Vision Care Plan

Summary Plan Description

windstream

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VISION CARE PLAN AT A GLANCE

BENEFIT	The Vision Care Plan ("the Plan") offers eye examinations, eyeglasses or contact lenses (certain restrictions apply), and discounts on other related services and products for a minimal co-payment or no additional cost.
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 in the Plan is voluntary; however, you must elect to enroll during your first 31 days of employment, during the Annual Benefit Enrollment Period, or after a Qualified Change of Status. If you enroll during the first 31 days of employment (new hire date + 30 calendar days), your coverage will be effective the first of the month following 56 days of employment.
COSTS	If elected, you pay 100% of the cost for your coverage under the Plan. You may also be required to pay a co-payment for services and eyewear. Bargaining employees should refer to their collective bargaining agreement for costs.
LIMITATIONS	There are annual benefit maximums provided under the Plan. Please refer to the Benefits section for additional details.
TERMINATION	Your coverage ends on the last day of the month in which your employment is terminated.

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 and certificate of coverage. Any discrepancies between this Summary Plan Description and the formal Plan documents (including the master insurance policy underwritten by Spectera, a division of United Healthcare, or by VSP) 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.

WINDSTREAM VISION CARE 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.

The Vision Care Plan is designed to offer employees a variety of vision care benefits.

- Benefits are available to you and your eligible dependents under the Plan. You pay the cost of your coverage through biweekly payroll deductions (or weekly for IBEW 1189 and 2374) and receive vision services from a Member Doctor as described in this Summary Plan Description. Bargaining employees should refer to their collective bargaining agreement for costs.

This Summary Plan Description and accompanying certificate describe benefits provided under the Plan.

CONTACT INFORMATION

If you have any questions regarding coverage for a particular treatment, procedure, or device, please contact the applicable customer service group.

VSP
800-877-7195 or www.vsp.com/go/windstream

Spectera
800-638-3120 orwww.myspectera.com

If you need assistance in understanding a provision of the Plan or making a change to your coverage due to a life event (for instance, marriage), please contact Coordinated Care by Quantum Health.

Telephone **877-550-3255**

ELIGIBILITY

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

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

If you are an eligible employee, you may choose one of the following levels of plan coverage:

- EMPLOYEE ONLY coverage, which applies only to you
- EMPLOYEE + SPOUSE coverage, which includes you and your
- EMPLOYEE + CHILD(REN) coverage, which includes you and your eligible child(ren)
- FAMILY coverage, which includes you, your spouse, and your eligible child(ren)

Eligible family members are defined as:

- Your lawful spouse who is not legally separately or divorced from you. This includes your common-law spouse only if common-law status is recognized in your state of legal residency and you meet the common-law requirements at the time you enroll the dependent in coverage.
- Your children up to age 26 without regard to school status, marital status, financial dependency, residency, or eligibility for their own employer's plan.
- Your children age 26 or over who are incapable of self-support because of a disability and were covered under the Windstream plans prior to reaching the limiting age of 26 may be able to continue coverage subject to annual recertification.

*Children include the following persons:

- Your biological children,
- Any of the following persons in a parent-child relationship with you, the employee:
    - Your stepchildren
    - Your adopted children
    - Your legal ward, or
    - Children lawfully placed with you for adoption, and

Grandchildren are eligible only if your child (who is the parent and is an eligible family member) is enrolled in the plan and your grandchild lives with you and is dependent on you for support (your grandchild or the parent of the grandchild must be listed on your federal tax return as a dependent).

For **Louisiana** state residents, grandchildren up to age 26 are eligible if you (the employee) have legal custody of your grandchild and your grandchild resides with you. The grandchild may be eligible regardless of student or marital status. Grandchildren age 26 or over who are incapable of self-support because of a disability and were covered under the Windstream plans prior to reaching the limiting age of 26 may be able to continue coverage subject to annual recertification.

Your spouse or child will not be eligible for coverage if they have employee coverage under this policy.

