Medical Reimbursement Plan

Summary Plan Description

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MEDICAL REIMBURSEMENT PLAN AT A GLANCE

BENEFIT	You may use pretax dollars to pay for certain health care expenses, thereby reducing your taxable income and saving you money.
ELIGIBILITY	All non-bargaining and bargaining employees of Windstream and its subsidiaries are eligible to participate if they are regularly scheduled to work at least 30 hours per week. Temporary, seasonal, leased, or independently contracted employees are not eligible.
ENROLLMENT	Enrollment is voluntary; however, you must elect to enroll during your first 31 days of employment (hire date + 30 days), during the Annual Benefit Enrollment Period, or after a Qualified Change of Status. You must reenroll annually to establish your contributions for the following year. If you enroll during the first 31 days of employment (hire date + 30 calendar days), your coverage will be effective the first of the month following 56 days of employment.
CONTRIBUTIONS	You decide how much you wish to contribute to the Medical Reimbursement Plan up to the plan contribution limit. The maximum plan contribution limit for the medical reimbursement plan is $2,600 annually.
LIMITATIONS	All eligible expenses must be incurred by December 31 of the plan year. Any funds not claimed by March 31 following the plan year in excess of the allowable $500 rollover amount will be forfeited.
TERMINATION	Coverage terminates on the date you leave employment. You may voluntarily withdraw from the Medical Reimbursement Plan during the Annual Benefit Enrollment Period or after a qualified change in status.

This Summary Plan Description is for informational purposes and is not legally binding. This Summary Plan Description does not contain all of the technical details and legal expressions contained in the formal Plan documents. Any discrepancies between this Summary Plan Description and the formal Plan documents will be resolved in favor of the formal Plan documents. The Plan Administrator shall have the sole discretionary power and authority to construe the provisions of the Plan and to make factual determinations in deciding whether an applicant is entitled to benefits under the Plan. In the event of any misstatement of any fact(s) affecting coverage under the Plan, the Plan shall be used to determine the proper coverage. Coverage means eligibility as well as the amount of any Benefit thereunder.

MEDICAL REIMBURSEMENT PLAN SUMMARY PLAN DESCRIPTION

This Summary Plan Description has been prepared specifically for all non-bargaining and bargaining employees of Windstream and its subsidiaries who are regularly scheduled to work at least 30 hours per week. Temporary, seasonal, leased, or independently contracted employees are not eligible.

Any other employees who do not meet the above criteria are not eligible to participate in the Medical Reimbursement Plan.

The Medical Reimbursement Plan reimburses you for certain medical expenses on a tax-free basis. The maximum plan contribution limit for the Medical Reimbursement Plan is $2,600. When you enroll, you decide how much you want to contribute to the Medical Reimbursement Plan annually, up to the $2,600 limit, by estimating how much you will need to pay for eligible medical and dental expenses during the year. The Company then deducts your contributions in equal amounts from your biweekly (or weekly for IBEW 2374 and 1189) paycheck before withholding federal income, Social Security, and, in most cases, state and local taxes.

When you incur eligible expenses not covered by your health care plan, you use your Flexible Spending Account (FSA) debit card or submit a request for reimbursement from the Medical Reimbursement Plan. In effect, the Medical Reimbursement Plan increases your spendable income and allows you to pay for eligible medical expenses with tax-free dollars.

All expenses must be incurred on or before December 31 of the plan year. Expenses must be submitted for reimbursement before March 31 following the plan year. For example, 2017 expenses must be submitted by March 31, 2018. Unclaimed funds in your account on March 31 in excess of the allowable $500 carryover must be forfeited. They cannot be carried over to the next Plan year, paid out in cash, or rolled over.

CONTACT INFORMATION

If you have questions regarding the eligibility/ineligibility of a specific charge, please contact the Windstream Benefits Center. Upon request, written verification of eligibility/ineligibility for reimbursement will be provided at no cost.

If you need assistance in understanding a provision of the Medical Reimbursement Plan, please contact the Windstream Benefits Center:

Telephone **844-689-7832**

ELIGIBILITY

All non-bargaining and bargaining employees of Windstream and its subsidiaries are eligible to participate in the Medical Reimbursement Plan if they are regularly scheduled to work at least 30 hours per week. Temporary, seasonal, leased, or independently contracted employees are not eligible.

