Prescription Drug Plan

Summary Plan Description

windstream

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PRESCRIPTION DRUG PLAN AT A GLANCE

BENEFIT	The Windstream Prescription Drug Plan provides coverage for many drugs that are prescribed by a physician to treat illnesses and injuries. Windstream members have access to the Express Advantage preferred retail network and the National Plus non-preferred network. However, your co-pay will be lower at an Express Advantage preferred retail pharmacy. An economical mail order service is required for maintenance medications after two retail fills.
ELIGIBILITY	All non-union employees of Windstream and its subsidiaries regularly scheduled to work at least 30 hours per week and all union employees of Windstream and its subsidiaries who are regularly scheduled to work at least 30 hours per week and whose collective bargaining agreement provides for the benefits described in this Summary Plan Description. The effective date of coverage under this Plan will be the Participant's effective date of coverage under the Employer's medical plan.
ENROLLMENT	Employees and dependents enrolled in a Windstream medical plan are automatically enrolled in the Windstream Prescription Drug Plan. There is no separate election required (or allowed) for prescription drug coverage.
CHANGE IN STATUS	If you have a change in status during the year (such as birth or adoption, marriage, divorce, death, etc.), you must request a change in medical coverage within 31 days of the event in order to have a change in prescription drug coverage become effective. Under the Children's Health Insurance Program Reauthorization Act of 2009, if an Eligible Employee or Dependent's coverage under Medicaid or a State Children's Health Insurance Program ("CHIP") is terminated as a result of loss of eligibility, or the Eligible Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, the Eligible Employee may request a change in medical coverage under the Plan within 60 calendar days (date of determination + 59) in order to have a change in prescription drug coverage.
COSTS	You and the Company share the costs of your coverage. Co-payment or co-insurance may be required for your prescription; generally, the co-payment or co-insurance amount is determined by the plan design and generic, formulary, or non-formulary classification of the drug. An extra $10 co-payment per prescription maybe also be apply if you fill your medication at a non-preferred (National Plus) network retail pharmacy.
LIMITATIONS	Prescriptions can be filled at Express Advantage preferred network pharmacies or National Plus non-preferred pharmacies, subject to co-payments, co-insurance, and limitations. If a prescription is filled at a non-network pharmacy, limited benefits are available for reimbursement of claims. Prescriptions that are needed on a long-term or maintenance basis must be filled using the Home Delivery Service.

CLAIMS	All claims for prescription drug expenses incurred during the calendar year must be submitted no later than March 31 of the following year.
TERMINATION	You may continue your medical insurance and prescription drug coverage for a limited amount of time after your employment terminates or until you no longer meet eligibility requirements.

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 (including the master insurance policy underwritten by Express Scripts) 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.

PRESCRIPTION DRUG PLAN
SUMMARY PLAN DESCRIPTION

The Windstream Prescription Drug Plan is administered by Express Scripts and provides coverage for many drugs that are prescribed by a physician to treat illnesses and injuries. You and the Company share in the cost of the Plan.

This Summary Plan Description has been prepared specifically for non-union employees of Windstream and its subsidiaries and union employees of Windstream and its subsidiaries whose collective bargaining agreement provides for the benefits described in this Summary Plan Description. Any other employees are not eligible to participate in the Plan.

CONTACT INFORMATION

If you have any questions regarding coverage for a particular medication or device, please contact Coordinated Care by Quantum Health at 877-550-3255 or on online at **www.WindstreamHealth.com** **or** **www.express-scripts.com**

ELIGIBILITY

All non-union employees of Windstream and its subsidiaries regularly scheduled to work at least 30 hours per week and all union employees of Windstream and its subsidiaries who are regularly scheduled to work at least 30 hours per week and whose collective bargaining agreement provides for the benefits described in this Summary Plan Description are eligible with concurrent enrollment in a Windstream medical plan.

If you are an eligible employee, you may choose one of the following levels of medical plan coverage. Your eligibility for prescription drug coverage mirrors your medical plan selection as listed below:

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

You may not make a separate election for prescription drug coverage. For example, you may not elect medical coverage for yourself and prescription drug coverage for your family. Your medical plan coverage election determines your coverage for the Prescription Drug Plan.

Eligible family members are defined as:

- Your 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 foster child, 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).

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. Domestic partners are not eligible for COBRA coverage. However, your premiums will not automatically be adjusted, so make sure you contact Coordinated Care by Quantum Health within 31 days of the qualifying event (event date + 30 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.

Your deductions will change on a go-forward basis only, as soon as your Qualifying Life Event is approved by the Benefits Center (upon receipt of required documentation substantiating the change). See the Contribution section of this SPD for details.

ENROLLMENT

Enrollment in prescription drug coverage is automatic for employees and dependents who are enrolled as plan participants in a Windstream medical plan option. You may enroll in a Windstream medical plan (which includes the Prescription Drug Plan), change coverage, and add dependents according to the requirements of your Windstream medical plan and/or the Windstream Comprehensive Plan of Group Insurance. Please refer to the terms of those plans for details.