If both the employee and spouse are insured as employees, their eligible children may be covered by only one parent.

IMPORTANT NOTICE

Your dependents will lose coverage if they do not meet eligibility requirements and you waive continuation of coverage under COBRA as explained later in this section. However, your premiums will not automatically be adjusted, so make sure you contact the Windstream Benefits Center within 31 days of the qualifying event (event date + 30 calendar days) to avoid paying for coverage that is no longer provided. Coverage will cease at the end of the month in which the eligibility requirements are not met.

SPECIAL ENROLLMENT PROVISIONS AND COVERAGE CHANGES

The Plan gives eligible employees special enrollment rights under the Plan if there is a loss of other health coverage, a change in family status, or for certain other events as explained below. In some cases, you may be able to or required to terminate coverage. You must request your enrollment change within 31 days (calculated as event date + 30 calendar days) by entering it online at the enrollment link on windstreambenefits.com.

If an employee or an employee's dependent loses coverage under Medicaid or a State Children's Health Insurance Program (CHIP) as a result of loss of eligibility, or if an eligible employee or an eligible employee's dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, then the employee must request their change within 60 days of such termination or determination of eligibility to enroll (calculated as date of determination + 59 days) by entering it online at the enrollment link on windstreambenefits.com.

During your online session, you will be prompted to return certain event and/or dependent documentation before your changes are approved.

In any event, your and your dependent’s coverage will never begin before your waiting period is satisfied (e.g. new hire waiting period). In any event, your change must correspond and be consistent with your event. For example, if your child loses eligibility status under the Plan, you will need to terminate coverage for that child rather than elect coverage.

Enrolling During Your First 31 Days of Employment

If you are a new employee, you must enroll in the Plan during your first 31 days (hire date + 30 days) of employment if you wish to have coverage. Coverage for you and your dependents, if applicable, will begin on the first day of the month following your first 56 days of employment.

If you decline coverage for yourself and/or your dependents under the Plan during your first 31 days of employment, future enrollment will only occur at the specific times detailed in this section.

If you are a re-hired Windstream retiree who was covered under the Retiree Medical Plan at the time of re-hire, you must enroll in the Plan during your first 31 days of re-employment (re-hire date + 30 calendar days). Your re-hire retiree coverage will begin on the 1st of the month following your re-hire date.

If you are a re-hired Windstream retiree who was not covered under the Retiree Medical Plan at the time of re-hire, you must follow the new hire enrollment process and your effective date will be the same as that of a new hire.

Change in Family Status

Employees and their dependents have a special opportunity to enroll or terminate coverage under this Plan if there is a change in family status:

- Change in marital status, including marriage; death of spouse; divorce, legal separation or annulment; or
- Change in the number of your dependents through birth, death, adoption, placement for adoption, or legal guardianship, or
- An event that causes a spouse or dependent to satisfy or cease to satisfy eligibility requirements under the Plan.

You must request your enrollment changes within 31 calendar days (event date + 30 calendar days) of your status change.

After Loss of Coverage Under Another Group Health Plan or Other Health Insurance Coverage

Employees and their dependents may have a special opportunity to enroll for coverage under this Plan if there is a loss of other vision coverage if the following conditions are met:

- You and/or your dependents were covered under a group plan or insurance policy at the time coverage under this Plan is offered; and the coverage under the other group plan or insurance policy was:
    - COBRA continuation coverage and that coverage was exhausted; or

- Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
- Terminated and no substitute coverage is offered; or
- Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or
- No longer receiving any monetary contribution toward the premium from the employer.

You or your dependent must request and apply for coverage under this Plan within 31 calendar days of the date the other coverage ends (calculated as date coverage ends + 30 calendar days). Loss of coverage includes loss of an Indian Tribal government or tribal organization, a state health benefits risk pool, or foreign government group health plan.