ENROLLMENT, CHANGE, AND TERMINATION

You may enroll in the Medical Reimbursement Plan, change contributions, or terminate participation, only at certain times due to IRS regulations as follows.

- **During Your First 31 Days of Employment**

  If you are a new employee, you may enroll in the Medical Reimbursement Plan during your first 31 days of employment (calculated as hire date + 30 calendar days). Your coverage will be effective on the first day of the month following 56 days of employment.

- **During the Annual Benefit Enrollment Period**

  If you didn't enroll in the Medical Reimbursement Plan during your first 31 days of employment, you have the option to enroll during the Annual Benefit Enrollment Period.

  If you enroll during the Annual Benefit Enrollment Period, your contributions will become effective January 1 of the following year.

  All employees who participate in this Plan must reenroll every year during the Annual Benefit Enrollment Period, usually held in November. If you don't enroll during the Annual Benefit Enrollment Period, you may not elect to participate again until the next Annual Benefit Enrollment Period unless you incur a qualified change in status.

- **After a Qualified Change in Status**

  You may enroll in the Medical Reimbursement Plan or change your contribution amount without waiting until the next Annual Benefit Enrollment Period under the following circumstances, subject to consistency requirements:

  - you have a change in marital status (*i.e.*, you get married, you get divorced, you become legally separated from your spouse, your marriage is annulled, or your spouse dies);
  - there is a change in the number of your dependents (*i.e.*, a child is born or dies, or is adopted by or placed for adoption with you);
  - you or your spouse have a change in employment that affects eligibility for the Medical Reimbursement Plan (for example, your spouse terminates employment and loses other group health plan coverage, you commence or return from an

unpaid leave of absence, or you begin working 30+ hours per week and gain eligibility for the Plan, etc.)

- change in the place of residence for you, your spouse, or your dependent provided that the change in the place of residence affects your, your spouse, or your dependent's coverage under the Plan;

- you or your spouse or dependent are able to enroll, terminate participation in, or change elections under another employer's medical flexible spending account; or, the period of coverage under this Plan is different from the period of coverage under your spouse or dependent's employer's medical flexible spending account plan (for instance, their Plan Year runs July 1 to June 30, instead of the Windstream Plan Year of January 1 to December 31);

In all cases, you must enroll within 31 days after the qualified change in status occurred. The enrollment or change must be consistent with the qualified change in status.

You must request your change by entering it online at **www.windstreambenefits.com** and return certain event and/or dependent documentation before your changes are approved. Once your event is received by the Windstream Benefits Center, your paycheck deductions will change on a go-forward basis as soon as administratively possible and will remain in effect until the end of the plan year. Refunds and retroactive adjustments are not provided, so promptly submitting your request and supporting documentation is important.

If you request to cancel or reduce your Medical Reimbursement Plan as provided herein, a refund may be requested for Medical Reimbursement Plan contributions taken after the effective date of your change. However, you cannot reduce your Medical Reimbursement Plan annual election to an amount less than what you have already contributed year to date (based on your effective date of change), or less than what you have already been reimbursed year to date (based on your effective date of change).

The effective date of any change is generally the Event Date (for instance, date of birth for childbirth event). However, some events are effective on the first of the month following the Event Date, including Death of a Dependent, Divorce, and Spouse Gain of Coverage. When you enter your changes online, you'll be able to review a Confirmation Statement reflecting the Effective Date of your change.

Only claims incurred on or after the effective date of the change, as reflected on your Confirmation Statement, are eligible for reimbursement from an increased contribution amount.

ELIGIBLE EXPENSES

The IRS has established guidance on medical, dental and vision care expenses that are eligible for reimbursement under this plan. The following partial lists provide general guidelines as to which expenses are eligible for reimbursement. You are encouraged to contact the Windstream Benefits Center at 844-689-7832 for more specific information as needed. You may also contact the Windstream Benefits Center for predetermination of eligible expenses.

Expenses are only eligible for reimbursement if they are incurred by you, your spouse, your tax dependents, or persons who would be your tax dependents if they were unmarried or earning less income.

