargaining Agreement: The Plan is maintained pursuant to the terms of one or more collective bargaining agreements. A copy of each such agreement, and a complete list of the Employers and union bargaining units covered under the Plan, may be obtained by Participants (and their Beneficiaries in the event of death) upon written request to the Plan Administrator. They are available for examination by Participants and Beneficiaries at (i) the principal office of each union bargaining unit that is a party to a covered collective bargaining agreement and (ii) each worksite of the Employer in which at least 50 Participants covered by the Plan are customarily employed. The Plan Administrator may impose a reasonable charge to cover the cost of furnishing any such collective bargaining agreement or list.

ARTICLE X
STATEMENT OF ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are 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 Plan documents including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents including insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description, upon written request to the Plan Administrator. The Plan Administrator may make 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.

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 the 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 the Employer, or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If a claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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 which 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 Claims 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. 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 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 who was sued to pay these costs and fees. If you are not successful, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator at (217) 258-9507.

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 the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SPD OF THE
CONSOLIDATED COMMUNICATIONS, INC.
ILLINOIS BARGAINING
LIFE, ACCIDENT AND LONG TERM DISABILITY BENEFITS PLAN

APPENDIX A

As of January 1, 2007, other than as specified in the definition of "Employer" in the Plan, there are no additional adopting Employers of the Plan.

SPD OF THE
CONSOLIDATED COMMUNICATIONS, INC.
ILLINOIS BARGAINING
LIFE, ACCIDENT AND LONG TERM DISABILITY BENEFITS PLAN

APPENDIX B

The following Welfare Programs are incorporated, in their entirety, by reference into this SPD:

1. Consolidated Communications, Inc. Group Life Insurance for Illinois Bargaining Active Employees;

2. Consolidated Communications, Inc. Group Life Insurance for Illinois Bargaining Retired Employees;

3. Consolidated Communications, Inc. Group Life Insurance for Illinois Bargaining Part-Time Employees (closed class);

4. Consolidated Communications, Inc. Group AD&D Insurance for Illinois Bargaining Active Employees;

5. Consolidated Communications, Inc. Group AD&D Insurance for Illinois Bargaining Part-Time Employees (closed class); and

6. Consolidated Communications, Inc. Long Term Disability Insurance for Illinois Bargaining Active Employees.

SPD OF THE
CONSOLIDATED COMMUNICATIONS, INC.
ILLINOIS BARGAINING
LIFE, ACCIDENT AND LONG TERM DISABILITY BENEFITS PLAN

APPENDIX C

The Welfare Program Documents are attached hereto and incorporated, in their entirety, into this SPD by reference.

SPD OF THE
CONSOLIDATED COMMUNICATIONS, INC.
ILLINOIS BARGAINING
LIFE, ACCIDENT AND LONG TERM DISABILITY BENEFITS PLAN

APPENDIX D

The following third party entity serves as Claims Administrator under the Plan with respect to the following Welfare Programs:

Welfare Program	Claims Administrator
1. Consolidated Communications, Inc. Group Life Insurance for Illinois Bargaining Active Employees; 2. Consolidated Communications, Inc. Group Life Insurance for Illinois Bargaining Retired Employees; 3. Consolidated Communications, Inc. Group Life Insurance for Illinois Bargaining Part-Time Employees (closed class); 4. Consolidated Communications, Inc. Group AD&D Insurance for Illinois Bargaining Active Employees; 5. Consolidated Communications, Inc. Group AD&D Insurance for Illinois Bargaining Part-Time Employees (closed class); and 6. Consolidated Communications, Inc. Long Term Disability Insurance for Illinois Bargaining Active Employees.	Life Insurance Company of North America / CIGNA Group Insurance 1601 Chestnut Street Philadelphia, PA 19192-2235 Telephone: (800) 732-1603

SPD OF THE
CONSOLIDATED COMMUNICATIONS, INC.
ILLINOIS BARGAINING
LIFE, ACCIDENT AND LONG TERM DISABILITY BENEFITS PLAN

APPENDIX E

As of January 1, 2007, the Plan covers Employees who are both (i) employed by the Employer at an Illinois location and (ii) subject to a collective bargaining agreement between the Employer and the following union:

Local Union No. 702, International Brotherhood of Electrical Workers (AFL – CIO)