Upon your enrollment, Express Scripts will mail a retail drug card (identification card) to your home address. You will use this retail drug card when you have prescriptions filled at a retail pharmacy.

CLAIM REIMBURSEMENT FORMS

Generally, claim reimbursement forms are not necessary. Your pharmacy will only charge you the amount you must pay under the Prescription Drug Plan. However, if necessary, claim reimbursement forms can be obtained by calling Coordinated Care by Quantum Health at 877-550-3255.

CHANGES IN STATUS

Adding Coverage

Coverage under the Prescription Drug Plan is automatic with coverage under a Windstream medical plan selection; therefore, if you and/or your dependents are not covered in a Windstream medical plan (which includes the Prescription Drug Plan), you may obtain coverage under the specific circumstances detailed in the Windstream Comprehensive Plan of Group Insurance.

Dropping Coverage

Coverage under the Prescription Drug Plan is automatic with coverage under a Windstream medical plan selection; therefore, if you and/or your dependents are covered in a Windstream

medical plan (which includes the Prescription Drug Plan), you may cancel coverage under the specific circumstances detailed in the Windstream Comprehensive Plan of Group Insurance.

LOSS OF COVERAGE DUE TO CHANGE IN ELIGIBILITY

If you lose medical coverage due to a loss of eligibility for any reason, your prescription drug coverage ceases on the date your medical coverage ceases.

If you change employment classification with Windstream from regular or occasional part-time (working more than 30 hours per week), or regular or occasional full-time to an ineligible employment classification such as:

- temporary
- leased
- or part-time working less than 30 hours per week

Medical coverage (including coverage under the Prescription Drug Plan) will be cancelled at the end of the month following receipt of the status change. COBRA continuation coverage will be offered to you (see COBRA section of this Summary Plan Description).

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, Windstream is obligated to provide medical 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) upon request at Coordinated Care by Quantum Health at 877-550-3255.

HOW THE PRESCRIPTION DRUG PLAN WORKS

The Windstream Prescription Drug Plan is a self-funded plan administered through a contractual agreement with Express Scripts. The Plan offers two convenient cost-effective ways to purchase prescription drugs.

- An Express Scripts ID card allows you to purchase prescription drugs at a discounted cost to the Plan through participating pharmacies.
- Participants enrolled in the PPO plans present their Express Scripts ID card to a participating pharmacist and pay the applicable co-payment or co-insurance amount. An

extra $10 co-payment per prescription is applied if you fill your medication at a non-preferred (National Plus) network retail pharmacy.

- Participants enrolled in the Consumer plans pay all eligible prescription drug expenses until the annual deductible is met. Then, after the deductible is met, you share the cost of your expenses with Windstream up to the out of pocket maximum. The sharing percentage is defined by the class of prescription and the insurance option you choose. You should present your Express Scripts ID card when filling a prescription to receive negotiated discounts and have payments count toward meeting your deductible and out of pocket maximum.
- A convenient mail order home delivery program is required for maintenance or long-term drugs such as those for high blood pressure or cholesterol. After two retail fills, maintenance or long-term drugs that are required to be filled through the mail order program will not be covered if you choose to fill them through a retail pharmacy.
- Prescription drugs must be ordered by a physician and require a prescription by federal law.
- Certain medications used for treating chronic or complex health conditions are handled through Express Scripts' Specialty Pharmacy, Accredo. See the Specialty Pharmacy Program of this summary for additional information.

FORMULARY LIST

The Plan pays benefits according to an established formulary, with different benefit levels for generic, formulary brand name, and non-formulary brand name drugs. The Express Scripts Preferred Formulary Drug List is posted at: windstreambenefits.com and is also available free of charge by contacting Coordinated Care by Quantum Health. The formulary list is updated periodically, so it is advisable to verify prescription drug classification on an ongoing basis.

EXPRESS SCRIPT'S NETWORK PHARMACIES

The Express Scripts **Express Advantage Network** includes over 28,500 preferred pharmacies nationwide, and the National Plus Network includes over 67,000 non-preferred pharmacies. Confirmation of participating pharmacies may be obtained by calling Coordinated Care by Quantum Health at 877-550-3255 or by accessing their web site at www.WindstreamHealth.com, or www.express-scripts.com. **You have the choice of both retail networks for non-maintenance medications, but your cost will be lower when you use an Express Advantage Network preferred pharmacy.**

Mail order prescription drug procedures, initial order forms, and postage paid envelopes may be obtained by calling Coordinated Care by Quantum Health at 877-550-3255. Mail order refills may be made on-line at www.express-scripts.com or by calling Coordinated Care by Quantum Health at 877-550-3255.

COSTS

The Windstream Prescription Drug Plan is a self-funded plan, which means the Company and employees pay for Plan benefits. Express Scripts processes claims and benefit payments pursuant to a contractual agreement between Windstream and Express Scripts. Express Scripts does not insure benefit payments to Plan participants.

