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EASTERN DISTRICT ARKANSAS
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**UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF ARKANSAS**
**CENTRAL DIVISION**

MATTHEW S. DETWILER, individually and on behalf of all others similarly situated,

Plaintiff,

vs.

WINDSTREAM SERVICES, LLC and WINDSTREAM BENEFITS COMMITTEE,

Defendants.

Civil Action No.: 4:26-cv-1238-KGB

CLASS ACTION COMPLAINT

This case assigned to District Judge Baker
and to Magistrate Judge Volpe

Plaintiff Matthew S. Detwiler ("Plaintiff"), individually and on behalf of the Class defined below of similarly situated persons, alleges the following against Windstream Services, LLC ("Windstream") and the Windstream Benefits Committee (the "Committee") (collectively, "Defendants") based upon personal knowledge with respect to himself and on information and belief derived from, among other things, investigation of counsel, review of Plan documents, and review of public documents as to all other matters:

## NATURE OF THE ACTION

1. It is both unfair and unlawful for an employer to require employees to pay more for health coverage because they use tobacco unless the employer complies with ERISA's wellness program requirements. Windstream does exactly that. Under the Windstream Services, LLC Welfare Benefit Plan (the "Plan"), Windstream assesses a tobacco-use surcharge of $23.08 per biweekly pay period on each enrolled employee or covered spouse identified as a tobacco user who has not completed the cessation program. A participant subject to that surcharge pays more for the same medical coverage. ERISA permits that differential only if the Plan makes available a

compliant reasonable alternative standard, provides the same, full reward to participants who satisfy it, and gives the notice the law requires. *See* 29 U.S.C. § 1182(b)(2)(B); 42 U.S.C. § 300gg-4(j)(3)(D)–(E).

2. Tobacco surcharges have become more prevalent in recent years but to be lawful plans must make available a *compliant* "wellness program" that provides employees with an avenue to avoid the surcharge. Making a compliant wellness program available means employers ***must*** adhere to strict rules set forth by ERISA and the implementing regulations established by the Departments of Labor, Health and Human Services, and the Treasury (collectively, the "Departments") over ten years ago in 2014. ERISA imbues the Departments with the authority to promulgate regulations interpreting ERISA § 702, 29 U.S.C. § 1182, the statute's non-discrimination provision. Accordingly, the Departments have developed a regulatory framework that "must be satisfied" to qualify for the statutory exception or safe-harbor. Employers can only invoke this safe harbor if they can demonstrate full compliance with all the requirements.

3. ERISA's strict regulatory requirements are meant to ensure that wellness programs actually promote health and preclude discrimination, instead of wellness programs that are "subterfuge[s] for discriminating based on a health factor." The Final Regulations[1] establish that for plans to be compliant, they must provide a clearly defined, reasonable alternative standard that allows participants to obtain the "full reward," including restoration of surcharges paid while completing the alternative standard. See id., 33159–63. A wellness program must be genuinely designed to improve health or prevent disease, rather than functioning as an improper penalty imposed on certain participants under the guise of a health initiative. Windstream's 2024 Plan

[1] *Incentives for Nondiscriminatory Wellness Programs in Group Health Plans*, 78 Fed. Reg. 33158, 33163 (June 3, 2013) (hereinafter the "**Final Regulations**").

materials tell participants that completion of the cessation program removes the surcharge only "prospectively"; do not notify them of the opportunity to obtain a physician-directed alternative; and do not ensure that all similarly situated participants completing an alternative receive the full reward for the Plan year.

4. The need for regulatory safeguards surrounding these types of wellness programs is underscored by studies showing little evidence that wellness programs effectively reduce healthcare costs through health improvement. Instead, the savings employers claim often result in cost-shifting onto employees with higher health risks, disproportionately burdening low-income and vulnerable workers who end up subsidizing their healthier colleagues.[2] The regulatory safeguards seek to prevent wellness programs from being misused as thinly veiled revenue-generating schemes at the expense of employees who are least able to afford the additional costs by shifting the burden to plan sponsors to demonstrate compliance once a participant alleges discriminatory surcharges. The goal is to ensure that wellness programs operate equitably and in a non-discriminatory manner, and to promote genuine health improvements.

5. Outcome-based programs, such as being tobacco-free or completing a smoking cessation program, must offer a clearly defined "reasonable alternative standard," which is an alternative way for all similarly situated individuals to obtain the reward (or avoid a penalty) if

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[2] Horwitz, J. R., Kelly, B. D., & DiNardo, J. E. (2013). *Wellness incentives in the workplace: Cost savings through cost shifting to unhealthy workers*. Health Affairs, 32(3), 468–476, 474 ("wellness programs may undermine laws meant to prevent discrimination on the basis of health status. Since racial minorities and people with low socioeconomic status are more likely than others to have more health risks, they are also more likely to be adversely affected by cost shifting"); *see also* Dorilas, E., Hill, S. C., & Pesko, M. F. (2022). *Tobacco surcharges associated with reduced ACA marketplace enrollment*. Health Affairs, 41(3), Abstract (finding that tobacco surcharges are significant barriers to affordable health insurance).

they do not meet the initial tobacco-free standard.[3] The implementing regulations require the same, full reward for participants who satisfy the reasonable alternative during the applicable plan year.[4] The Departments explained that every individual participating in a wellness program should be able to receive the full amount of the reward or incentive. Final Regulations, 33160, 33163. Defendants violate these requirements by administering and communicating a prospective-only surcharge reduction rather than the full annual reward, and by omitting the required personal-physician accommodation notice. These failures defeat the statutory exception that otherwise permits a health-contingent premium differential.

6. Defendants cannot qualify for the statutory safe harbor because the tobacco-surcharge program fails mandatory conditions that "***must*** be satisfied" for a health-contingent wellness program to be lawful. 78 Fed. Reg. at 33160. The 2024 Annual Enrollment Guide ("2024 Guide") states that a $23.08 surcharge per pay period will apply to each enrolled employee or spouse who uses tobacco products and has not completed the tobacco-cessation program. Ex. A at 7. If participants complete the program or stop using tobacco the surcharge can be "removed

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[3] "An outcome-based wellness program is a type of health-contingent wellness program that requires an individual to attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward. . . if a wellness program tests individuals for specified medical conditions or risk factors . . . and provides a reward to individuals identified as within a normal or healthy range for these medical conditions or risk factors, while requiring individuals who are identified as outside the normal or healthy range (or at risk) to take additional steps . . . to obtain ***the same reward***" as the individual within the normal range. 29 C.F.R. § 2590.702(f)(1)(v) (emphasis added).

[4] *See* Final Regulations, 33163 ("while an individual may take some time to request, establish, and satisfy a reasonable alternative standard, ***the same, full reward must be provided to that individual*** as is provided to individuals who meet the initial standard for that plan year. (For example, if a calendar year plan offers a health-contingent wellness program with a premium discount and an individual who qualifies for a reasonable alternative standard satisfies that alternative on April 1, the plan or issuer must provide the premium discounts for January, February, and March to that individual.)" (emphasis added)).

***prospectively*** during the year." *Id.* at 7, 13. The 2024 Annual Enrollment Frequently Asked Questions ("2024 FAQ") repeats that the surcharge can be "removed prospectively" by updating tobacco status in the enrollment platform. Ex. B at 4–5. Neither document states that a participant who completes the alternative will be reimbursed or otherwise credited for surcharges previously paid during the Plan year.

7. That defect matters because the regulations require the "same, full reward" for the Plan year. *See* Final Regulations, 33163; 29 C.F.R. § 2590.702(f)(4)(iv). The 2024 Guide does more than remain silent on retroactive make-whole treatment: it affirmatively describes prospective-only removal. Ex. A at 7. A participant who completes the cessation program after paying surcharges has received less economic value than a similarly situated participant who met the tobacco-free standard from the beginning of the year unless the Plan restores those earlier payments. Nothing in the 2024 Guide or the 2024 FAQ promises that restoration.

8. Defendants also fail to provide the notice required by 42 U.S.C. § 300gg-4(j)(3)(E) and 29 C.F.R. § 2590.702(f)(4)(v). The 2024 Guide describes the surcharge, the program, and the procedure for removal, including a telephone number, but does not state that the Plan will accommodate recommendations from a participant's personal physician. Ex. A at 7, 13. The 2024 FAQ likewise describes the amount of the surcharge, the cessation alternative, the prospective-only rule, and the enrollment-platform procedure, without mentioning any right to a physician-directed alternative. Ex. B at 4–5. The Wrap SPD lists a separate Wellness Program Notice at the benefits website. Ex. C at 63. That separate reference does not contain a physician-accommodation statement and does not substitute for the required disclosure in each Plan material that describes the terms of the surcharge. The regulation requires the specified notice in ***all*** Plan materials describing the terms of the program.

9. This Complaint alleges that Defendants impose a tobacco-based premium differential without satisfying the conditions necessary to invoke ERISA's wellness program exception. The same Plan materials that establish the $23.08 biweekly surcharge expressly limit its removal to prospective periods and do not disclose the personal physician accommodation required by law. Windstream and the Committee bear the burden of establishing any affirmative defense on which they rely. *Cunningham v. Cornell Univ.*, 604 U.S. 693, 702–04 (2025) (explaining that defendants may bear the burden of persuasion on matters properly characterized as affirmative defenses or exemptions).

10. Participants like Plaintiff may challenge a premium differential when the employer's own Plan materials establish the deficiencies in the asserted wellness-program exception. Once a participant alleges the discriminatory differential and identifies the facts supporting the deficiency, Defendants must establish that the exception applies. *See id.* (explaining that statutory exemptions structured as exceptions are ordinarily affirmative defenses to be pleaded and proved by the party invoking them).

11. Plaintiff was enrolled in Windstream-sponsored medical coverage in 2024. His pay statements reflect a tobacco-use surcharge of $23.08, and he paid the surcharge through biweekly payroll deductions. That deduction increased his required contribution for medical coverage because of the tobacco-use standard applied to him. Plaintiff and similarly situated participants were subject to Defendants' uniform published surcharge terms and did not receive the same lower premium charged to participants who met the initial tobacco-free standard.