Eligible health care expenses include the following:

Medical Expenses

- deductibles and co-payments associated with health care plans
- routine physical exams
- routine lab tests and X-rays not covered by the medical plan
- prescriptions that are not cosmetic and are obtained from a pharmacy
- birth control pills and surgical devices
- childbirth classes as long as they are directly related to delivery of a child (The cost for caring for a newborn or breastfeeding classes are not reimbursable.)
- cardiac rehabilitation classes
- alcohol and/or drug dependency treatment center expenses not covered by the medical plan
- smoking cessation programs, if prescribed by a licensed physician, and prescription drugs that alleviate nicotine withdrawal
- charges for treatments of a mental health disorder that exceed the medical plan's limits
- co-payments for retail and mail order prescriptions
- charges for treatments that exceed the medical plan's annual or lifetime maximum
- charges over and above what is considered usual, customary, and reasonable under the medical plan
- charges for vitamins obtained by prescription
- charges for over-the-counter drugs obtained by prescription
- charges for over-the-counter medical related supplies (e.g. bandages, blood pressure kits, canes, walkers, wheelchairs, contact lens solution, diabetic supplies, thermometers)
- weight loss programs if you supply a letter from the attending physician stating that the medical condition the program is treating and/or alleviating results from a medical diagnosis and is deemed medically necessary (No foods are considered eligible expenses.)

Vision Expenses

- routine eye examinations
- prescription eyeglasses, including tinting
- contact lenses
- Laser/Lasik eye surgery

Hearing Expenses

- routine hearing examinations
- hearing aids/batteries and repair thereof
- repair of special telephone equipment for the hearing-impaired

Dental Expenses

- deductibles and co-payments
- orthodontic expenses beyond the costs covered by the dental plan
- dental facings and noncosmetic veneers on molar crowns and molar false teeth
- charges for treatments that exceed the dental plan's annual or lifetime maximum
- charges over and above what is considered usual and customary under the dental plan

INELIGIBLE EXPENSES

Ineligible expenses include, but are not limited to, the following:

- any expense covered under another medical or dental plan or that could be filed under a medical or dental plan
- any expense incurred prior to the effective date of Plan participation or the effective date of a qualified change in status
- over-the-counter items that are merely beneficial to general health, such as vitamins and nutritional supplements
- over-the-counter drugs that are not prescribed by a physician
- cosmetics, toiletries, etc.
- meals, bottled water
- marriage or family counseling
- insurance premiums
- custodial care in an institution
- health club dues

- most elective cosmetic surgical procedures
- stress management clinics
- social activities such as dance lessons (even though recommended by a qualified physician for general health improvement)
- salary for a nurse to care for a healthy newborn at home
- funeral and burial expenses
- household and domestic help (even though recommended by a qualified physician due to an employee's or dependent's inability to perform physical housework)
- costs for sending a child to a special school for benefits the child receives from the certain courses of study and/or disciplinary methods
- automobile insurance premiums
- transportation expenses to and from work (even though a physical condition may require special means of transportation)

CONTRIBUTIONS

You determine your contribution by estimating your annual out-of-pocket expenses for medical and dental services for you and your dependents. The maximum plan contribution limit for the medical reimbursement plan is $2,600.
When you enroll, you will elect an annual contribution amount. This annual amount will be divided by the remaining pay periods until the end of the calendar year to arrive at your per pay period contribution amount. The minimum contribution is $5 per pay period, or $130 per year. When calculating your contribution to the medical reimbursement plan, do not include medical and dental premiums.
Keep in mind that you cannot change your contributions to the medical reimbursement plan until the beginning of the next calendar year or until the occurrence of a qualified event.

The pretax amounts you direct to your Medical Reimbursement Plan do not affect your other salary-based benefits such as life insurance, disability insurance, and contributions under the 401(k) plan. They will, however, affect your Social Security benefits and, if applicable, your unemployment and worker's compensation benefits.
The following worksheet is designed to help you estimate your contribution.