You or your dependents may not enroll for coverage under this Plan due to loss of coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact, or
- You or your dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

Cancellation of an individual plan (for instance, coverage through an individual exchange marketplace), unless it meets the Loss of Coverage criteria above, does not constitute a Special Enrollment Provision under this Plan.

New Eligibility or Loss of Eligibility for Premium Assistance Under Medicaid or Children's Health Insurance Program (CHIP)

If an employee or an employee's dependent loses coverage under Medicaid or a State Children's Health Insurance Program (CHIP) as a result of loss of eligibility, or if an eligible employee or an eligible employee's dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, then the employee must request their corresponding change within 60 days of such termination or determination of eligibility to enroll (calculated as date of determination + 59 days).

After a Change in Employment Classification

If you change employment classification with Windstream that affects your, your spouse's, or your dependent's eligibility under the Plan:

- Regular or occasional working less than 30 to more than 30 scheduled hours per week,
- Temporary or leased to regular or occasional working 30 or more hours per week,
- Return from an unpaid leave of absence

You are eligible to enroll you and your dependents in this Plan within 31 days of

your change in employment classification (event date + 30 calendar days).

Enrolling or Changing Elections during the Annual Benefit Enrollment Period

You may elect to enroll yourself and/or your eligible dependents or to change your coverage election in any way during the Annual Benefit Enrollment Period. Elections made during the Annual Benefit Enrollment Period will be effective the following January 1.

Change to Correspond to a Change Made Under Dependent's Employer's Plan

If your spouse's, former spouse's, or dependent's employer allows an election change based on a status change due to (1) marriage, divorce, death, birth, adoption, legal guardianship, or (2) loss of eligibility status under the other employer's plan, including termination of employment or change in place of residence making them ineligible for the other employer's plan, you may make an election change under this Plan. The change must be on account of and correspond with the change made under your spouse's, former spouse's, or dependent's plan. You must request the change within 31 days (event date + 30 calendar days).

You may also be eligible to enroll or terminate you and your eligible dependents from the Plan within 31 days of your dependent's annual enrollment period if the plan year for your dependent does NOT coincide with this Plan's year (January 1 through December 31).

Your election change must correspond with a change and must actually be made under your dependent's employer's plan. For example, if your spouse elects to cover your family under your spouse's vision plan, you may drop coverage for your family under this Plan. An election change will only be effective if you request your change within 31 days after the end of your spouse's open enrollment period (last day of enrollment window + 30 calendar days). Once approved, your election change will be effective as of the start date of your spouse's Annual Enrollment (e.g. your spouse's annual enrollment occurs in June for a July 1 effective date; therefore your election would be effective July 1).

Significant Changes in Cost of Coverage

If you are enrolled in the Plan and there is a significant increase in the cost (as determined by the Plan Administrator) during the period of coverage, you may elect coverage under another Plan option available in your geographic location that provides similar coverage. If no other Plan option is available, you may terminate your coverage prospectively.

If you are enrolled in the Plan and there is a significant reduction in the Plan coverage (as determined by the Plan Administrator) during the period of coverage

or if the Plan ends during the period of coverage, you may elect coverage under another Plan option available in your geographic location that provides similar coverage.

If there is a plan option added or significantly improved or eliminated during the period of coverage, you may elect the newly added option (or elect another option if an option has been eliminated).

Special Provisions Relating to the Family and Medical Leave Act (FMLA)

If you take a leave under the FMLA you may drop coverage under the Plan and make another election for the remaining portion of the period of coverage as may be provided for under the FMLA.

Special Provisions Relating to a Judgment, Decree, or Order

If you are subject to the terms of a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires health coverage for your child who is your dependent, you can add coverage for your child or foster child. If the judgment, decree, or order requires your spouse, former spouse, or other individual to provide coverage for the child, you are eligible to drop the child from your coverage.