There is no guarantee that the cost of coverage will not increase in the future. Periodically, this amount may change to adjust for the overall cost of coverage.

CONTRIBUTIONS

As an employee, you share the premium costs for your prescription drug benefit with the Company through your medical plan payroll deductions. The cost of your Prescription Drug Plan coverage is included in your medical coverage premium. Because your contribution is on a pretax basis as governed by Section 125 of the Internal Revenue Code, you may not discontinue medical plan coverage (which includes prescription drug coverage) during the calendar year, except upon your separation from service or due to a status change (as described in a prior section).

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.

IMPORTANT NOTICE

If you are enrolled in one of the PPO Medical Plan options, your co-payment paid to purchase prescription drugs will accumulate to satisfy your annual medical plan out-of-pocket maximum. **Prescription co-pays will not apply to deductibles, so you will still need to meet your individual or family deductible.**

If you are enrolled in one of the Consumer plans your prescription drug costs will count toward your medical deductible and out-of-pocket maximum. The Consumer plans are high-deductible health plans which coordinate your prescription drugs costs with your medical benefits.

WHAT YOU WILL PAY FOR YOUR PRESCRIPTIONS

In addition to your share of the premium costs (included with your medical premium) participants enrolled in the Consumer plans will pay all eligible prescription drug expenses until you meet your deductible. Then, after your deductible is met, you share the cost of your expenses with Windstream up to the out of pocket maximum. IRS defined preventive drugs are available at a co-insurance rate whether you have met the deductible or not for those enrolled in a Consumer plan with an out of pocket maximum different from the deductible. Participants enrolled in the PPO plans will pay a co-payment or co-insurance each time you have a prescription filled. **Mail maintenance medications (after two retail fills) must be filled using Home Delivery mail order, or you will be responsible for the full cost.**

UMR Consumer Medical Plans

The following co-payment schedule applies only to employees enrolled in one of the Consumer medical options.

	Consumer 5000	Consumer 6000	Consumer 6300
	Preventive Rx - Waive deductible; coinsurance applies	**Preventive Rx - waive deductible; coinsurance applies**	**Preventive Rx - Deductible applies**
Retail Pharmacy Co-Insurance Per Script (Specialty drugs – See Below)			

Generic (max 30-day supply). You pay full price until deductible is met	You pay 20% coinsurance until out-of-pocket max is met	You pay 20% coinsurance until out-of-pocket max is met	You pay full cost until deductible/out-of-pocket max is met
Formulary Brand-Name (max 30-day supply). You pay full price until deductible is met	You pay 30% coinsurance until out-of-pocket max is met	You pay 30% coinsurance until out-of-pocket max is met	You pay full cost until deductible/out-of-pocket max is met
Nonformulary (Nonpreferred) Brand Name. You pay full price until the deductible is met. (max 30-day supply)	You pay 40% coinsurance until out-of-pocket max is met	You pay 40% coinsurance until out-of-pocket max is met	You pay full cost until deductible/out-of-pocket max is met
Home Delivery (Mail order) co-insurance			
Generic (90-day supply). You pay full price until the deductible is met.	You pay 20% coinsurance until out-of-pocket max is met	You pay 20% coinsurance until out-of-pocket max is met	You pay full cost until deductible/out-of-pocket max is met
Formulary Brand-Name (max 90-day supply). You pay full price until deductible is met	You pay 30% coinsurance until out-of-pocket max is met	You pay 30% coinsurance until out-of-pocket max is met	You pay full cost until deductible/out-of-pocket max is met
Nonformulary (Nonpreferred) Brand Name. You pay full price until the deductible is met. (max 90-day supply)	You pay 40% coinsurance until out-of-pocket max is met	You pay 40% coinsurance until out-of-pocket max is met	You pay full cost until deductible/out-of-pocket max is met
Accredo (Mail order) for specialty drugs*			
Drugs requiring Accredo delivery via mail order (typically maximum 30-day supply). You pay full price until the deductible is met.	50% of the cost $100 maximum per script	50% of the cost $100 maximum per script	You pay full cost until deductible/out-of-pocket max is met
* *Specialty medications are defined by ESI and are typically those used for chronic or complex disease states such as: Hepatitis, Multiple Sclerosis, Growth Hormone Deficiency, Rheumatoid Arthritis, Infertility, Hemophilia, and Oncology.*			

UMR PPO Medical Plans

The following co-payment schedule applies only to employees enrolled in one of the PPO medical options.