ESTIMATED ANNUAL OUT-OF-POCKET HEALTH CARE EXPENSES

	For You	Your Spouse	Your Children
Deductibles			
(Keep family maximum in mind)	$_____	$_____	$_____
Your Co-payments			
Doctor or clinic visits	$_____	$_____	$_____

Surgical expenses	$_____	$_____	$_____
Prescription drugs	$_____	$_____	$_____
Routine physicals/exams	$_____	$_____	$_____
Mental health and substance abuse services	$_____	$_____	$_____
Dental care	$_____	$_____	$_____
Orthodontics	$_____	$_____	$_____
Vision care	$_____	$_____	$_____
Hearing care	$_____	$_____	$_____
Miscellaneous	$_____	$_____	$_____
Total annual estimated health care expenses eligible for reimbursement	**$_____**	**$_____**	**$_____**

Your Notes:

AVAILABILITY OF FUNDS

Your claims submitted under the Medical Reimbursement Plan can be paid up to the annual amount you elected even though you may not yet have deposited adequate funds into the Medical Reimbursement Plan. Funds become available after the first paycheck of the plan year. To determine the availability of funds in your Plan or to check the status of a claim, call the Windstream Benefits Center at 844-689-7832. Or, view your account online at www.windstreambenefis.com.

MEDICAL REIMBURSEMENT TIMING

All medical care generally must be incurred before amounts are reimbursed.

CLAIMS

All medical reimbursement claims are processed by Your Spending Account (YSA), a division of Aon Hewitt. For reimbursement, you have two options:

1. You will be issued an FSA debit card. When you use your card to pay for qualified purchases, the money is instantly deducted from your flexible spending account(s). Please keep all receipts. You will be asked to submit receipts from certain purchases made with your debit card. If you are an active employee new to the Plan, your debit card is activated on the 1st pay period in which Medical Reimbursement deductions are taken from your paycheck.

2. If you are not able to use your debit card at a provider/merchant, you can submit your claims (claim form and documentation required) by website, fax or mail to YSA. Claim forms with fax and address information are available from www.windstreambenefits.com. Be sure to include proof of expenses such as original receipts, Explanations of Benefits, or an itemized statement from the provider that includes the dates of service, services rendered, and your cost (after insurance payment, if applicable).

All claims for expenses must be incurred by December 31 of the plan year. Expenses must be submitted before March 31 following the plan year. Funds left in your account on March 31 in excess of the $500 carryover if applicable will be forfeited.

Claim Denials

If a request for reimbursement is denied, in whole or in part, YSA will provide you with written notice of the decision, which will include the following information:

- The specific reason or reasons for the denial;
- Specific reference to the plan provisions on which the denial is based;
- A description of any additional material or information necessary to complete the claim and explanation of why this material or information is necessary; and

- An explanation of the steps to be taken if you wish to submit your claim for review, and an explanation of your right to file suit in a federal court after you have exhausted your appeals.

The notice must be provided within 30 days of the date that YSA receives your request for reimbursement, unless special circumstances require an extension of the period for processing the request. If such an extension is required, written notice of the extension shall be provided to you before the end of the 30-day period.

First Level Appeal

You may appeal a denial of a claim by sending a written request to the Plan Administrator or its designee not later than (180) days after your receipt of written notification of denial of a claim. You or your duly authorized representative:

- May review pertinent documents; and
- May submit issues and comments in writing.

The determination on appeal will consider your submissions, regardless of whether they were considered in a previous decision.

Failure to make written request for appeal within the 180-day period after receipt of a claim denial notice shall render the decision regarding the claim final, binding, and conclusive on all parties.

A decision on review of a denied claim shall be made by the Plan Administrator not later than thirty (30) days after the Plan Administrator's receipt of a request for review.

The decision on review shall be in writing and shall include:

- The specific reason or reasons for the denial;
- Specific reference to the plan provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claim for benefits; and
- An explanation of the steps to be taken if you wish to submit your claim for review, and an explanation of your right to file suit in a federal court after you have exhausted your appeals.

Second Level Appeal

You may appeal a denial of a first level appeal by sending a written request to the Plan Administrator or its designee not later than (180) days after your receipt of written notification of denial of a first level appeal. You or your duly authorized representative:

- May review pertinent documents; and
- May submit issues and comments in writing.

The determination on appeal will consider your submissions, regardless of whether they were considered in a previous decision.