Entitlement to Medicare or Medicaid

If you, your spouse, or dependent who is enrolled in the Plan becomes entitled to coverage under Medicare or Medicaid, you may make an election to drop coverage or reduce coverage for you, your spouse, or dependent. If you, your spouse, or dependent who has been entitled to coverage under Medicare or Medicaid loses eligibility for coverage, you may add or increase the coverage for you, your spouse, or your dependent.

You must request your change within 31 days of the effective date or termination date of Medicaid or Medicare coverage (effective date of termination + 30 calendar days).

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISIONS

Note: The Plan has the right to ask for certain documents to verify the event and determine eligibility.

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective:

- In the case of marriage, on the date of the marriage; or
- In the case of divorce, legal separation, or annulment on the first of the month following the event; or
- In the case of a spouse's commencement or termination of employment with a gain/loss of coverage, on the date of the loss/gain of coverage; or
- In the case of a child's commencement or termination of employment with a gain/loss of coverage, on the date of the loss/gain of coverage; or
- In the case of employee's change in employment status from less than 30 to 30 or more regularly scheduled hours per week, on the date of the employment status change; or
- In the case of an employee, spouse, or family member becoming eligible for Medicare, on the date of the Medicare effective date. This event allows you to cancel or reduce coverage only for the individual who is eligible for Medicare; or
- In the case of a change of coverage to correspond with spouse or family member's change under another employer's plan due to marriage, divorce, death, birth/adoption/legal guardianship, end of eligibility status under the other employer's plan, change in place of residence making them ineligible for the other employer's plan, or because the other employer's plan year is different than this Plan (the spouse or family member's plan year does not run January 1 to December 31), on the date corresponding to the effective date of change; or
- In the case of loss of coverage under a vision care program of an Indian Tribal government or tribal organization, a state health benefits risk pool, or foreign government group plan on the event date; or
- In the case of a spouse's employer terminating a vision plan or beginning to offer a vision plan, on the date of the event; or
- In the case of a dependent's birth, on the date of such birth; or
- In the case of a dependent's adoption, the date of such adoption or placement for adoption; or
- In the case of acquiring a legal ward or guardianship, on the date of acquiring such a legal ward or guardianship; or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan (CHIP), on the date the approved request for coverage is received.
- In the case of return from an unpaid leave of absence, on the date you returned from leave.

TERMINATION AND LOSS OF ELIGIBILITY

Your coverage under this Plan will end on the earliest of:

- The end of the period for which your last contribution is made, if you fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for your eligible class is canceled (for instance, a collective bargaining agreement change); or

- The last day of the Plan year if you voluntarily cancel coverage by not enrolling while remaining eligible during the Annual Enrollment Period; or
- The last day of the month in which you are no longer a member of a covered class (for instance, a collective bargaining unit), as determined by Windstream;
- The last day of the month in which your employment ends or you are temporarily laid off; or
- The last day of the month in which you retire; or
- The date you submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan; or
- In the case of Special Enrollment, the termination date will be the date prior to the effective date listed for any of the Special Enrollment events defined in the prior section, even if you voluntarily cancel coverage due to an event and remain eligible for the Plan.

Your Dependent's Coverage

Coverage for your dependent will end on the earliest of the following:

- The end of the period for which your last contribution is made, if you fail to make any required contribution toward the cost of your dependent's coverage when due; or
- The day of the month in which your coverage ends; or
- The effective date of death on which your deceased spouse will be removed from your vision coverage (if applicable); or
- The last day of the month in which your dependent is no longer your legal spouse or does not meet the definition of Common Law Marriage spouse due to legal separation or divorce, as determined by the law of the state where the employee resides; or
- The last day of the month in which your dependent child attains the limiting age listed under the eligibility section, or
- The last day of the month in which your dependent child no longer satisfies a required eligibility criteria listed in the Eligibility section; or
- In the case of Special Enrollment, the termination date will be the date prior to the effective date listed for any of the Special Enrollment events defined in the effective date section, even if the employee voluntarily cancels dependent coverage and that dependent is still eligible for the Plan; or
- The last day of the Plan year if You voluntarily cancel coverage by not enrolling while remaining eligible during the Annual Enrollment Period; or
- The day prior to the effective date in which the dependent becomes covered as an employee under this Plan; or
- The date you or your dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

COBRA continuation coverage may be offered to you or your dependent for certain events (see COBRA section of this Summary Plan Description for details).