Retail pharmacy co-payments per script	Preferred Pharmacies - Express Advantage Network	Non-Preferred Pharmacies - National Plus Network	Out-of-Network
Generic (30-day supply)	$10	$20	If a prescription is filled at a non-network Pharmacy, you will be responsible for paying 100% of the cost up front and then must submit a paper claim form along with receipts to Express Scripts. Reimbursement is limited to the
Formulary Brand-Name (30-day supply)	*$40	$50	
Nonformulary (Nonpreferred) Brand Name (30-day supply)	*50% The minimum co-payment for any Non-formulary Brand-Name	*50% The minimum co-payment for any Non-formulary	

	Drug is *$40 or the cost of the prescription if less.	Brand-Name Drug is *$50 or the cost of the prescription if less.	amount which would have been paid by the plan had a Network Pharmacy filled the order. This reimbursement limitation does not apply to participants living outside the United States. Express Scripts claim forms are available by contacting Coordinated Care by Quantum Health.
Home Delivery (Mail order) co-payments	**In-Network**	**Out-of-Network**	
Generic (90-day supply)	▸ $20	No benefits for non-network mail order services.	
Formulary Brand-Name (90-day supply)	*$80 (with certain restrictions – see Brand-Name Penalty section)	No benefits for non-network mail order services	
Nonformulary (Nonpreferred) Brand Name (90-day supply)	*50% The minimum co-payment for any Non-formulary Brand-Name Drug is *$80 or the cost of the prescription if less.	No benefits for non-network mail order services	
Drugs requiring Accredo delivery via mail order (maximum 30-day supply)	Participant pays 50% of the cost, maximum $100 for a 30-day supply of each medication under this program.	No benefits for non-network mail order services	

PRESCRIPTIONS FULLY COVERED

Certain prescriptions are covered at no cost to you under the Plan, even if received over-the-counter, as provided by the Patient Protection and Affordable Care Act. Over-the-counter drugs will only be covered if accompanied by a prescription from your physician. For coverage details, contact Coordinated Care by Quantum Health.

Drug Category	Dosage/ Form
Aspirin (to prevent cardiovascular disease)	Oral dosage forms typically used by adults (e.g., tablets) in strengths providing ≤ 325 mg/day
Fluoride	Oral dosage forms typically used by children/infants (e.g., drops, chewable tablets) in strengths providing ≤0.5mg/day

Folic Acid	Oral dosage forms typically used by adult women (e.g., tablets) in strengths providing 0.4 to 0.8 mg/day
Iron Supplements	Concentration and oral dosage forms typically used by infants (e.g., drops, syrups, suspensions)
Immunizations	Recommendations are based on age, not dose. Recommended ages per Centers for Disease Control Vaccination Schedule (See Excluded Prescription Drug List for details.)
Contraceptives	For women only, through age 50 years. Diaphragm barrier; Emergency Generics; Oral Generics Brands (including non-formulary brands) may be fully covered under the following circumstances: • When your individual health care provider determines that covered generic (or single source brands) would be medically inappropriate, and the prescribed brand is appropriate, AND • When a generic version does not exist for one of the FDA approved contraceptive methods.
Smoking Cessation Generics	Limit 90 days of therapy per rolling 365 days.
Smoking Cessation – Chantix	Limit 180 days of therapy per rolling 365 days.
Vitamin D	For participants age 65 or greater. • Prescription is required. • Generic over the counter and generics are covered. • Single entity Vitamin D2, D3 products, and combination products that also contain calcium, with Vitamin D doses of 1,000 IU or less per dosage form.
Bowel Preps for Colonoscopy's	For participants greater than 49 and less than 75 years: Only generic prescription products (no over the counter) are fully covered.

EXPRESS SCRIPTS MAIL ORDER

You can get started with Home Delivery via the web or by phone. Your prescriptions may be mailed to:

Express Scripts
P.O. Box 66566
St. Louis, MO 63166-6566

Please use an Express Scripts Mail order form for initial Home Delivery request. Mail order forms confirm such things as your Member ID, method of payment, etc. Initial Mail order forms, and postage paid envelopes, may be obtained by calling Coordinated Care by Quantum Health at 1-877-550-3255.

Your Physician may also fax your prescription to Express Scripts at 1-866-662-5267. Only Physician offices are allowed to use this fax number.

Mail order refills may be made on-line at www.WindstreamHealth.com or www.express-scripts.com or by calling Coordinated Care by Quantum Health at 1-877-550-3255.

EXPRESS SCRIPTS MAINTENANCE MEDICATIONS

Please refer to the Express Scripts Maintenance Medication List posted on windstreambenefits.com for prescriptions that require the use of the Home Delivery mail order program. The list is not an all-inclusive list of maintenance medications, and it is subject to change. Not all the drugs listed are covered by the prescription-drug benefit program; check the formulary and this summary for the specific drugs covered and the co-payments or co-insurance required. For specific questions related to maintenance medication coverage call Coordinated Care by Quantum Health at 1-877-550-3255.

RETAIL AND MAIL ORDER PRIOR AUTHORIZATION LIMITATIONS

Certain prescription drugs (including generics) may require prior authorization to confirm appropriateness of treatment. The prescribing physician should call Express Scripts before submission to the pharmacy to avoid delays and to expedite the authorization process. Your physician may request a prior authorization by calling the Physician Prior Authorization Hotline at 1-800-417-8164. This retail prior authorization limitation also applies to non-network pharmacies.

Certain prescription drugs require prior authorization include, but are not limited to (Specialty STEP Management)(SSM) A listing of these drugs are posted on http://www.windstreambenefits.com or can be found by calling Coordinated Care by Quantum Health at 877-550-3255. Please note this list is subject to change.