12. Plaintiff brings this action individually and on behalf of similarly situated Plan participants and beneficiaries to recover the amounts by which they were required to pay more for medical coverage and to obtain appropriate equitable and Plan-wide relief. Plaintiff also seeks

disgorgement of profits realized through the administration of the tobacco-use surcharge. The Plan's summary plan description ("SPD") states that medical coverage is funded through contributions from both employees and the Company and, critically, that "[w]here the Company and employees share the cost of coverage, the Company shall contribute the difference between the amount employees contribute and the amount required to pay benefits under the Plan." Ex. C at 58. Increasing employees' required contributions thereby reduces the difference Windstream must fund from its own resources.

13. Plaintiff brings this lawsuit individually and on behalf of all similarly situated Plan participants and beneficiaries, seeking to recover these unlawfully charged fees and for Plan-wide equitable relief to hold Defendants accountable for their violations under 29 U.S.C. § 1109. Under 29 U.S.C. § 1109, Defendants are fiduciaries of the Plan who have a legal obligation to act in the best interests of Plan participants and to comply with federal law. Plaintiff, on behalf of himself and the Plan as a whole, seeks appropriate equitable relief under 29 U.S.C. §§ 1132(a)(2) and (a)(3) to address Defendants' ongoing violations of ERISA's anti-discrimination provisions.

## PARTIES

14. Plaintiff Matthew S. Detwiler is an individual resident of Oklahoma and former employee of Windstream. During 2024, he worked at Windstream as a regional sales manager and participated in medical coverage provided through the Plan. He paid a tobacco-use surcharge as part of his medical coverage under the Plan, which his paystubs reflect.

15. Plaintiff paid the tobacco-use surcharge at the stated rate of $23.08 every two weeks. He thereby paid more for Plan coverage than a similarly situated participant who satisfied the initial tobacco-free standard. The surcharge was charged under the uniform Plan materials issued for the 2024 Plan year, including the Guide and FAQ attached as Exhibits A and B.

16. Plaintiff is a participant in the Plan with a colorable claim to benefits under the Plan, within the meaning of ERISA § 3(7), 29 U.S.C. § 1002(7).

17. Defendant Windstream Services, LLC is a major telecommunications company with its principal executive offices in Little Rock, Arkansas. Windstream is identified in the Wrap SPD as the Plan sponsor, is a participating employer, establishes employee-contribution levels, and funds the employer share of medical coverage. Ex. C at 57–59. Upon information and belief, Windstream also exercises authority and control over the payroll deductions and contributions collected for the Plan and, to that extent, acts as a fiduciary under 29 U.S.C. § 1002(21)(A).

18. Defendant Windstream Benefits Committee (the "Committee") is the Plan Administrator and named fiduciary identified in the Wrap SPD. Ex. C at 57, 59. The Committee is responsible for general Plan administration, has discretionary authority to interpret Plan terms, determine eligibility and benefit amounts, remedy omissions, and administer the Plan on a reasonable and nondiscriminatory basis. *Id.* at 59. Windstream and the Committee sponsored, maintained, administered, or exercised authority over relevant aspects of the Plan, an employee welfare benefit plan subject to ERISA under 29 U.S.C. § 1002(3).

## JURISDICTION AND VENUE

19. The Court has subject matter jurisdiction pursuant to 29 U.S.C. § 1132(e)(1) and 28 U.S.C. § 1331 because this suit seeks relief under ERISA, a federal statute.

20. This Court has personal jurisdiction over Defendants. Windstream maintains its principal executive offices in Little Rock, Arkansas. The Committee's principal address and the address at which the Plan is administered are likewise in Little Rock. The acts concerning the design, administration, funding, and communication of the challenged Plan terms arose from or were directed through Defendants' activities in this District.

21. Venue is proper in this District under 29 U.S.C. § 1132(e)(2) because the Plan is administered here and both Defendants reside or may be found here. Windstream's principal offices and the Plan Administrator's address are in Little Rock, Pulaski County.

## FACTUAL BACKGROUND

### I. DEFENDANTS' TOBACCO-USE SURCHARGE VIOLATES ERISA'S ANTI-DISCRIMINATION RULE

#### A. Statutory and Regulatory Requirements

22. ERISA prohibits any health insurer or medical plan from discriminating against participants in providing coverage or charging premiums based on a "health-related factor," including tobacco use. Under this rule, a plan "may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution that is greater than such premium or contribution for a similarly situated individual enrolled in the plan based on any health-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual." ERISA § 702(b)(1), 29 U.S.C. § 1182(b)(1); 42 U.S.C. § 300gg-4(b)(1).

23. The statute permits group health plans to "establish[] premium discounts or rebates . . . in return for adherence to ***programs of health promotion and disease prevention***" (29 U.S.C. § 1182(b)(2)(B) (emphases added)); however, these "wellness programs"—to qualify for this statutory safe-harbor exception—must strictly adhere to the mandated regulatory requirements.

24. Under ERISA § 505, 29 U.S.C. § 1135, Congress granted the Department of Labor the authority to issue regulations, including the power to establish regulations prohibiting discrimination against participants and beneficiaries based on their health status under ERISA § 702, 29 U.S.C. § 1182. This authority empowers the Secretary of Labor (the "Secretary") to

"prescribe such regulations as he finds necessary or appropriate to carry out the provisions of" Title I of ERISA. (29 U.S.C. § 1135). Furthermore, ERISA § 734, 29 U.S.C. § 1191c, explicitly reinforces the Secretary's authority to issue regulations concerning group health plan requirements, which grants the power to "promulgate such regulations as may be necessary or appropriate to carry out the provisions" of ERISA Title I, Part 7. 29 U.S.C. § 1191c.

25. Exercising this delegated authority, in 2006, the Secretary issued regulations through the notice-and-comment rulemaking process outlining the criteria that a wellness program must meet to qualify for the premium non-discrimination exception under ERISA § 702(b). *See* Final Regulations, 33158–59. Following the amendments to ERISA adopting the anti-discrimination provisions, the Departments published proposed regulations in November 2012 to "amend the 2006 regulations regarding nondiscriminatory wellness programs." *Id.*, 33159. These regulations (i.e., the Final Regulations) were approved and signed in 2013 to be effective January 1, 2014. *Id.*, 33158.

26. The Final Regulations specify that health promotion or disease prevention programs, such as outcome-based wellness initiatives (i.e., smoking cessation programs), must meet detailed requirements to qualify for the statutory safe harbor. As the Departments explained, these criteria "***must be satisfied*** in order for the plan or issuer to qualify for an exception to the prohibition on discrimination based on health status." *Id.*, 33163. "That is," the Departments explained, "these rules set forth criteria for an ***affirmative defense*** that can be used by plans and issuers in response to a claim that the plan or issuer discriminated" against participants. *Id.* (emphasis added). That means once a participant alleges a discriminatory surcharge along with facts showing that the alternative standard offered to them is deficient, the burden then shifts to the employer to prove that the wellness program satisfies *all* the necessary criteria.

27. The criteria in the Final Regulations are not optional. They serve as the only lawful pathway for plans to impose health-based premium differentials by ensuring that wellness programs do not arbitrarily penalize participants and they prevent employers from using surcharges as a revenue-generating mechanism rather than a genuine tool for health promotion. If a wellness program fails to meet even one of these stringent requirements, the program is noncompliant and the employer cannot benefit from the statutory carve-out. *See* § 2590.702(f)(4) (describing the "[r]equirements for outcome-based wellness programs," stating that a program "does not violate the provisions of this section ***only if all of the [] requirements are satisfied***.").

**B. Regulatory Criteria**

28. To comply with ERISA and avoid unlawful discriminatory surcharges, outcome-based wellness programs must meet the following five (5) criteria:

(a) Frequency of opportunity to qualify: Participants must be given at least one chance annually to qualify for the reward associated with the program to ensure ongoing accessibility and fairness. 29 C.F.R. § 2590.702(f)(4)(i).

(b) Size of reward: penalties or rewards cannot exceed 50% of the cost of employee-only coverage. § 2590.702(f)(4)(ii).

(c) Reasonable design: programs must be "reasonably designed" to promote health and cannot be "a subterfuge for discriminating based on a health factor." This determination is based on all the relevant facts and circumstances. "To ensure that an outcome-based wellness program is reasonably designed to improve health and does not act as a subterfuge for underwriting or reducing benefits based on a health factor, a reasonable alternative standard to qualify for the reward must be provided to any individual who

does not meet the initial standard based on a measurement, test, or screening. . . ." § 2590.702(f)(4)(iii).

(d) Uniform availability and reasonable alternative standards: "The full reward under the outcome-based wellness program must be available to all similarly situated individuals." § 2590.702(f)(4)(iv).

(e) Notice of availability of reasonable alternative standard: notice must include (a) instructions on how to access the reasonable alternative standard; (b) contact information for inquiries about the alternative standard; and (c) an explicit statement that recommendations from participants' personal physicians will be accommodated. *See* § 2590.702(f)(4)(v).

29. The Departments provided valuable insight into each of the criteria, reflecting their intent to operationalize the statute's protections in a manner that both promotes health and prevents discriminatory practices under ERISA.

30. Regarding the first criterion, "the once-per-year requirement was included as a bright-line standard for determining the minimum frequency that is consistent with a reasonable design for promoting good health or preventing disease." Final Regulations, 33162. The once-per-year requirement ensures that participants have a meaningful opportunity to participate in a reasonable alternative standard.

31. A key requirement of the fourth criterion for outcome-based programs is that the "full reward" must be available to "all similarly situated individuals[,]" regardless of when they meet the reasonable alternative standard during the plan year. *See* Final Regulations, 33165. Critically, the Departments clearly state that it is "[t]he intention of the Departments . . . that, regardless of the type of wellness program, ***every individual*** participating in the program should

be able to receive the ***full amount of any reward or incentive***. . . ." *Id.* (emphases added). While plans have flexibility in determining the manner in which they provide the "full reward," providing the "full reward" to every participant is ***mandatory***, regardless of when the participant satisfies the alternative standard. The Departments have made this clear:

> While an individual may take some time to request, establish, and satisfy a reasonable alternative standard, ***the same, full reward must be provided to that individual as is provided to individuals who meet the initial standard for that plan year***. (For example, if a calendar year plan offers a . . . premium discount and an individual . . . satisfies that alternative on April 1, the plan or issuer must provide the premium discounts for January, February, and March to that individual.) Plans and issuers have flexibility to determine ***how*** to provide the portion of the reward corresponding to the period before an alternative was satisfied (e.g., payment for the retroactive period or pro rata over the remainder of the year) ***as long as . . . the individual receives the full amount of the reward***.