Failure to make written request for appeal within the 180-day period after receipt of the Administrator's notice of denial of the first level appeal shall render the Administrator's decision regarding the appeal final, binding, and conclusive on all parties.

A decision on review of a denied appeal shall be made by the Plan Administrator not later than thirty (30) days after the Plan Administrator's receipt of a request for review. The decision shall be made by someone other than the person, or a subordinate of the person, who made the first level appeal determination.

The decision on review shall be in writing and shall include:

- The specific reason or reasons for the denial;
- Specific reference to the plan provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claim for benefits; and
- An explanation of your right to file suit in a federal court.

TERMINATION

Normally, your coverage under the Medical Reimbursement Plan ends on the earliest of the following:

- the date your employment is terminated;
- the last day of the Plan year when you fail to reenroll in the Medical Reimbursement Plan during the Annual Benefit Enrollment Period or you withdraw from the Medical Reimbursement Plan because of a qualified change in status;
- when you no longer meet eligibility requirements; or
- the date you no longer have carryover funds available for use; or
- the date the Medical Reimbursement Plan terminates.

If you leave employment or terminate from the Medical Reimbursement Plan, you may receive reimbursement for any eligible medical expenses you incur prior to your termination date from any unused funds you might have in your account. The deadline for filing a claim is March 31 of the year following your termination of employment.

When you leave employment, it is Windstream's administrative practice to withhold benefit deductions, including Medical Reimbursement Plan deductions, through your last paycheck with regular pay. However, you will not be able to incur claims past your termination of employment date. For instance, if you leave Windstream on June 7,

you will continue to contribute to the Medical Reimbursement plan through your last paycheck with regular pay. However, you will only be able to submit claims incurred before June 7.

If your employment terminates, you have the right to continue making contributions to your account under COBRA on a post-tax basis as explained in the next section.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that requires employers to offer continued access to group health care coverage to former participants of the Medical Reimbursement Plan. Employees or their dependents that elect this continued coverage must pay the entire premium plus a 2% administrative fee.

If you have a positive balance in your account under the Medical Reimbursement Plan as of the date of a qualifying event (as explained below), you and/or your dependents may elect to continue coverage under COBRA on a post-tax basis for the remainder of the plan year.

Qualifying events under COBRA include the following:

- You and your dependents lose coverage because you leave the Company (other than for gross misconduct) or experience a reduction in work hours.
- Your dependents lose coverage because you die, become eligible for Medicare, or divorce or separate.
- One of your children loses coverage because he/she no longer fits the definition of "eligible dependent."

If you need continued coverage because of a divorce or separation or because your child loses dependent status or for any other reason, contact the Windstream Benefits Center. You or your dependents have up to 60 days after the date coverage would cease to elect continuation of coverage.

Upon separation of service from Windstream, a detailed notice containing coverage, continuation period information, notice and election requirements and procedures, and premiums will automatically be mailed to you.

Children born or lawfully adopted during a period of COBRA coverage are eligible for coverage. For additional information, please contact the Windstream Benefits Center at 844-689-7832 for assistance.

FAMILY AND MEDICAL LEAVE

This Medical Reimbursement Plan complies with the Family and Medical Leave Act of 1993 (FMLA).

During any leave taken under the FMLA, you may elect to continue or suspend your participation in the Medical Reimbursement Plan. If you suspend your participation, you will not be reimbursed for any expenses incurred during your leave. However, you may elect to participate again when you return from FMLA leave if you make the election within 31 days of your return, as long as your election is under the same terms that applied prior to your FMLA period.

NOTICE OF PRIVACY PRACTICES (HIPAA)

In accordance with the privacy regulations issued by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Regulation), a complete notice of the Windstream privacy practices is available for your review on the WIntranet. The notice describes how medical information about you may be used and disclosed and how you can obtain access to the information. The notice also describes various rights you may have regarding your information. Upon request, a written copy will be provided to you by contacting your local Human Resources representative or by contacting the Windstream Benefits Center at 844-689-7832.

RECOVERY OF OVERPAYMENTS

Despite YSA' best efforts, it may make a claim payment for an expense that is not reimbursable under the Medical Reimbursement Plan, or it may provide a reimbursement that is larger than the Medical Reimbursement Plan allows. For purposes of this section, a payment or partial payment that should not have been made under this Medical Reimbursement Plan will be called an "overpayment."