If you have a question regarding a particular drug, please call Coordinated Care by Quantum Health at 877-550-3255.

The following steps should be taken in order to obtain a Prior Authorization:

1. Your pharmacy or physician calls the Prior Authorization Hotline at 1-800-417-8164. Note: Your physician can also mail or fax requests to Express Scripts.
2. Once the prior authorization clinical guidelines are met, your prior authorization will be approved and entered into the system and you receive your medication.
3. If the clinical guidelines are not met, your physician will be notified of the denial.

4. If the prior authorization is denied, you can still get your prescription but you will be financially responsible for the full charge of the prescription.
5. Your physician may appeal the denial. The instructions to appeal the denied prior authorization request are included with the denial form.

STEP THERAPY

"Step therapy" is a drug protocol management tool used to ensure appropriate drug therapies for certain conditions. The step therapy program recommends using an inexpensive treatment that is known to be safe and effective for most people – referred to as a first-line drug – prior to using a more expensive drug for the same condition.

For example, under step therapy, a person with a new prescription for a brand NSAID would—be denied the second-line, more expensive brand-name drug prescription and encouraged to try a generic alternative (such as Diclofenac). If it is determined that you currently are taking, or have taken in the last 130 days, a second-line drug (a newer or more expensive drug) according to the information in Express Scripts' system, this program will not apply for that particular drug. If the system does not find a recent prescription for a first-line or second-line drug, it will alert the pharmacist that your medication requires prior authorization. If this occurs, you will need to contact your physician to either switch to a first-line drug or have your physician call Express Scripts for information on how to obtain a prior authorization for a second-line drug. This list is not all inclusive of the conditions that may require step therapy. Step Therapy programs can be added to the plan at any time, without notice. Examples of Drugs and Classes subject to Step Therapy are posted on http://www.windstreambenefits.com, or can be found by calling Coordinated Care by Quantum Health at 1-877-550-3255. Please note this list is subject to change.

SPECIALTY PHARMACY PROGRAM

You must obtain certain medications used for treating chronic or complex health conditions through Express Scripts' Specialty Pharmacy, Accredo. Please contact Coordinated Care by Quantum Health at 1-877-550-3255, or Accredo at 1-866-848-9870 with any specialty drug needs.

Accredo is a specialty pharmacy used for purchasing high-cost, injectable medications and selected oral drugs designed to target and treat chronic, often complex, conditions such as (but not limited to): multiple sclerosis, rheumatoid arthritis, HIV/Aids, cancer, hepatitis B & C, hemophilia, and growth hormone deficiency. Specialty drugs/biotech/injectable medications are dispensed up to a 30-day supply due to their high cost, short shelf life, and to prevent wastage should the physician decide to change your therapy.

Specialty drugs are **not** obtained through Express Scripts Mail Order. Coverage only applies when you use Accredo. Failure to use Accredo for a covered specialty drug will result in no payment under the Plan for medication costs.

Additional specialty drugs may be added to the specialty pharmacy from time to time. You will be contacted by Accredo if you are taking a specialty drug that requires you to use the Accredo program. Accredo will work with you to deliver your specialty drug to your doorstep at a convenient time. Often this will be an overnight delivery and will include the medical supplies, such as needles, syringes, or tubing, necessary for their use (included at no additional cost to the patient). In addition, patients will receive specific instructions and assistance in the administration of their medications. Accredo is staffed with pharmacists and registered nurses trained to assist employees and their physicians with their particular disease state and the medication(s) prescribed to treat the condition.

Split Fill / Clinical Day Supply Programs A new specialty patient, maybe subject to quick changes due to adverse side effects or the ineffectiveness of the drug as originally written. For these therapies, it's important that Accredo, Express Scripts specialty Pharmacy works with patient's prescribers to help achieve the maximum effectiveness of the drug therapy.

When a new specialty patient meets the criteria for split-fill, the patient is notified of the program at the time of the first shipment. The patient is then contacted again on day eight, offered additional clinical education, assessed for intolerance or other adherence issues, and asked if the treatment is still appropriate. If it is determined that the treatment is no longer appropriate, the next partial or whole shipment is cancelled and the patient's prescriber is notified (if the prescriber is not already aware). If the patient is successful with the initial fill, they receive additional 15 day shipments until the patient titrates up to a 30-day fill.

Please note patients of some scripts can receive a 90 day's supply at one time, as there may be little if any need for continued clinical evaluation. Other specialty prescriptions may be limited to a 30 day, or in some cases 15 day supply.

This approach can help create successful therapies while reducing product waste and generating cost savings.

CHOLESTERAL CARE VALUE PROGRAM

The Cholesterol Care Value (CCV) Program provides optimal care to all patients with high cholesterol. The program features:

- **A rigorous clinical review process by a dedicated clinical team:** Access to PCSK9 inhibitors will be based upon clinical determination. With every new request for PCSK9 inhibitors, a dedicated clinical team, including specialist pharmacists, will contact the

prescriber for required medical documentation, including lab values and medical chart notes. Our clinicians will evaluate this data along with prescription drug history and will apply robust criteria based on P&T guidance and in alignment with FDA-approved indications.