Final Regulations, 33163 (emphases added).

32. The Final Regulations provide an example of a non-compliant plan that imposes a tobacco use surcharge but does not facilitate the participant's enrollment in or participation in a smoking cessation program. *See id.*, Example 8. Instead, the employer advises the participant to find a program, pay for it, and provide a certificate of completion. *Id.* The Final Regulations conclude that the plan is not compliant because it "has not offered a reasonable alternative standard . . . and the program fails to satisfy the requirements of paragraph (f) of this section." *Id.*; Final Regulations, 33180.

33. For health-contingent wellness programs, the Final Regulations require the notice be disclosed "in ***all plan materials*** describing the terms of" the program. 42 U.S.C. § 300gg-4(j)(3)(E); 45 C.F.R. § 146.121(f)(4)(v) (emphasis added). Further, the Final Regulations establish that "[f]or ERISA plans, wellness program terms (including the availability of any reasonable alternative standard) are generally required to be disclosed in the summary plan description (SPD),

as well as in the applicable governing plan documents . . . if compliance with the wellness program affects premiums . . . under the terms of the plan." Final Regulations, 33166. Plans that charge participants more based on tobacco use and fail to provide the prescribed notice cannot invoke the wellness-program exception.

## II. DEFENDANTS CANNOT AVAIL THEMSELVES OF ERISA'S SAFE HARBOR

34. Windstream's tobacco-use surcharge creates a premium differential based on tobacco use. The 2024 Guide states that an additional $23.08 per pay period applies to each enrolled employee and/or spouse who uses tobacco, including e-cigarettes and vaping products, and has not completed the cessation program. Ex. A at 7. The 2024 FAQ describes the same surcharge as $50 monthly ($23.08 per pay period). Ex. B at 4–5. An enrolled participant identified as a tobacco user therefore pays more for the same medical coverage because of a health-related factor.

35. ERISA permits a health-contingent tobacco premium differential only when it is imposed as part of a wellness program that satisfies every applicable statutory and regulatory requirement. *See* 29 C.F.R. § 2590.702(f)(4). Among other things, the Plan must make available a reasonable alternative standard that provides the same, full reward to participants who satisfy it; give participants at least one opportunity each year to qualify for that reward; and disclose the availability and terms of the alternative standard in all Plan materials describing the premium differential.

36. The Final Regulations illustrate what a compliant tobacco program requires. In Example 6, tobacco users may avoid the premium differential by participating in a smoking-cessation program, regardless of whether they successfully stop using tobacco. 78 Fed. Reg. at

33180. The program is available without cost, is not unreasonably burdensome, provides access to the full reward, explains how participants may enroll, supplies contact information, and states that the Plan will accommodate recommendations from a participant's personal physician. The premium differential is permissible only because the plan satisfies each of those requirements.

37. The Plan offered Clickotine as a tobacco-cessation program. The 2024 Guide describes Clickotine as a digital program, with support tools and up to eight weeks of nicotine-replacement therapy. Ex. A at 13. But the Guide states that, after completing Clickotine or ceasing tobacco use, the surcharge "can be removed ***prospectively*** during the year." *Id.* at 7 (emphasis added). The FAQ repeats the prospective-only rule. Ex. B at 4–5. Neither disclosure provides an alternative that restores the surcharge paid earlier in the Plan year when the participant later satisfies the cessation alternative.

38. The 2024 Guide confirms the premium differential. It announces a $23.08 per-pay-period charge for each employee or covered spouse identified as using tobacco and explains that participants may have the charge removed by completing Clickotine or ceasing tobacco use. Ex. A at 7, 13. The 2024 FAQ restates those terms and tells participants to change their tobacco status in the enrollment platform. Ex. B at 4–5. But both documents tell participants that the removal is prospective, rather than advising that the Plan will restore previously paid surcharges after completion of the alternative.

39. Defendants' notice is independently deficient. The 2024 Guide describes the amount of the surcharge, the tobacco standard, Clickotine, and how to contact the benefits center. Ex. A at 7, 13. Yet it does not state that recommendations from a participant's personal physician will be accommodated. The 2024 FAQ likewise sets out the surcharge and the prospective removal process but omits that statement. Ex. B at 4–5. The Wrap SPD separately identifies a Wellness

Program Notice on the benefits website but makes no mention whatsoever of a reasonable alternative standard and even the notice on the benefits website fails to provide a physician-accommodation statement. Ex. C at 63. Under § 2590.702(f)(4)(v), the personal-physician disclosure must appear in all materials describing the terms of the challenged outcome-based program.

40. The full reward defect is equally apparent from the 2024 documents. A participant who pays the tobacco surcharge while participating in Clickotine continues to bear the higher medical cost unless the Plan makes the participant whole for the earlier periods. The Guide and FAQ instead direct that the surcharge will be removed "prospectively." Exs. A at 7; B at 4–5. That limitation denies the same annual economic reward provided to participants who were not assessed the surcharge at the beginning of the Plan year.

41. The omission cannot be attributed to a mere failure to discuss refunds. Windstream affirmatively selected the word "prospectively" in both the 2024 Guide and the 2024 FAQ. In its Guide, it also directs participants to enroll in Clickotine, a program intended to help them gradually stop tobacco use. Ex. A at 7, 13. Participants who devote time to that reasonable alternative cannot receive the same full annual reward if earlier surcharges are never refunded or otherwise credited.

42. Defendants therefore fail at least two independent conditions necessary to invoke ERISA's wellness-program exception. First, their published Plan terms make surcharge removal prospective rather than promising the same, full reward for the Plan year after completion of the reasonable alternative. Second, those materials omit the mandatory statement that participants' personal-physician recommendations will be accommodated. *See* 42 U.S.C. § 300gg-4(j)(3)(D)–(E); 29 C.F.R. § 2590.702(f)(4)(iv)–(v).

43. To comply with ERISA, Defendants should have provided any participant who satisfies the cessation alternative the same full reward available to a participant who meets the initial tobacco-free standard, including the portion attributable to the period before completion. They also should have made the cessation program meaningfully accessible, at no cost and without unreasonable burden, and provided the disclosures required by the regulation.

44. Defendants also should have included a clear and specific notice in every Plan material describing the tobacco-surcharge program. That notice should have explained the availability of a reasonable alternative, provided contact information for obtaining it, explained how the same reward could be obtained, and stated that Defendants would accommodate recommendations from participants' personal physicians.

45. Plaintiff was subject to the uniform program throughout 2024. His 2024 pay statements identify a $23.08 tobacco-use surcharge, which he paid through payroll deductions at the biweekly rate. Neither the 2024 Guide nor the 2024 FAQ informed him that he would receive the full reward for the year upon satisfying the alternative; indeed, they stated that the surcharge could be removed only prospectively. Neither disclosed the right to have his personal physician's recommendations accommodated. Plaintiff therefore paid more for coverage under a program whose participant-facing terms failed to satisfy ERISA's conditions for the wellness program safe-harbor. Because Defendants have not complied with all conditions governing that differential, they cannot invoke the wellness program exception.

46. Allowing an employer to assess surcharges for months while a participant completes the employer-selected alternative, yet retain those surcharges after completion and omit the prescribed personal-physician notice, would defeat ERISA's antidiscrimination protections.

Windstream's surcharge structure shifts medical-coverage costs to participants while reducing the contribution Windstream otherwise would owe under the Plan's express funding formula.

## III. DEFENDANTS' SELF-DEALING AND PROFIT FROM THE TOBACCO-USE SURCHARGE

47. Windstream and the Committee administered the tobacco-surcharge differential through enrollment attestations, the process for changes to tobacco status, and the payroll contributions withheld for medical coverage. The 2024 Guide directs employees to attest to tobacco status and to call a number for a prospective reduction; the FAQ directs them to update the enrollment platform. Exs. A at 7; B at 4–5. The Wrap SPD gives the Committee discretion over Plan administration, benefit determinations, and the correction of omissions; Windstream establishes employee contribution levels. Ex. C at 58–59. The administration of the surcharge thus directly affects the amounts withheld from employees' paychecks.

48. The Wrap SPD establishes a direct funding relationship between higher employee contributions and Windstream's own costs. It specifies that the Medical and Wellness plans are self-insured. Ex. C at 1. It states that employees pay their medical-coverage contributions on a pre-tax basis, with the Company setting contribution levels. Id. at 10–11. More importantly, the SPD states that the cost of Medical coverage is shared by Windstream and covered employees and that "[w]here the Company and employees share the cost of coverage, the Company shall contribute the difference between the amount employees contribute and the amount required to pay benefits under the Plan." *Id.* at 58. Each unlawful $23.08 surcharge deducted from an employee's pay increases the employee-funded share and correspondingly decreases the contribution required of Windstream under that formula.

49. That retained contribution is an identifiable financial benefit to Windstream. ERISA § 409, 29 U.S.C. § 1109(a), provides separately for restoration of "any profits of such

fiduciary which have been made through use of assets of the plan." Defendants had fiduciary responsibilities over Plan administration and, upon information and belief, over participant contributions once withheld for Plan purposes. Windstream may not use Plan administration to increase participant contributions and reduce its own funding obligations for its own benefit.

50. Participant premium contributions withheld from wages for Plan coverage become Plan assets as of the earliest date they can reasonably be segregated from the employer's general assets. 29 C.F.R. § 2510.3-102(a)(1). Upon information and belief, Defendants exercised authority or control over those contributions and their application to medical coverage. By increasing the participant share through the noncompliant tobacco surcharge, Defendants reduced Windstream's required corporate contribution. Their use of discretionary Plan administration and control of Plan contributions to confer that benefit on a party in interest constituted self-dealing and a prohibited transaction. At a minimum, Windstream obtained avoided expenditures and the time value of amounts it otherwise would have had to contribute; the precise amount is within Defendants' records.