By accepting reimbursements under the Medical Reimbursement Plan, you agree that the Medical Reimbursement Plan has what's called an "equitable lien" on any overpayment. This means that the Medical Reimbursement Plan can recover the overpayment from you. The Plan Administrator may ask you to repay the overpayment, or the Plan Administrator may choose to reduce or withhold future reimbursement payments until the overpayment is repaid.

AMENDMENT AND TERMINATION OF THE MEDICAL REIMBURSEMENT PLAN

The Company reserves the right to amend, modify, terminate, and partially terminate the Medical Reimbursement Plan at any time.

STATEMENT OF ERISA RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to the following:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. 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.

Continue Medical Reimbursement Plan Coverage

Continue Medical Reimbursement Plan coverage for yourself if there is a loss of coverage under the Medical Reimbursement Plan as a result of a qualifying event. You may have to pay for such coverage. Review this summary plan description and the documents governing the Medical Reimbursement Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries.

No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your 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 a suit in 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 Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state

or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay court costs and legal fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance With Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 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.

PLAN DATA

Name of Plan: The Windstream Medical Reimbursement Plan is a component of the Windstream Comprehensive Plan of Group Insurance.

The Windstream Comprehensive Plan of Group Insurance includes: Windstream Preferred Provider Organization Plan, Windstream Consumer Plan, Windstream Prescription Drug Plan, Windstream Dental Care Plan, Windstream Executives Dental Group Policy, Windstream Vision Care Plan, Windstream Medical Reimbursement Plan, Windstream Dependent Care Plan, Windstream Services, L.L.C. Executive Medical Group Policy , Windstream Basic Life and AD&D Insurance Plan, Windstream Supplemental Life Insurance Plan, and Windstream Supplemental AD&D Plan, Windstream Long Term Disability Plan, Windstream Income Advantage Benefit Plan, Windstream Employee Assistance Plan, Windstream Severance Pay Plan and any other plans included as a constituent plan to the Comprehensive Plan of Group Insurance from time to time.

The remainder of this section provides information about the Windstream Comprehensive Plan of Group Insurance as a whole.

Plan Sponsor and Primary Agent for Service of Legal Process:

Windstream Services, LLC
4001 Rodney Parham Road
Little Rock, AR 72212

Plan Information may be obtained by writing to:

You may obtain Summary Plan Descriptions ("SPDs") about Windstream's benefit plans at WindstreamBenefits.com. If you do not have access to a computer, you may also write to Windstream Benefits Department, 4001 N Rodney Parham Rd, Little Rock AR 72212 to request a copy of any SPD.

Collective Bargaining Agreements:

The Windstream Medical Reimbursement Plan is maintained pursuant to one or more collective bargaining agreements. You may obtain a copy of the applicable collective bargaining agreement upon written request to the Plan Administrator, or you may examine a copy of the applicable agreement at the Plan Administrator's office.

Plan Administrator: Windstream Benefits Committee
Windstream Services, LLC
4001 Rodney Parham Road
Little Rock, AR 72212
(501) 748-7000

Employer Identification Number: 20-0792300

Type of Plan: The Comprehensive Plan of Group Insurance is a welfare benefit plan offering group health, dental, vision, life, long term disability, AD&D, wellness and EAP benefits, as well as medical and dependent care flexible spending accounts. The Windstream Medical Reimbursement Plan is the component of the welfare benefit plan that offers a medical flexible spending account.

Plan Identification Number: 501

Type of Administration: Some components of the Windstream Comprehensive Plan of Group Insurance use contract administration while others use insurers. The Medical Reimbursement Plan contracts with Aon Hewitt to administer benefits.

Sources of Contributions and Funding Medium: Some components of the Windstream Comprehensive Plan of Group Insurance are self-funded by contributions from the Plan Sponsor and the employees, and benefits under those components are paid from the general assets of the Plan Sponsor. Other components are insured, and the insurance premiums are paid by the Plan Sponsor and the employees.

Contributions for the Medical Reimbursement Plan are paid entirely by employees, and reimbursements are provided from the Plan Sponsor's general assets.

Plan Year: January 1 - December 31