If you leave employment, you have the right to continue coverage as required by COBRA (explained later in this document).

The Employer or Plan has the right to rescind any coverage of the employee and/or dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

Reinstatement of Coverage

If your coverage ends due to termination of employment, leave of absence, reduction of hours or return from unpaid leave and you qualify for eligibility under this Plan again at a later date, you must meet all requirements of a new employee.

If your coverage ends due to termination of employment or layoff, and you qualify for eligibility under this Plan again within 31 days from the date your coverage ended under this Plan, you are eligible for coverage on the date you again meet all the eligibility requirements. Coverage will be in effect retroactive to the date in which your coverage ended without a break in coverage. If you regain eligibility after the 31 day period, you must meet all requirements of a new employee.

Bargaining Employees, refer to the provisions outlined in your collective bargaining agreement.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Employee Retirement Income Security Act of 1974 requires an administrator of a group health plan to determine whether a medical child support order presented to the plan is a Qualified Medical Child Support Order (QMCSO). If the order is a QMCSO, the Vision Care Plan is obligated to provide benefits to an employee's child in accordance with the terms of such order. Written procedures for QMCSOs are available to employees and beneficiaries (including prospective alternate payees and alternate recipients), free of charge, upon request to Coordinated Care by Quantum Health at 877-550-3255.

The effective date of coverage for a child named in a QMCSO will be the date specified in the order, or the first of the month following receipt of the QMCSO.

PLAN PREMIUMS AND COSTS

Save by Using Member Doctors

You can choose any vision provider you wish. However, if you choose an eye doctor who is not a member of the network (a "Nonmember Provider"), you will only be reimbursed according to the out-of-network schedule included in this Summary Plan Description. Plan benefits are maximized by using services provided by a doctor who is a member of the network (a "Member Doctor"). You may find a member doctor by using the phone number or website listed in the Contact section of this document.

Contributions

You pay 100% of the cost of the premiums for your Plan coverage. After you enroll in the Plan, your premium is deducted from your pay on a pre-tax basis. Periodically, this amount may change to adjust for the overall cost of the coverage. If you are a bargaining employee, refer to your Collective Bargaining agreement for costs.

When you enroll for coverage as a new hire, your premium contributions will begin as soon as administratively possible on or following your effective date of coverage.

When you enroll for coverage during the Annual Enrollment period, your new Plan Year premium contributions will begin on the first pay date on or following January 1.

When you make changes to your coverage due to a qualifying life or work event, your premium contribution and coverage changes will not update until your event has been approved by Windstream. Windstream will approve your changes upon receipt of required supporting documentation for your event and proof of dependent eligibility. After your requested changes are approved, your paycheck deductions will change on a go-forward basis as soon as administratively possible. Refunds and retroactive premium adjustments are not provided, so promptly submitting your documentation is important. Although premium contributions are not adjusted retroactively, your coverage changes will be effective per the effective date of coverage rules in the Plan.

PLAN BENEFITS

Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Nonmember Providers.

The vision insurance provider authorizes benefits according to the Plan and the

latest eligibility information furnished by Windstream. When you or your covered dependent request services under the Plan, prior utilization of plan benefits will be reviewed by the vision insurance provider to determine eligibility for new services.

A Benefit Authorization is recommended before receiving plan benefits from a Member Doctor. The Member Doctor will request the Benefit Authorization from when you schedule your appointment. You may confirm with the Member Doctor that a Benefit Authorization has been obtained prior to your appointment. Plan benefits received from a Member Doctor without a Benefit Authorization may be considered to have been received from a Nonmember Provider, and the benefits will be limited to those for a Nonmember Provider, if any.