## CLASS DEFINITION AND ALLEGATIONS

51. Plaintiff brings this action individually and on behalf of all other similarly situated individuals, pursuant to Rule 23(b)(1) of the Federal Rules of Civil Procedure.

52. Plaintiff proposes the following Class definition, subject to amendment as appropriate:

> **Tobacco Surcharge Class**
> All individuals residing in the United States who, during the applicable limitations period through the time of judgment, participated in the Plan and paid a tobacco-use surcharge based on the tobacco-use status of the participant or a covered spouse.

53. Excluded from the Class are Defendants' officers and directors, judicial officers assigned to this case and their immediate families and court staff.

54. Plaintiff reserves the right to modify or amend the proposed Class definition before the Court determines whether certification is appropriate.

55. The proposed Class meets the criteria for certification under Fed. R. Civ. P. 23(a), (b)(1), (b)(2), and (b)(3).

56. **Numerosity.** This action is appropriately suited for a class action. The members of the Class are so numerous that joinder of all members is impracticable. The surcharge was uniformly described in annual enrollment materials for thousands of Windstream medical-plan participants and eligible spouses. Upon information and belief, hundreds or thousands of participants paid it. Their identities, coverage dates, and the amounts deducted are readily ascertainable from Defendants' payroll and enrollment-platform records.

57. **Commonality.** This action involves questions of law and fact common to the Class. The common legal and factual questions include, but are not limited to, the following:

a. Whether Windstream's tobacco-use surcharge creates a premium differential based on a health-status-related factor;

b. Whether the Clickotine cessation alternative makes the same, full reward available to participants who satisfy it, including reimbursement or credit of surcharges assessed before completion;

c. Whether Defendants provided the required notice in all Plan materials describing the terms of the tobacco-use surcharge;

d. Whether those materials contained the required statement that recommendations of participants' personal physicians would be accommodated;

e. Whether Windstream's surcharge program violated ERISA and the Final Regulations;

f. Whether Defendants breached fiduciary duties by administering participant premium contributions and the tobacco surcharge for Windstream's own financial benefit;

g. Whether Defendants breached fiduciary duties by failing to periodically review surcharge administration, the cessation alternative, and participant communications to ensure compliance with ERISA;

h. The appropriate mechanisms to determine Class-wide relief, restitution, and disgorgement of financial benefits Defendants obtained;

58. **Typicality.** Plaintiff's claims are typical of the Class because he and Class members were subject to the same tobacco-surcharge terms and paid more for medical coverage based on tobacco-use status. Plaintiff advances the same claims and legal theories on behalf of himself and Class members, and the central questions concerning uniform Plan terms, notices, funding, and administration can be resolved with common proof.

59. **Adequacy of Representation.** Plaintiff will fairly and adequately protect the interests of Class members. Plaintiff and Class members participated in Windstream-sponsored health benefits and were harmed by the same alleged premium differential and fiduciary misconduct. Plaintiff has retained counsel experienced in complex ERISA and class-action litigation, has no interests antagonistic to the Class, and is not subject to any presently known defense that defeats adequacy.

60. **Superiority.** A class action is superior to other methods for fair and efficient adjudication of this controversy. The financial harm suffered by individual Class members is relatively small compared with the burden and expense of separate litigation. It would be impractical for most Class members to obtain effective relief individually. Individual litigation would create the risk of inconsistent judgments and duplicate expense. A class action permits the common Plan terms, notices, funding practices, and surcharge records to be adjudicated in one proceeding.

61. Plaintiff seeks declaratory, restitutionary, and other appropriate equitable relief on grounds generally applicable to the Class. Class-wide adjudication will permit the Court to address

the uniform 2024 Plan materials, the prospectivity policy, and the fiduciary administration of participant contributions in a single proceeding.

## CAUSES OF ACTION

### COUNT I

### UNLAWFUL PREMIUM DIFFERENTIAL – FAILURE TO PROVIDE THE FULL REWARD

**(Violation of ERISA § 702, 29 U.S.C. § 1182(b) and PHSA § 2705, 42 U.S.C. § 300gg-4(j)(3)(D); 29 C.F.R. § 2590.702(f)(4)(iv); 45 C.F.R. § 146.121(f)(4)(iv))**

62. Plaintiff re-alleges and incorporates herein by reference allegations 1–61 of this Complaint.

63. ERISA prohibits group health plans from requiring participants to pay more for coverage based on a health-status-related factor. 29 U.S.C. § 1182(b)(1); 42 U.S.C. § 300gg-4(b)(1). Tobacco use is a health-status-related factor. Windstream's tobacco-use surcharge causes enrolled participants identified as tobacco users to pay more for the same medical coverage and is therefore unlawful unless Defendants satisfy every applicable condition of the statutory and regulatory exception for health-contingent wellness programs. 29 U.S.C. § 1182(b)(2)(B); 42 U.S.C. §§ 300gg-4(b)(2)(B), 300gg-4(j)(3); 29 C.F.R. § 2590.702(f)(4).

64. Among those conditions, the Plan must make available a reasonable alternative through which similarly situated participants may obtain the same, full reward offered to participants satisfying the initial tobacco-free standard. 42 U.S.C. § 300gg-4(j)(3)(D); 29 C.F.R. § 2590.702(f)(4)(iv). The full reward cannot be limited to prospective avoidance of the surcharge based on the date on which a participant satisfies the alternative. *See* Final Regulations, 33163.

65. Windstream's 2024 Guide allows a tobacco user to complete Clickotine and then seek removal of the surcharge, but states the charge can be "removed prospectively during the year." Ex. A at 7, 13. The 2024 FAQ repeats that completion of cessation or quitting tobacco

results in prospective removal through a change in the enrollment platform. Ex. B at 4–5. Neither states that the Plan will refund or credit surcharges already paid during the Plan year.

66. Because participants may take weeks or months to complete a cessation alternative while continuing to pay the higher medical premium, providing only a prospective reduction does not provide all similarly situated individuals with the same, full reward that the non-smoker received. A participant who satisfies the alternative must receive the full amount attributable to the Plan year, including the period before completion. *See* Final Regulations, 33163. Windstream's 2024 materials affirmatively describe a smaller reward. The 2024 Guide and FAQ make the deficiency explicit: each says the tobacco surcharge may be removed "prospectively." Exs. A at 7; B at 4–5. Upon information and belief, Defendants administered the surcharge consistently with those published terms and did not provide every participant who completed the alternative a full-year refund or equivalent credit.

67. By administering and describing an alternative that does not make the full reward available for the Plan year, Defendants fail to satisfy 29 U.S.C. § 1182(b)(2)(B), 42 U.S.C. § 300gg-4(j)(3)(D), and 29 C.F.R. § 2590.702(f)(4)(iv), and therefore cannot invoke the wellness program exception.

68. The resulting tobacco-surcharge differential is an unlawful difference in the cost of coverage based on a health-related factor, in violation of 29 U.S.C. § 1182(b) and 42 U.S.C. § 300gg-4(b).

69. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes a participant or beneficiary to sue to enjoin practices that violate ERISA and to obtain other appropriate equitable relief to redress violations or enforce ERISA. Because Defendants' surcharge program does not satisfy the

criteria for the exception, Plaintiff and Class members seek restitution, equitable surcharge, disgorgement, an accounting, and appropriate declaratory relief.

**COUNT II**
**UNLAWFUL PREMIUM DIFFERENTIAL – FAILURE TO SATISFY THE NOTICE REQUIREMENTS**
**(Violation of 29 U.S.C. § 1182(b) and 42 U.S.C. § 300gg-4(j)(3)(E); 29 C.F.R. § 2590.702(f)(4)(v))**

70. Plaintiff re-alleges and incorporates herein by reference allegations 1–61 of this Complaint.

71. ERISA prohibits group health plans from charging participants different premiums or contributions based on a health-status-related factor. 29 U.S.C. § 1182(b)(1); 42 U.S.C. § 300gg-4(b)(1). Windstream's tobacco-use surcharge imposes such a differential and is unlawful unless Defendants satisfy every condition of the exception for health-contingent wellness programs. 29 U.S.C. § 1182(b)(2)(B); 42 U.S.C. §§ 300gg-4(b)(2)(B), 300gg-4(j)(3).

72. To qualify for that exception, Defendants were required to disclose the availability of a reasonable alternative standard in ***all*** Plan materials describing the terms of the tobacco-use surcharge. 42 U.S.C. § 300gg-4(j)(3)(E); 29 C.F.R. § 2590.702(f)(4)(v).

73. The required notice must describe the availability of an alternative standard (or waiver, if applicable), provide contact information for obtaining it, and expressly state that the recommendations of a participant's personal physician will be accommodated. 29 C.F.R. § 2590.702(f)(4)(v). The requirement applies to every Plan material that describes the terms of the outcome-based wellness program.

74. Windstream's 2024 Guide describes the tobacco surcharge, its $23.08 biweekly amount, the initial tobacco standard, the Clickotine alternative, and the process for having the surcharge removed. Ex. A at 7, 13. The 2024 FAQ provides the same substantive information,

including the prospective-only term and method of changing tobacco status. Ex. B at 4–5. Neither contains any statement that recommendations from a participant's personal physician will be accommodated in establishing or completing the alternative.

75. The Plan materials also fail to tell participants that completing the cessation alternative entitles them to the same, full reward available to participants meeting the initial standard, including recovery of the surcharge paid before completing the alternative. The 2024 Guide and FAQ say only that the surcharge will be removed prospectively. Exs. A at 7; B at 4–5. A reasonable participant reviewing them would not learn that the Plan must restore the earlier amount to make the annual reward equal.

76. These omissions appear in two widely distributed participant-facing documents that describe the actual terms of the tobacco-surcharge program. The 2024 Guide expressly identifies itself as a Summary of Material Modifications to the Wrap SPD. Ex. A at 27. Thus, the missing personal-physician disclosure is a uniform Plan-disclosure defect, not an isolated omission in an informal reminder.

77. The 2024 Guide provides a generic benefits-center telephone number, and the FAQ describes how to change an enrollment-platform response. But contact information alone does not satisfy the separate requirement that materials describing an outcome-based wellness program also state that a participant's personal-physician recommendations will be accommodated. *See* 29 C.F.R. § 2590.702(f)(4)(v). Further, while the Wrap SPD names a separate Wellness Program Notice, that notice does not contain the physician-accommodation statement and does not excuse the absence of the personal-physician statement from the Guide and FAQ. Ex. C at 63.