- **Enhanced care for patients starting PCSK9s:** Patients changing therapy will receive assistance and education from Express Scripts' Cholesterol Care team at Accredo, our specialty pharmacy. Accredo, will initially dispense three 30-day prescriptions to ensure therapy tolerance before moving to a 90-day fill. Before dispensing, we will contact patients to educate them on all aspects of the medication and will closely monitor adherence.
- **Broader cholesterol patient management through home delivery: Patients on statins who have difficulty achieving optimal cholesterol levels because of nonadherence are at risk of moving to PCSK9 inhibitors. Only Express Scripts has a Cardiovascular Therapeutic Resource Center® (TRC) with a team of specialist pharmacists and other clinicians extensively trained in cholesterol therapies and adherence management. Express Scripts specialist pharmacists are equipped and required to take action on alerts that could affect patient safety and plan costs.**

BRAND EXCLUSIONS AND BRAND-NAME PENALTY

The Brand Exclusion program will target brand name medications that are not available as a generic. Instead, these brands have therapeutically equivalent generic alternatives available. Therapeutically equivalent means that these medications can be expected to produce essentially the same therapeutic outcomes. For example, Crestor and simvastatin (generic for Zocor) are indicated to treat high blood cholesterol. Under the Brand Exclusion program a prescription for Crestor will be denied because there is a therapeutically generic alternative available. Remember that using generics helps you get your medicine at the lowest possible cost, and helps keep the Plan cost low (to help keep your paycheck premiums to a minimum).

Certain brand name therapy classes are not covered under the Windstream Plan:

- Acne – topical with antibiotic
- Acne – topical
- Fenofibrates (e.g. for cholesterol treatment)
- Nasal antihistamines
- Nasal steroids
- Proton Pump Inhibitors (PPIs) (e.g. for gastric acid treatment)
- Statins (e.g. for cholesterol treatment)
- Sedative hypnotics
- Triptans (e.g. for migraine headaches)

If you choose to use a brand-name drug in the above therapy classes, you will be financially responsible for the full cost of the medication. However, if you use a generic alternative, your responsibility will be limited to the amount listed in the "What You Will Pay for Your Prescriptions" section of this document.

In rare circumstances, use of the brand name may be medically necessary for treatment. In those cases, your physician may request a prior authorization by calling the Physician Prior Authorization Hotline at 1-800-417-8164. If the prior authorization is denied, you can still get your prescription, but you will be financially responsible for the full charge of the prescription.

Brand Penalty - PPO Medical Plan Only

Note that when a brand name drug becomes available as a generic, by law, the generic drugs must meet the same standards for safety, purity, strength and quality. These generics are considered to be chemically equivalent to the brand name drug. If a generic drug equivalent is available and you choose to use a brand-name drug instead of a generic, you will pay a penalty in addition to the brand-name co-payment or co-insurance. You have the option of choosing the brand-name drug over the generic, but you must pay the price difference between the costs of the two drugs. The penalty does not apply when the physician has specified a brand-name product and has specified that the prescription must be dispensed as written.

There are certain brand therapy classes that are not covered under the Windstream Plan, as listed in the section above. If you choose to use a brand in those classes, you will be financially responsible for the full cost of the medication.

Example Penalty:

If you are enrolled in a PPO medical plan, suppose you have a choice between a brand-name drug costing $120 for a 30-day supply and the generic equivalent that costs $30 for a 30-day supply. If you voluntarily choose the brand-name drug, you will pay $100 for a 30-day supply, which is the difference between what the plan would have paid for a generic and the cost of the brand-name drug.

If you choose a generic, you pay only your co-pay or co-insurance, and the cost for a 30-day supply is:

Cost of Generic Drug $30	Cost of Brand-Name Drug $120
Plan Payment $20	Generic Brand Plan Payment $20
Employee Cost (Co-Pay) $10	Employee Cost With Penalty $100

EXCLUDED PRESCRIPTION DRUGS

The following prescription drugs are not covered under this Plan:

- Certain brand name therapy classes listed in the Brand Exclusion section in this document, unless determined as medically necessary by Express Scripts.
- Over-the-counter products or their equivalents that may be purchased without a written prescription. This does not apply to injectable insulin, insulin syringes and needles, and diabetic supplies, which are specifically included.
- Devices of any type even though such devices may require a prescription. This includes (but not limited to) therapeutic devices or appliances such as implantable insulin pumps and ancillary pump products.
- Immunization agents, biological serum, and vaccines except for Zostavax and Synagis*.
- Implantable time-released medications.
- Experimental or investigational drugs or drugs prescribed for experimental, non-FDA approved indications (i.e. progesterone suppositories).
- Drugs approved by the FDA for cosmetic use only.
- Compounds made of raw bulk chemicals or combination of federal legend drugs in a non-FDA approved dosage form.
- Nutritional supplements except for metabolic conditions only.
- Fertility agents once you reach the $5,000 lifetime maximum.