Under the Plan, you pay only the co-payment (if any) to a Member Doctor for the services covered by the Plan. The vision insurance provider will pay the Member Doctor directly according to its agreement with the doctor. Please see below for information about payments to Nonmember Providers.

In emergency conditions, when immediate vision care of a medical nature, such as for bodily trauma or disease is necessary, you can obtain covered services by contacting either a Member Doctor or Nonmember Provider. No prior approval is required for you or your covered family member to obtain vision care for emergency conditions of a medical nature. However, services for medical conditions, including emergencies, are not covered. These services may be covered by any medical insurance that you have. Emergency vision care is subject to the same benefit frequencies, plan allowances, and co-payments as nonemergency care.

The vision insurance provider guarantees service from Member Doctors only. If you choose a Member Doctor, Plan benefits are subject to the following terms.

Your Coverage

When visiting a Member Doctor, you'll receive products and services at rates outlined in the certificate of coverage. The service year in the calendar year for frequency eligibility.

	VSP Choice Plan	**Spectera**
Exam Copay	$10	$10
Material Copay	$10	$10
Retinal Imagining	$39 maximum	Not covered
Benefit Frequency		
Exam	Every 12 months	Every 12 months
Lenses	Every 12 months	Every 12 months
Frames	Every 12 months	Every 24 months

Retail Frame Allowance	$150; 20% off overage	$130
Lens Coverage		
Standard Anti-Reflective Coating	$41	Discount varies by provider
Polycarbonate for Children	Covered in full	Covered in full
Polycarbonate for Adults	$31 Single Vision $35 Multi-focal	Discount varies by provider
Standard Progressive Lenses	$55	Discount varies by provider
All other Progressive Lenses	$95 - $175	Discount varies by provider
Photochromic Adaptive Lenses	$70 Single Vision $82 Multi-focal	Discount varies by provider
Standard Scratch Resistant Coating	$17	Covered in full
Elective Contact Lens Allowance Materials and Exam	$150	$130
Necessary contacts Lens Allowance Materials and Exam	Covered in full after material copay	Covered in full after material copay
Out of Network Allowances		
Exam	$45	$45
Single Vision Lenses	$30	$45
Bifocal Lenses	$50	$65
Trifocal Lenses	$65	$85
Frame	$70	$47
Elective Contact Lenses	$135	$105
Medically Necessary Contact Lenses	$210	$210
Contact for provider search or questions		
Phone	800-877-7195	800-638-3120

Website	https://www.vsp.com/go/windstream	www.myspectera.com

Extra Discounts and Savings

- Laser vision correction discounts.
- Discounts and savings for prescription glasses as listed below.
    - Polycarbonate lenses for dependent children.
    - Up to 20% savings on lens extras such as scratch resistant and anti-reflective coatings and progressive lenses.

Coordination of Benefits

If a covered member is covered by more than one vision plan, and therefore has duplicate coverage, he / she may:

- Receive two separate sets of service; **or**
- Choose to have both plans pay for one set of services. In this case the covered member is "coordinating benefits."

Determine Primary and Secondary Plan

When a covered member has duplicate coverage and wants to coordinate benefits, the vision insurance provider must determine the order of assignment.

- The plan that covers the covered member as an employee is "primary"
- The plan that covers the covered member as a dependent is "secondary"

If the covered member is a dependent child and is covered under both parents' plans, the parent whose birth date falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, or the parent decreed by the court to be responsible is primary.

Primary Plan

The primary plan must pay or provide its benefits as if the secondary plan does not exist.

Secondary Plan

If a plan is the secondary plan, the covered member will receive allowances (exam, lenses, and frame) that will be used to pay up to, but not more than the billed amount. Only services used on the primary benefit may be used for coordinating like services on the secondary benefit. Secondary allowances are applied first to

the same service or product of the primary plan.