78. Had Defendants included the required physician-accommodation statement, Plaintiff and other participants would have known that they could request a reasonable alternative

based on their personal physicians' recommendations and could have taken steps to pursue that option to avoid the surcharge. By omitting that statement, Defendants deprived Plaintiff and similarly situated participants of the information necessary to understand and exercise that right, thereby denying them a meaningful opportunity to pursue a physician-directed alternative.

79. Defendants' failure to provide notice of a *reasonable* alternative standard that makes available the full reward and failure to provide the mandatory physician-accommodation notice independently prevent Defendants from invoking the wellness program exception, regardless of whether they satisfy other regulatory requirements.

80. The resulting tobacco-surcharge differential is an unlawful difference in the cost of coverage based on a health-status-related factor, in violation of 29 U.S.C. § 1182(b) and 42 U.S.C. § 300gg-4.

81. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes Plaintiff and Class members to seek appropriate equitable relief to enjoin Defendants' unlawful practices, redress their violations, and enforce ERISA. Plaintiff and Class members therefore seek restitution, disgorgement, equitable surcharge, an accounting, declaratory relief, and other just and appropriate equitable relief.

## COUNT III
## BREACH OF FIDUCIARY DUTY (PLAN-LEVEL RELIEF)
## (Violation of ERISA §§ 404, 406 and 409, 29 U.S.C. §§ 1104, 1106 and 1109; Brought Under 29 U.S.C. § 1132(a)(2))

82. Plaintiff re-alleges and incorporates herein by reference allegations 1–61 of this Complaint.

83. At all relevant times, the Committee was a Plan fiduciary because the Wrap SPD identifies it as the Plan Administrator and grants it discretionary authority over Plan interpretation,

eligibility, benefit determinations, correction of omissions, and administration. Ex. C at 57, 59; 29 U.S.C. § 1002(21)(A). Windstream acted as a fiduciary to the extent it exercised discretionary control over administration or authority or control over participant contributions or other Plan assets, rather than merely making settlor decisions about Plan design. *Id.*; 29 U.S.C. § 1002(21)(A).

84. ERISA required fiduciary Defendants to act "solely in the interest of participants," with the "care, skill, prudence, and diligence" of a prudent fiduciary, "in accordance with the documents and instruments governing the plan," and to refrain from dealing with Plan assets for their own interests. 29 U.S.C. §§ 1104(a)(1), 1106(b)(1). The Plan's own Wrap SPD separately provides that the Committee will administer the Plan on a reasonable and nondiscriminatory basis and apply uniform rules to similarly situated persons. Ex. C at 59.

85. The Committee exercised discretionary fiduciary authority over the Plan's administration and the preparation, supervision, or delegation of Plan disclosures. The Wrap SPD authorizes the Committee to designate others to prepare and disclose Plan materials while preserving its role as Plan fiduciary except as otherwise specified. Ex. C at 59. Upon information and belief, Windstream exercised authority or control over participant premium contributions deducted from wages and their application to Plan coverage.

86. Participant contributions withheld from wages for a welfare plan become Plan assets as of the earliest date they can reasonably be segregated from the employer's general assets. 29 C.F.R. § 2510.3-102(a)(1), (c). Plaintiff's surcharge was deducted from wages for Plan medical coverage. By administering the additional charge, Defendants caused participants to contribute more of their compensation for the same Plan benefits.

87. Defendants' own Plan documents establish the resulting financial benefit. The Wrap SPD explains that Medical and Wellness benefits are self-insured. Ex. C at 1. Employees

pay their share of Medical coverage on a pre-tax basis; Windstream fixes the level of their contribution. *Id.* at 10–11. The cost of medical coverage is shared. Most significantly, the SPD directs: "Where the Company and employees share the cost of coverage, the Company shall contribute the difference between the amount employees contribute and the amount required to pay benefits under the Plan." *Id.* at 58. Each unlawful $23.08 surcharge shifted a corresponding portion of the coverage cost to a participant and reduced Windstream's contractual funding obligation.

88. That financial benefit supports Plan-wide fiduciary relief under ERISA § 409, 29 U.S.C. § 1109(a). The statute requires a breaching fiduciary to make good Plan losses and separately to restore to the Plan "any profits of such fiduciary which have been made through use of assets of the plan." The claim therefore includes profits arising from use of Plan assets, even if those profits are not identical to a Plan balance-sheet loss. Upon information and belief, Windstream obtained the use and benefit of corporate funds it otherwise would have contributed, including avoided contributions, float, and the time value of those funds.

89. Defendants also breached fiduciary obligations in administering and communicating the tobacco surcharge. The Committee had discretionary authority to interpret Plan rights, correct omissions, and oversee participant disclosures. Ex. C at 59. Yet the 2024 Guide and FAQ informed participants that surcharge removal after completing the cessation alternative would be prospective only and omitted the mandatory statement concerning recommendations of personal physicians. Exs. A at 7, 13; B at 4–5.

90. To the extent Defendants contend that the Plan in fact provided make-whole refunds or a physician-directed alternative through some other process, they failed to prudently communicate those rights in the 2024 materials describing the surcharge. The Guide was expressly

designated a Summary of Material Modifications to the Plan's SPD. Ex. A at 27. Defendants thereby deprived participants of information material to obtaining the full annual reward.

91. Upon information and belief, Defendants failed to conduct a prudent and periodic review of the tobacco surcharge, the handling of participant premium contributions, the Clickotine alternative, and participant communications. They permitted the continuing assessment of higher participant contributions, prospective-only removal, and corresponding corporate savings for Windstream's benefit.

92. Defendants' fiduciary conduct violated ERISA's duties of loyalty and prudence. In administering and overseeing Plan contributions and participant disclosures, Defendants increased the cost borne by participants, allowed Windstream to reduce its own required contribution under the SPD's express formula, and failed to communicate material rights necessary for participants to avoid the surcharge. 29 U.S.C. § 1104(a)(1).

93. Defendants' conduct also constituted prohibited transactions to the extent they exercised fiduciary control over Plan assets for Windstream's benefit. Defendants caused Plan assets to be transferred to or used for the benefit of a party in interest, Windstream, in violation of ERISA § 406(a)(1)(D), 29 U.S.C. § 1106(a)(1)(D). To the extent Windstream was acting in a fiduciary capacity, it also dealt with Plan assets in its own interest in violation of ERISA § 406(b)(1), 29 U.S.C. § 1106(b)(1).

94. As a result of Defendants' breaches, Windstream obtained profits or other financial benefits by increasing contributions deducted from participant wages and retaining corporate funds it otherwise would have contributed toward Plan benefits. The amounts of those avoided expenditures, float, interest, and other benefits are uniquely within Defendants' records and can be calculated through discovery and an accounting.

95. Plaintiff is authorized to bring this representative action on behalf of the Plan under ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2). Under ERISA § 409, 29 U.S.C. § 1109, a breaching fiduciary is liable to restore to the Plan profits made through the use of Plan assets and is subject to such other equitable or remedial relief as the Court deems appropriate. Plaintiff therefore seeks disgorgement and restoration of ill-gotten profits, an accounting, removal or other appropriate fiduciary relief, and all other Plan-wide relief authorized by §§ 1109 and 1132(a)(2).

**COUNT IV**
**BREACH OF FIDUCIARY DUTY (INDIVIDUAL RELIEF)**
**(Violation of ERISA §§ 404 and 406, 29 U.S.C. §§ 1104 and 1106; Brought Under 29 U.S.C. § 1132(a)(3))**

96. Plaintiff re-alleges and incorporates by reference all preceding paragraphs as though fully set forth herein, including allegations concerning Defendants' fiduciary status, the administration of the surcharge and participant contributions, the financial benefit to Windstream, and the failure to communicate the availability of the full reward and a physician-directed alternative.

97. Defendants breached fiduciary duties of loyalty and prudence by administering and communicating the tobacco surcharge for Windstream's financial benefit rather than solely for Plan participants. Plaintiff paid the $23.08 surcharge through his wages while the 2024 Plan materials described only a prospective reduction after completing Clickotine and failed to disclose the physician-accommodation right. Had Plaintiff been informed of that right, he could have consulted his personal physician and sought an appropriate alternative to the cessation program, potentially avoiding the surcharge altogether

98. To the extent Defendants contend that the Plan provided full-year refunds or a physician-directed alternative, they failed to prudently disclose those rights in the materials that

described the surcharge. Plaintiff was not informed in those materials that he could obtain the full reward, that he could involve his personal physician in tailoring an alternative, or that earlier surcharges would be restored.

99. As a result of Defendants' fiduciary breaches, Plaintiff paid more for medical coverage than he would have paid under a lawfully administered tobacco-surcharge program. He was deprived of material information necessary to exercise his rights to a reasonable alternative standard provided by ERISA and to obtain the full reward available to similarly situated participants.

100. Upon information and belief, Windstream retained and used corresponding corporate funds for its own benefit, consistent with the Wrap SPD's formula tying its contribution to the amount paid by participants. Ex. C at 58. Plaintiff lost the use of the amount deducted from his paycheck, while Windstream received the corresponding savings and financial benefit.

101. Pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), Plaintiff and the Class seek appropriate individual equitable relief to redress Defendants' fiduciary breaches, including restitution, equitable surcharge, disgorgement, an accounting, the imposition of a constructive trust or equitable lien over traceable funds or profits, declaratory relief, and other appropriate equitable relief.

## PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays that judgment be entered against Defendants on all claims and requests that the Court award the following relief:

A. An Order certifying this action as a class under Rule 23 of the Federal Rules of Civil Procedure, appointing Plaintiff as Class representative and appointing the undersigned as Class Counsel;

B. A declaratory judgment that the tobacco-use surcharge imposed under the Windstream Services, LLC Welfare Benefit Plan violates ERISA's antidiscrimination provisions, including ERISA § 702, 29 U.S.C. § 1182;

C. An Order requiring Defendants to reimburse or credit Class members for the tobacco surcharges paid as a result of the unlawful premium differential;

D. A declaratory judgment that fiduciary Defendants breached the duties imposed by ERISA § 404, 29 U.S.C. § 1104, by administering the tobacco surcharge and participant premium contributions for Windstream's own financial benefit, failing to prudently review or correct the program, and failing to communicate material rights to participants;

E. An Order requiring Defendants to account for all tobacco-use surcharges assessed and collected, participant contributions attributable to the differential, and any profits or financial benefits obtained from the challenged practices;

F. Appropriate declaratory and injunctive relief, including enjoining unlawful surcharge administration, requiring compliant notices and a reasonable alternative that provides the full annual reward, and directing appropriate changes in Plan administration;

G. Disgorgement of benefits, profits, avoided expenditures, float, interest, investment returns, or other financial benefits realized through the challenged practices and fiduciary breaches;

H. Restitution of amounts Plaintiff and Class members paid for medical coverage because Defendants imposed the unlawful tobacco-use surcharge;

I. Equitable surcharge against appropriate fiduciary Defendants for losses caused by their breaches or unjust enrichment resulting from their administration of the tobacco-surcharge program;

J. Relief to the Plan under ERISA §§ 409 and 502(a)(2), 29 U.S.C. §§ 1109 and 1132(a)(2), including restoration of any profits realized through the use of Plan assets, an accounting, and other appropriate Plan-wide equitable and remedial relief;

K. An award of prejudgment interest on amounts awarded to Plaintiff and the Class, as authorized by law;

L. An award of Plaintiff's attorneys' fees, litigation expenses, and taxable costs pursuant to ERISA § 502(g), 29 U.S.C. § 1132(g), and other applicable authority; and

M. Such other and further relief as the Court deems just and proper.

Dated: November 9, 2026

Respectfully submitted,

/s/ Chris Jennings
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**Pro Hac Vice applications forthcoming*

# EXHIBIT A

# Your Benefits. YOUR LIFE.

## Your 2024 Annual Enrollment Guide



## YOUR ENROLLMENT CHECKLIST

We want you to feel confident in the choices you're making, so Windstream offers easy-to-access resources to help you choose and use your benefits.

- ☐ **Explore your 2024 benefits** and see what's changing, using this guide and other resources on ***windstreambenefits.com***. Take time to review your options and consider your health care needs and personal priorities.
- ☐ **Enroll in your 2024 benefits: Oct. 4 – 18, 2023.** Go to ***windstreambenefits.com*** or call 888.850.1712 to choose the benefits that will support you and your family in the coming year.
- ☐ **Make sure to confirm coverage** by approving your enrollment selections.

*Information in this document pertains to all full-time, U.S.-based employees. Participation in Windstream's benefit plans by employees in bargaining units is subject to the terms of their collective bargaining agreement. Canadian employees should refer to Canada Life for coverage information and* ***windstreambenefits.com*** *for additional information.*

WINDSTREAM

## YOU MUST TAKE ACTION

**You must enroll Oct. 4 – 18, 2023 to have Windstream coverage in 2024.**

If you do not enroll, you will not have access to Windstream medical, dental, vision, or savings or spending accounts coverage in 2024. Once the enrollment window closes on Oct. 18, 2023, changes to benefits enrollment will only be allowed following a life event, such as marriage, divorce, birth of a child, or change in status (such as gain or loss of non-Windstream coverage).

Health care is personal, and what you need from your medical plan can differ from one year to the next. Annual Enrollment is your once-a-year opportunity to stop, reflect, and enroll in the benefits that will be with you in the moments that matter.

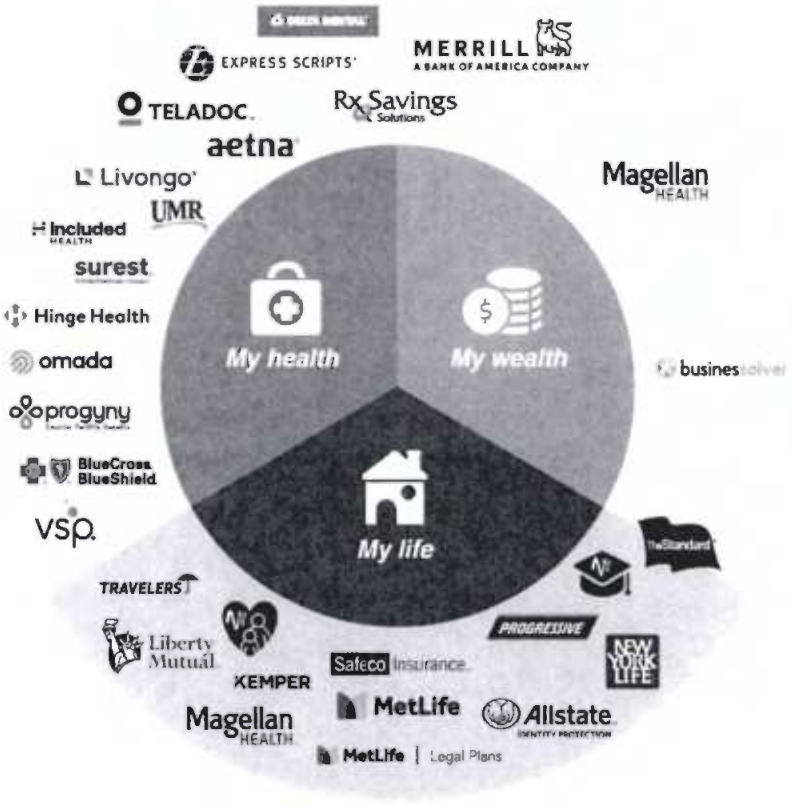


# YOUR BENEFITS AT A GLANCE

| BENEFIT | KEY HIGHLIGHTS | PAGE |
|---|---|---|
| **New for 2024** | • You will have the opportunity to enroll in a new medical plan, the Surest Choice Plan. This plan features no deductible or coinsurance and you pay a copay, or set dollar amount, for all covered services from day one. With the Surest Choice Plan, you have the option to enroll in a Health Care Flexible Spending Account (FSA) to save money on eligible healthcare expenses. You are not eligible to enroll in a Health Savings Account (HSA) | 2 |
| **Medical** | • Five plan options and choice of three carriers, Blue Cross Blue Shield, UMR and Surest | 4 – 10 |
| **Prescription** | • Prescription coverage is provided through Express Scripts for all Windstream medical plans<br>• Additional prescription savings possible through RxSavings Solutions | 11 |
| **Supplemental medical** | • In order to offer benefits that are relevant and valuable, we continually evaluate our plans and administrators to ensure they meet the needs of our employees and support the company's benefits strategy. Beginning in 2024, we are partnering with Aetna to administer our supplemental medical plans. You will continue to have three options: accident, critical illness and hospital indemnity insurance | 12 |
| **Well-being** | • Programs and resources to help you and your family live healthier, happier and more fulfilling lives | 13 – 14 |
| **Dental** | • Three plan options from Delta Dental | 15 |
| **Vision** | • Two plan options from VSP | 16 |
| **Health Savings and Spending Accounts** | • If you enroll in a Windstream medical plan and an HSA, Windstream will contribute up to $600 into your HSA to help cover your out-of-pocket expenses<br>• If you are not eligible for an HSA, or choose not to enroll in an HSA, you can enroll in a Health Care FSA<br>• Per IRS limits, the amount you are allowed to rollover in your FSA is $610 in 2024 | 17 – 18 |
| **Life and accident insurance** | • Company-provided life and AD&D insurance as well as additional supplemental options | 19 |
| **Disability insurance** | • Company-provided short-term and long-term disability | 20 |
| **Additional voluntary benefits** | • 401(k), identity theft protection, pet insurance, auto & home insurance and a legal plan | 21 |

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the creditable prescription drug coverage and Medicare notice in the legal notices at the back of this booklet for more details.

# WELCOME TO YOUR 2024 BENEFITS




Windstream is committed to helping you and your family be healthy so that you can make the most of your life – at work, at home and in your community.

Providing access to a variety of valuable benefits that support your overall well-being is an important part of that commitment.

Our benefits fall into these three categories:

| MY HEALTH: to fit your budget and keep you healthy | MY WEALTH: to invest in yourself now and in the future | MY LIFE: to protect those you love and manage personal priorities |
|---|---|---|
| • Medical (BCBS, UMR, Surest)<br>• Prescription Drug Program (Express Scripts)<br>• Dental (Delta Dental)<br>• Vision (VSP)<br>• Personal Health Care Assistance (Included Health and Surest)<br>• Digital/Virtual Physical Therapy (Hinge Health)<br>• Hospital Indemnity (Aetna)<br>• Accident (Aetna)<br>• Critical Illness (Aetna)<br>• Virtual visits for primary care, urgent care and mental health (Teladoc)<br>• RxSavings Solutions<br>• Tobacco Cessation Program (Magellan-Clickotine)<br>• Weight Management Programs (Omada)<br>• Diabetes and Hypertension Program (Livongo)<br>• Fertility Benefits (Progyny)<br>• BetterHelp (Magellan-mental health)<br>• myStrength (Magellan-mental health) | • Health Savings Account (Businessolver)<br>• Health Care Flexible Spending Account (FSA) (Businessolver)<br>• Daycare/Eldercare FSA (Businessolver)<br>• Commuter FSA (Businessolver)<br>• 401(k) Plan (Merrill)<br>• NextGen College Investing Plan (Merrill)<br>• Financial Well-being (Merrill, Magellan) | • Basic Group Life and Accidental Death & Dismemberment (AD&D), and Life and Accident Insurance (Standard Insurance Company)<br>• Short-Term and Long-Term Disability Insurance (New York Life)<br>• Employee Assistance Program (Magellan)<br>• Legal Plan (MetLife)<br>• Identity Theft Protection (MetLife)<br>• Pet Insurance (MetLife)<br>• Choice Auto & Home Insurance (Liberty Mutual, Farmer's GroupSelect℠, Kemper, Safeco, Travelers, Progressive)<br>• Adoption Assistance<br>• REACH Educational Assistance<br>• Parental Leave |

# WHAT'S NEW IN 2024?



## NEW MEDICAL PLAN OPTION

Your Windstream benefits are designed to give you meaningful choice, with options that are relevant and valuable. For 2024, we are piloting a new type of medical plan, the Surest Choice Plan. This plan features no deductible or coinsurance, and you pay a copay, or set dollar amount, for all covered services from day one. You'll have resources to compare provider costs and treatment options in advance—so you can make the best choice for your needs. We believe the Surest Choice Plan can provide high-quality coverage and simplified healthcare experiences at a lower cost for both you and the company.