*However, the following immunizations are covered by the Plan:

- Hepatitis A – Anyone age 1 or greater.
- Hepatitis B and Haemophilus – No age restriction.
- Rotavirus – Children from birth to 12 months of age.
- Diptheria, Tetanus, Pertussis (Tdap) - Anyone 7 years or greater.
- Diptheria, Tetanus, Pertussis (DTaP) – Children from birth to age 7.
- Tetanus – Anyone 7 years or greater.
- Pneumococcal – No age restriction.
- Polio – Children from birth to 18 years of age.
- Influenza (A, B, H1N1) – No age restriction.
- MMR, Varicella – Anyone 1 year or greater.
- Meningococcal – Anyone 2 years or greater.
- Human papillomavirus (HPV4) – Anyone age 9 through 26 years old; No gender limitation. (HPV2) - Cervarix – for females only.
- Zoster – Anyone age 60 years or greater.
- Haemophilus – Children from birth to 2 years of age.

CLAIMS

If you use a pharmacy that is not in the Express Advantage network (or you do not present your Express Scripts ID card at a network pharmacy at the time of purchase), you pay the full cost of the prescription, and then may file a claim with Express Scripts to request reimbursement. Claim forms are available by calling Coordinated Care by Quantum Health at 877-550-3255.

The instructions on the claim form should be followed carefully to expedite the processing of the claim.

Claims Submission Deadline

All claims for prescription drug expenses incurred during the calendar year must be submitted no later than March 31 of the following year. Any claims received after that date will be denied.

FILING AN APPEAL

Level 1 Appeal

An initial appeal is a Level 1 Appeal and is a request for review. You can ask for a review of a pharmacy claim if you do not agree with how it was processed. The appeal must be in writing and should be sent to Express Scripts, Inc., Attn: Pharmacy Appeals, 6625 West 78th Street, Mail Route BL0390, Bloomington, MN 55439. You may appeal a denial of any type, even if the service has not taken place. Some examples of appeal topics are:

- prior authorization
- clinical appeal (a request that was processed using clinical criteria and guidelines for use)
- administrative appeal (benefit exclusion, co-pay assignment, refill limit, vacation override, and any clinical program where criteria is unavailable to complete the initial review)

The deadline for filing an appeal is 180 days from the date the benefit or related item was denied. If you can provide a reasonable explanation for a delay beyond 180 days, Express Scripts will use its best judgment to waive the 180-day rule. For clinical appeals (i.e., medical necessity, experimental drug, etc.), you must include detailed written documentation from your physician. Express Scripts will complete its review and issue a written response to you within 30 days of receipt of the written appeal. If Express Scripts requires additional time to complete the review, Express Scripts will issue a written notice within that same 30 days stating the

reason for the delay. All extended appeals will be completed within 4 days from receipt of the initial written appeal. Level 1 Prior Authorization appeals are reviewed by an Express Scripts Prior Authorization pharmacist. Level 1 Clinical and Administrative Appeals are reviewed by an independent specialist physician(s). Upon completion of the review, you will receive a letter notifying you of the approval or denial of the appeal.

Level 2 Appeal

An appeal of a Level 1 review is a Level 2 Appeal, and is the final request for review at Express Scripts, Inc., Attn: Pharmacy Appeals, 6625 West 78th Street, Mail Route BL0390, Bloomington, MN. A Level 2 Appeal must be in writing and must indicate that you are filing a Level 2 Appeal. You should include any additional supporting documentation, along with a copy of the original Level 1 Appeal and the Level 1 decision.

The written appeal must be filed within 60 days of receipt of the Level 1 decision. If an appeal is not filed in that 60-day time frame, no further action will be taken and a request for an appeal at a later date will be denied. Express Scripts will complete its review and issue a written response to you within 30 days of receipt of the written Level 2 Appeal. If Express Scripts requires additional time to complete the review, Express Scripts will issue a written notice within that same 30 days stating the reason for the delay. All extended appeals will be completed within 45 days from receipt of the initial written Level 2 Appeal. All Level 2 appeals will be decided by the Benefit Appeals Group. All decisions made by the Benefit Appeals Group are considered final and binding with no additional opportunity to appeal to Express Scripts.

Voluntary Level 3 Appeal

Once you have completed the second-level appeal, you will have completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA") and you will be able to sue the Plan in federal court if you disagree with the final determination.

However, instead of taking the issue to court, you may request a voluntary third level appeal from the Windstream Benefits Committee. If you request a voluntary third-level appeal, deference will not be given to the initial denial of the claim or the denial at any level of appeal, and the Windstream Benefits Committee's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether this information was previously submitted.