Terms and Conditions

- Eye examination. Covered in full subject to a $10 co-payment. Covered members may have one eye exam every plan year. If the exam is classified as medical treatment instead of a routine vision exam, it will not be covered.
- Materials. An additional $10 co-payment is payable at the time materials are ordered. This includes the following lenses: single vision, bifocal, trifocal, and lenticular. There is an allowance of $130 towards frames. However, the co-payment for materials does not apply to elective contact lenses.
- Contact Lenses. If visually necessary, professional fees and materials are covered in full, subject to the $10 co-payment. If chosen as an elective, professional fees and materials will be covered up to the defined allowance.

Choosing Nonmember Providers

You receive the best value from your Plan benefit when you visit a Member Doctor. If you decide not to see a Member Doctor, co-pays still apply. You'll also receive a lesser benefit and typically pay more out-of-pocket. You are required to pay the Nonmember Provider in full at the time of your appointment and submit a claim for partial reimbursement.

Contact Lenses
If visually necessary, professional fees and materials are covered up to $210.

EXCLUSIONS

The Plan will not pay benefits under the following circumstances:
- solutions or cleaning products for spectacle glasses or contact lenses
- orthoptics or vision training and any associated supplemental testing
- plano lenses
- medical or surgical treatment of the eyes
- optional cosmetic processes
- anti-reflective coating
- color coating
- mirror coating
- scratch coating
- blended lenses
- cosmetic lenses
- laminated lenses
- oversize lenses
- photochromic lenses, tinted lenses except Pink #1 and Pink #2
- progressive multifocal lenses
- UV (ultraviolet) protected lenses

Discounts on these items may be available from Member Doctors.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that requires employers to offer continued access to group health care coverage to former members of the Vision Care Plan. Employees or their dependents who elect this continued coverage ("qualified beneficiaries") must pay the entire premium plus a 2% administrative fee.

Plan benefits shall be identical to those the qualified beneficiary had immediately before the qualifying event that triggered the right to COBRA continuation. If the coverage has been changed, the coverage must be identical to the coverage

provided to similarly situated active employees who have not experienced a qualifying event (in other words, similarly situated non-COBRA beneficiaries).

The duration of COBRA, as modified by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), applies as follows.

- If you and your dependents lose coverage because you leave employment with Windstream and its subsidiaries or experience a reduction in work hours, you and your dependents may continue coverage for up to 18 months from the date of the termination or reduction in hours.
- If your dependents lose coverage because you die, divorce, or separate, they may continue coverage for up to 36 months following your death, divorce, or legal separation.
- If one of your children loses coverage because he/she no longer fits the definition of "eligible dependent," he/she may continue coverage for up to 36 months following the date he/she ceases to be an eligible dependent.
- If you and your dependents lose retiree coverage because Windstream files for Title 11 bankruptcy, you may continue coverage until your death (or, if earlier, until your COBRA coverage would otherwise be terminated) and your dependents may continue coverage for up to 36 months after your death.
- If an employee or family member is disabled at any time before or during the first 60 days of continuation coverage (running from the date of termination of employment or reduction in hours), the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours, subject to a 50% administration fee. The Social Security Administration must formally determine under Title II (Old Age, Survivors and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of determination of disability under the Social Security Act must be provided by the disabled individual to Windstream within the 18-month coverage period and within 60 days after the date of determination.
- If a second qualifying event other than Windstream's Title 11 bankruptcy occurs (for example, the employee dies or becomes divorced) within the 18-month or 29-month coverage period, the maximum coverage period becomes three years from the date of the initial termination or reduction in hours.
- If the employee's employment terminates (other than for gross misconduct) or the employee's hours are reduced within 18 months after the employee becomes entitled to Medicare, the maximum coverage period (for the spouse and dependent child) ends three years from the date the employee became entitled to Medicare.

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 under COBRA.