## HIGH-QUALITY CARE FOR BARIATRIC SURGERY

If your doctor recommends bariatric surgery, your out-of-pocket costs may be lower when you visit a designated Blue Distinction Center provider from the BCBS network or a Bariatric Resource Services Center from the UMR and Surest networks. These providers meet high quality and cost standards and are evaluated on their performance to ensure you receive the best available care in order to improve and maintain your health. A care coordinator from Included Health or Surest is available to help you find a preferred provider.

Windstream's medical plans provide travel and lodging benefits if a designated provider is not available within 100 miles of your home. Travel benefits provide reimbursement of up to $5,000 of eligible expenses annually and apply to bariatric surgery in addition to all other procedures that are covered under our medical plans.

## INTRODUCING VIRTUAL PRIMARY CARE

Virtual care will be expanded to include primary care, regardless of your medical carrier. You can get convenient and confidential access to primary care or medical treatment for a non-emergency condition like a cold, allergies, infection or rash and even get a prescription sent to your local pharmacy. All providers have experience building relationships with patients in a primary care setting and can provide ongoing care for chronic conditions, order lab work and screenings or vaccinations and refer you to in-network specialists, if needed. For all Windstream medical plans, virtual visits have a set fee for services – whether or not you've met your deductible. Note, the set fee does not apply to virtual visits with your local doctor.

You also have access to Teladoc's urgent care and mental health services. With Teladoc, you have 24/7 access to a doctor by phone, video or app from anywhere. Licensed therapists and psychiatrists can be added to your care team for video sessions and can also support your teenage children (ages 13-17) with school stress, family challenges and more.

## MEDICAL PLAN CHANGES

The 3000 HDHP Plan will become the 3200 HDHP Plan, and the individual deductible will increase to $3,200. This change is due to annual IRS updates on deductible levels to maintain an individual embedded deductible feature.

## INCREASING ORTHODONTIA BENEFITS

In the Enhanced dental plan, we are increasing the lifetime maximum orthodontia benefit to $2,000. The increased benefit will apply to employees and covered dependents with in-progress treatment, as well as those who have not started treatment yet.

## ENHANCEMENTS TO VISION COVERAGE

As an alternative to prescription glasses or contacts, you and your dependents can choose to use a $200 allowance towards non-prescription sunglasses or non-prescription blue light filtering eyewear from a VSP network doctor. This allows you to take advantage of the frame allowance benefit even if you do not need prescription glasses or contacts in a calendar year.

## MEDICAL PLAN PREMIUMS

To keep our plans competitive and sustainable, we review the healthcare costs shared by Windstream and our employees each year. Healthcare is a significant investment we make in our employees, and we must balance that investment with others that support our business. As a result of rising U.S. healthcare costs, our 2024 medical plan and dental plan premiums will increase. Your individual increase will depend on your plan and who you cover. All other benefit plan premiums remain unchanged.

You play an important role in sharing costs with Windstream by making smart choices to manage your health and your healthcare expenses. From proactively seeking preventive care to using virtual care, when appropriate—your actions can lead to lower claims costs, which translates to lower out-of-pocket costs for you and Windstream.



# MEDICAL



## SUMMARIES OF BENEFITS AND COVERAGE

You have access to a Summary of Benefits and Coverage (SBC) for each of your Windstream medical plan options. These documents provide detailed information about coverage and costs to help you compare plans and make informed decisions. To access the SBCs, visit ***windstreambenefits.com***.

*Information in this document pertains to all full-time, non-bargaining, U.S.-based employees. Participation in Windstream's benefit plans by employees in bargaining units is subject to the terms of their collective bargaining agreement.*

## 2024 MEDICAL PLAN OPTIONS

Windstream offers you a choice of medical plans with a range of coverage levels and costs, giving you the flexibility to select the option that is best for you.

### What is included?

Most of the features below are included in all Windstream medical plans. The Surest Choice Plan has no deductible or coinsurance.

1. **Your choice of carriers – Blue Cross Blue Shield (BCBS), UMR or Surest.** See *page 5* for more details.
2. **Prescription drug coverage.** Coverage for prescription medications comes with each plan and is provided by Express Scripts. Specialty medications are provided by Accredo, a subsidiary of Express Scripts. You can also take advantage of RxSavings Solutions as a resource to potentially save money on prescriptions. See ***page 11*** for more details.
3. **Free in-network preventive care.** Services such as annual physicals, immunizations and routine screenings are fully covered at 100%. That means you pay nothing for those services.
4. **Annual deductible.** You pay for initial medical and prescription drug costs until you meet your annual deductible. This may be the full cost of the service or prescription on an HDHP plan or the copay if applicable on the 4000 Copay Plan. In the 4000 Copay Plan, your copay costs do not count towards meeting your deductible.
5. **Coinsurance.** After meeting your deductible, you pay a percentage of eligible costs through coinsurance, then the plan pays the rest. ***Keep in mind: With the 1850 HDHP Plan – per IRS regulations – coinsurance for any person covered under an employee plus dependent plan begins only after the entire family deductible has been met. This means you will have to pay $3,700 to meet the deductible.***
6. **Telemedicine.** You have 24/7 access to doctors through phone, video or mobile app visits. This service is available in all states. Set up your account so when you need care, a doctor is just a call or click away. See ***page 10*** for more details.
7. **Tax-saving opportunity.** If eligible, you can contribute to an HSA on a before-tax basis to help pay for your eligible out-of-pocket health care costs – in 2024 and in the future. Your HSA funds roll over year after year; they are always yours to keep! In 2024, Windstream will contribute up to $600 tax free to your HSA, deposited over the course of the year (per pay period).

   If you enroll in a Windstream medical plan and do not meet HSA eligibility requirements, or choose not to enroll in one, you can still enroll in a Health Care Flexible Spending Account (FSA).
8. **Out-of-pocket maximum.** Each plan protects you by capping the total amount you will pay each year for in-network medical care. Once you meet your out-of-pocket maximum, the plan pays 100% of your eligible expenses for the rest of the year. Medical premiums are not included in the out-of-pocket maximum.
9. **Expert medical guidance.** A team of care coordinators can provide personalized medical support, connect you with trusted doctors and specialists, give you a list of questions to ask your physician, schedule appointments for you and answer your questions.

# COMPARE THE PLANS

If you enroll in the 1850 HDHP Plan, 3200 HDHP Plan, 6550 HDHP Plan or the 4000 Copay Plan, these plans are offered through your choice of Blue Cross Blue Shield (BCBS) or UMR. In each state, one carrier has a lower cost than the other, referred to as Carrier 1. This represents the larger discount that doctors and facilities have with one carrier over the other in a state. No matter which Windstream medical plan you choose, the benefits covered by each option are the same.




The Surest Choice Plan uses a single carrier; your network will be the UnitedHealthcare Choice Plus network, which is the same network as UMR.

All plans cover in-network preventive care such as blood pressure and cholesterol tests, mammograms, colonoscopies, screenings for osteoporosis, vaccines and well-woman visits – all at no cost to you! Be sure to follow the recommended age guidelines outlined in the medical summary plan description when scheduling your preventive care.

## Carrier 1 by State (Lower Premium)

| | |
|---|---|
| **BCBS** | AL, AK, AZ, CA, DC, DE, GA, HI, IA, ID, IL, IN, KY, LA, MA, ME, MI, MT, NC, ND, NV, NY, OH, PA, SC, SD, TX, UT, VA, VT, WV, WY |
| **UMR** | AR, CO, CT, FL, KS, MD, MN, MO, MS, NE, NH, NJ, NM, OK, OR, RI, TN, WA, WI |
| **Surest** | Offered in all states |





## EXPERT MEDICAL GUIDANCE

Navigating the health care system can be frustrating and complicated. If you are enrolled in a Windstream medical plan, you have access to expert health care assistance to help you save time, money, and worry. From basic checkups to chronic conditions, connect with a team of medical professionals, record specialists, and care coordinators to arrive at the best possible solution for you and your family.

Care coordinators can help you focus on your health when you need:

- **Expert second opinion.** A leading specialist can provide their expert medical opinion and answer your questions about a medical diagnosis, chronic condition, treatment, or surgery.
- **Information.** Get questions answered about your medical plan, including what's covered.
- **Guidance.** Manage claims, track progress towards meeting your deductible and fix billing errors.
- **Answers.** Get personalized health care recommendations for any new or existing condition.
- **Doctors.** Find trusted, in-network doctors and specialists that match your preferences.
- **Clarity.** Understand your health benefits and when to use them.

### Care Management Support

If you have a serious injury or medical diagnosis, your medical plan provides you with personalized support to help you coordinate the full-spectrum of Windstream benefits available and guide you through a care plan.

A care team member will contact you directly via phone to help you get the right care, so you can:

- Find providers with a proven record of higher quality, efficiency, and effectiveness
- Connect with an experienced registered nurse who assist with your specific care needs
- Manage costs by taking care of your health before your condition becomes more complex and expensive to treat

If your medical carrier is BCBS or UMR, these services will be provided through Included Health. If you enroll in the Surest Choice Plan, these services will be provided through their member services team. See ***page 25*** for contact information.