If you choose to submit a voluntary third level appeal to the Windstream Benefits Committee, you must submit your appeal within 60 calendar days from the date you received written notice of the second level appeal determination. The Windstream Benefits Committee or its designee shall resolve any third level appeal within 60 calendar days. Your appeal can be submitted to:

Windstream Benefits Committee, 4001 Rodney Parham Rd., Mailstop 170-B1F02-93, Little Rock, AR 72212.

FAMILY AND MEDICAL LEAVE

This Prescription Drug 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 Prescription Drug 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.
If you continue your participation in the Prescription Drug Plan while on Paid FMLA Leave or Unpaid FMLA Leave, you will continue to be responsible to make contributions.
During any leave taken under the FMLA, Windstream will maintain coverage under the Prescription Drug Plan on the same conditions as coverage would have been provided if you had been continuously employed during the entire leave period.

REFUND OF OVERPAYMENTS

If benefits are paid under this Plan for expenses incurred on account of a covered person, that covered person or any other person or organization that was paid must make a refund to the Plan if:

- all or some of the expenses were not paid by the covered person or did not legally have to be paid by the covered person, or
- all or some of the payment made under this Plan exceeded the benefits under this Plan.

The refund equals the amount of benefits paid in excess of the amount that should have been paid under this Plan.

If the refund is due from another person or organization, the covered person agrees to help Windstream obtain the refund upon request.

If the covered person, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under this Plan. The Plan may have other rights in addition to the right to reduce future benefits.

TERMINATION OF COVERAGE

Normally, coverage under the Plan ends with the termination of coverage under a Windstream medical plan which occurs on the earliest of:

- The last day of the month in which your employment is terminated
- When you voluntarily withdraw from a Windstream medical plan (which includes prescription drug coverage under this Plan) (You may only voluntarily withdraw from a Windstream medical plan (which includes coverage under this Plan) during the Annual Benefit Enrollment Period or upon the occurrence of a qualified event.)
- The last day of the month in which you or a dependent no longer meets eligibility requirements under a Windstream medical plan
- When you fail to make any required premium payments under a Windstream medical plan
- Upon termination of the Plan
- If you leave employment, you have the right to continue medical coverage (which includes coverage under this Plan) as required by COBRA (explained in the next section).

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 a healthcare plan. Since coverage under this Plan is automatic based on participation in a Windstream medical plan, your only election is whether to continue coverage under the Windstream medical Plan which will automatically include coverage under this Plan. Employees or their dependents who elect this continued coverage must pay the entire premium plus a 2% administrative fee. Domestic partners are not eligible for COBRA coverage.

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.

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 Windstream medical plan during FMLA leave.

If you need continued coverage because of a divorce or separation or because your child loses dependent status or for any other reason, contact Coordinated Care by Quantum Health. 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 Coordinated Care by Quantum Health at 1-877-550-3255.

A certificate of creditable coverage will be provided to you, free of charge, when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, 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.

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 Prescription Drug Plan 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 @windstreambenefits.com . 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 Coordinated Care by Quantum Health at 877-550-3255.

MISCELLANEOUS INFORMATION

No Employment Contract

The purpose of this Summary Plan Description is to provide you with information about the benefits available under the Plan. The benefits described are not conditions of employment, nor is the Summary Plan Description intended to create an employment contract between you and the Company. Nothing in this Summary Plan Description should be interpreted as a

limitation on your right or the Company's right to terminate your employment at any time, with or without cause.

Administration

The Plan Administrator is responsible for the administration of the Plan and has sole discretionary authority to interpret and construe the terms of the Plan, determine your eligibility for benefits under the Plan, and resolve any disputes that arise under the Plan. The expenses of administering the Plan may be paid from Plan assets. To the extent administrative expenses are not paid from Plan assets, they shall be paid directly by the Company.

Reduction, Change, Termination, Forfeiture, or Suspension of Benefits

The following circumstances may lead to a reduction, change, termination, forfeiture, or suspension of benefits:

- a delay in filing a proper application on a timely basis
- amendment or termination of the Plan
- calculation errors discovered by subsequent audit
- becoming a member of a collective bargaining unit, if your collective bargaining agreement does not provide for participation in the Plan
- a marital situation resulting in a qualified medical child support order
- any reduction, change, termination, forfeiture, or suspension of benefits that is necessary to maintain the tax-qualified status of the plan

AMENDMENT AND TERMINATION OF THE PLAN

The Company reserves the right to amend, modify, terminate, or partially terminate the Plan at any time by action of its officers.

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 Prescription Drug Plan Coverage

Continue Prescription Drug 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 preexisting 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 Prescription Drug 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 Services, L.L.C. 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, 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 on the windstreambenefits.com. If you do not have access to a computer, you may also call 1-888-392-7597 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 Prescription Drug 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, and EAP benefits, as well as medical and dependent care flexible spending accounts. The Prescription Drug Plan is the component of the Comprehensive Plan of Group Insurance that offers prescription drug benefits.

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 Prescription Drug Plan uses Express Scripts as the administrator.

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. The Prescription Drug Plan is self-funded. Contributions for the Prescription Drug Plan are paid by the company and the employee.

Plan Year: January 1 - December 31