The taking of leave under the Family and Medical Leave Act of 1993 (FMLA) does not constitute a qualifying event. A qualifying event occurs, however, if an

employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a qualifying event occurs, it occurs on the last day of FMLA leave, and the applicable maximum coverage period is measured from this date. The covered employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during FMLA leave.

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 Coordinated Care by Quantum Health at 1-877-550-3255.

COMPLAINTS

If you have a concern or question regarding the provision of Services or benefits under the Plan, you should contact the insurance carrier's customer service department at the phone number in the Contacts section of this document. If the customer service representative cannot resolve the issue to your satisfaction over the phone, he or she can provide you with the appropriate address to submit a written complaint. If you are not satisfied with their decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

FAMILY AND MEDICAL LEAVE

This Vision Care 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 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 (return date + 30 calendar days).

If you continue your participation in the Plan while on FMLA Leave, you will continue to be responsible to make contributions. Please contact the Windstream Benefits Center to discuss the payment options available to you.

MILITARY LEAVE

Employees going into or returning from military service have rights mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA).

These rights include up to 24 months of extended coverage upon payment of the entire cost of coverage plus a reasonable administrative fee. The rights apply only to employees covered under the Vision Care before leaving for military service.

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 My Benefits page of the Windstream Intranet. 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. If you do not have access to a computer, you may also call 1-877-550-3255 or write to Windstream Benefits Center, P.O. Box 11657, Pleasanton, CA 94588 to request a copy of the policy.

MISCELLANEOUS INFORMATION

No Employment Contract

The purpose of this Summary Plan Description is to provide you with information about the benefits available under the Vision Care Plan. The benefits described are not conditions of employment, nor is the Summary Plan Description intended to create an employment contract between you and Windstream. Nothing in this Summary Plan Description should be interpreted as a limitation on your right or Windstream's right to terminate your employment at any time, with or without cause.

Administration

The Plan Administrator is responsible for the administration of the Vision Care Plan and has sole discretionary authority to interpret and construe the terms of the Vision Care Plan, determine your eligibility for benefits under the Vision Care Plan, and resolve any disputes that arise under the Vision Care Plan. The Plan Administrator has delegated certain of this authority to Spectera or VSP as the insurer of the Vision Care Plan. The expenses of administering the Vision Care Plan may be paid from plan assets (i.e., included in the cost of the premium). To the extent administrative expenses are not paid from plan assets, they shall be paid directly by Windstream.

AMENDMENT AND TERMINATION OF THE PLAN

Windstream Services L.L.C. reserves the right to amend, modify, terminate, and partially terminate the Plan at any time. Windstream Services L.L.C. may make amendments or modifications through an action of the Windstream Benefits Committee, and may terminate or partially terminate the Plan through a Board of Directors resolution.

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 Vision Care Plan Coverage

Continue Vision Care Plan coverage if there is a loss of coverage under the plan(s) 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 plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer, when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, and when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your

enrollment date in your coverage.

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 Your 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 Vision Care 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 Prescription Drug Plan, Windstream Dental Care Plan, Windstream Vision Care Plan, Windstream Medical Reimbursement Plan, Windstream Dependent Care Plan, Windstream Executive Medical Group Policy, Windstream Health Savings Option Plan, 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, L.L.C.
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 on windstreambenefits.com. If you do not have access to a computer, you may also call 888-392-7597 or write to Windstream Benefits Center, P.O. Box 11657, Pleasanton, CA 94588 to request a copy of any SPD.

Collective Bargaining Agreements:

The Windstream Vision Care 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, L.L.C.
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, and EAP benefits, as well as medical and dependent care flexible spending accounts. The Vision Care Plan is the component of the Comprehensive Plan of Group Insurance that offers vision insurance.

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 Vision Care Plan uses insurer administration and has hired Spectera and VSP as insurers.

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 Plan are paid entirely by the employee and remitted to Spectera and VSP. Certain bargaining employees may share the cost of coverage with Windstream, per the respective Collective Bargaining Agreements.

Plan Year: January 1 - December 31