# COMPARE YOUR COSTS

## Your 2024 medical plan costs

| Bi-weekly premiums | 1850 HDHP Plan | 3200 HDHP Plan | 6550 HDHP Plan | 4000 Copay Plan | Surest Choice Plan |
|---|---|---|---|---|---|
| **Carrier 1** | | | | | |
| Employee only | $129.34 | $72.77 | $52.98 | $79.14 | $71.78 |
| Employee + spouse | $323.57 | $182.15 | $132.67 | $198.06 | $179.68 |
| Employee + children | $226.36 | $127.37 | $92.73 | $138.51 | $125.64 |
| Employee + family | $382.68 | $215.24 | $156.65 | $234.08 | $212.32 |
| **Carrier 2** | | | | | |
| Employee only | $155.89 | $94.90 | $73.57 | $101.77 | |
| Employee + spouse | $389.94 | $237.48 | $184.14 | $254.63 | |
| Employee + children | $272.82 | $166.10 | $128.77 | $178.11 | |
| Employee + family | $461.26 | $280.75 | $217.60 | $301.06 | |

*Due to rounding, some costs may vary by a cent in the enrollment system versus what's printed above. The premium cost in the enrollment system will be the amount that is payroll deducted.*

## Spousal surcharge

When reviewing the costs for medical coverage, keep in mind that Windstream has a spousal surcharge of $46.15 per pay period. The spousal surcharge is applied if your spouse has coverage available through his/her employer but chooses to be on a Windstream medical plan. The surcharge does not apply if your spouse is not offered medical coverage through their employer, is not employed, or if your spouse is also employed by Windstream.

## Tobacco use surcharge

A $23.08 per pay period surcharge will be applied to each employee and/or spouse who uses tobacco products, including e-cigarettes and vaping, and has not completed the tobacco cessation program. During Annual Enrollment, you will be asked to attest to your tobacco status and that of your enrolled spouse (if applicable). By completing the Clickotine tobacco cessation program described on page 13, or by stopping your use of any tobacco products, the surcharge can be removed prospectively during the year by calling **888.850.1712**.

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# MEDICAL (CONTINUED)

| In-network benefits | 1850 HDHP Plan | 3200 HDHP Plan | 6550 HDHP Plan | 4000 Copay Plan | Surest Choice Plan |
|---|---|---|---|---|---|
| **Health Savings Account eligibility** | | | | | |
| Eligible for a Health Savings Account per IRS regulations | Yes | Yes | Yes | No | No |
| Windstream Health Savings Account annual contribution | $600 | $600 | $600 | n/a | n/a |
| **Annual limits** | | | | | |
| ***Individual coverage*** | | | | | |
| Deductible | $1,850 | $3,200 | $6,550 | $4,000 | n/a |
| Out-of-Pocket Maximum | $3,500 | $5,500 | $6,550 | $6,550 | $7,000 |
| ***Employee + Spouse, Employee + Child(ren), and Employee + Family coverage*** | | | | | |
| Embedded Individual Deductible* | n/a | $3,200 | $6,550 | $4,000 | n/a |
| Family Deductible | $3,700 | $6,400 | $13,100 | $8,000 | n/a |
| Embedded Individual Out-of-Pocket Maximum* | n/a | $5,500 | $6,550 | $6,550 | $7,000 |
| Family Out-of-Pocket Maximum | $6,500 | $11,000 | $13,100 | $13,100 | $14,000 |
| **What you pay for medical services** | | | | | |
| Preventive care | $0 | $0 | $0 | $0 | $0 |
| Office visit and virtual care | 20% coinsurance, after deductible is met | 30% coinsurance, after deductible is met | 0% coinsurance, after deductible and out-of-pocket maximum are met (which are the same) | $40 copay | $20 – $125 copay |
| Specialist visit | | | | $80 copay | $20 – $125 copay |
| Fertility treatments | | | | 30% coinsurance, after deductible is met | Office visit: $250 copay Smart Cycles: $500 - $2,000 copay |
| Urgent care visit | | | | $50 copay | $110 copay |
| Emergency room visit | | | | $300 copay and 30% coinsurance | $1,000 copay |
| Hospital, laboratory, X-ray | | | | 30% coinsurance | $200 – $1,150 copay |

** With an embedded deductible or out-of-pocket maximum, a single member of your family can meet the embedded amount – and enter the coinsurance phase or have the plan begin paying 100% of costs for that covered person – without all covered members reaching the full plan deductible or out-of-pocket maximum. The 1850 HDHP Plan does not meet the IRS requirements to have an embedded deductible or out-of-pocket maximum.*

## IMPORTANT INFORMATION ABOUT THE 4000 COPAY PLAN

- When you pay a copay for medical services, that amount does not count towards meeting your deductible. However, your copays do apply towards meeting your out-of-pocket maximum.
- In the event of an emergency room visit, you will pay both the $300 copay plus the 30% coinsurance for hospital services, after you've met your deductible. Generally, you pay 100% of the costs from providers until you meet the deductible and then coinsurance will apply.

## Which medical plan is right for me?

### AN HDHP PLAN

With an HDHP Plan, you'll pay the full cost of covered services before you meet the deductible. After you meet the deductible, you and the plan share the cost of services through coinsurance. This plan allows you to contribute tax-free to a Health Savings Account (HSA), and also receive a contribution from Windstream. These pre-tax contributions can be used to pay for qualified eligible out-of-pocket medical expenses, like doctor visits or prescriptions before you meet deductible – and even dental and vision care. Money in your HSA rolls over year after year, so if you know about future expenses – or if you want to save for your health care costs in retirement – you can set aside a little extra each paycheck so your balance grows over time.

### A COPAY PLAN

A Copay Plan offers clear, predictable costs when you need routine care. You'll pay a copay, or set dollar amount, for most services before you meet your deductible. This includes care such as primary care physician and specialist office visits, and prescription medications. This means you'll know exactly what's covered and how much it will cost you. For non-routine care, you'll pay the full cost of covered services before you meet the deductible. **Your copay costs do not count towards meeting your deductible, but they do apply towards your out-of-pocket maximum.** After you meet the deductible, you and the plan share the cost of services through coinsurance.

### SUREST CHOICE PLAN

The Surest Choice Plan is designed to give you more control of your cost and coverage. Just like with the 4000 Copay Plan, you'll pay a copay when you receive routine care. However, with the Surest Choice Plan, there are no deductibles to meet and no coinsurance for services. Copays are based on the quality and cost-effectiveness of each provider, and they are known in advance. You'll pay lower copays for providers with a proven record of higher quality, efficiency and effectiveness. With Surest, you have access to the UnitedHealthcare Choice Plus network of doctors, clinics, and hospitals—this is the same network used by Windstream's UMR plans.

Using the Surest app or website, you'll see clear prices for treatments, doctors and prescription drugs so you can compare options and make informed decisions. In addition, the Surest Choice Plan comes with a supportive Help Team and online tools that provide instant answers to coverage questions, from cost and treatment to finding the doctors and clinics you need. Want to learn more about how the Surest Choice Plan works? Check out ***britehr.app/windstream-2024*** for quick and simple explanations of cost and coverage under the Surest Choice Plan.





**VIRTUAL VISITS**

Teladoc virtual visits have a set fee for services – whether or not you've met your deductible.

# CONNECT WITH YOUR DOCTOR, TODAY

## Find a doctor

Using in-network providers saves you money. You can easily find doctors in your medical plan network by visiting your provider's website or contacting a benefits counselor once the enrollment window opens:

**Blue Cross Blue Shield and UMR**

To find a high quality in-network provider, you have a few options:

- Visit *includedhealth.com/windstream*
- Call **855.524.8426** to talk to a Care Coordinator
- Download Included Health app from your app store

**Surest**

1. Visit *join.surest.com/windstream* and enter code: **Windstream2024**
2. Select Search Coverage
3. Confirm your zip code
4. Enter your doctor's name, facility or specialty in the keyword search

## See a doctor from anywhere, anytime with telemedicine

All Windstream medical plans provide 24/7 access to doctors through phone, video or mobile app visits. This service is available in all states. Set up your account today so that when you need care, a doctor is just a call or click away. Visit *windstreambenefits.com* to learn more about costs.

**Surest:**
Visit *join.surest.com/windstream* and enter code: **Windstream2024**

**BCBS and UMR:**
Visit *teladoc.com* or call **800.teladoc (835.2362)**

# PRESCRIPTION

## EXPRESS SCRIPTS

Express Scripts will provide prescription coverage and is included with each of the Windstream medical plans.

| Prescription Plan Rates | 2024 PLANS | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1850 HDHP Plan | | 3200 HDHP Plan | | 6550 HDHP Plan | | 4000 Copay Plan | | Surest Choice Plan | |
| | Preventive Rx (see IRS list) | All Other Rx | Preventive Rx (see IRS list) | All Other Rx | Preventive Rx (see IRS list) | All Other Rx | Preventive Rx (see IRS list) | All Other Rx | Preventive Rx (see IRS list) | All Other Rx |
| Before Deductible is Met | You pay coinsurance (20%) | You pay 100% | You pay coinsurance (30%) | You pay 100% | You pay coinsurance (30%) | You pay 100% | Generic: $20 copay<br>Preferred Brand: $60 copay<br>Non-Preferred Brand: $120 copay | | Generic: $20 copay<br>Preferred Brand: $60 copay<br>Non-Preferred Brand: $120 copay | |
| After Deductible is Met | You pay coinsurance (20%) | You pay coinsurance (20%) | You pay coinsurance (30%) | You pay coinsurance (30%) | You pay 0% | You pay 0% | | | | |
| After Out-of-Pocket Max is Met | You pay 0% | You pay 0% | You pay 0% | You pay 0% | You pay 0% | You pay 0% | You pay 0% | You pay 0% | You pay 0% | You pay 0% |

** Certain medications are defined by the IRS as preventive. A complete preventive medication list is available at windstreambenefits.com.*

### Your costs are capped when you use in-network providers

Your medical plan's out-of-pocket maximum includes prescription costs. If you reach the out-of-pocket maximum, Windstream pays 100% of your prescription costs for covered medications for the rest of the year. All prescription costs filed with your insurance card will apply toward meeting your out-of-pocket maximum.

### Ways to lower your prescription costs

Before you fill a prescription:

- Ask your doctor about your options. Generic prescriptions are usually less expensive than name brand medications.
- Consult with your pharmacist about the cost, as many retailers offer generic discount programs that may save you more.
- Research the cost of prescriptions by logging in to your Express Scripts account at ***express-scripts.com***.
- Take advantage of **RxSavings Solutions** at ***myrxss.com***, a free price comparison online tool accessible through your computer or mobile device that can show your potential prescription savings.
- Check if your pharmacy is in-network using the Express Scripts app or visiting ***express-scripts.com***.
- In addition to using the mail order service for your long-term prescriptions, you can also receive a 90-day supply of medication at the same cost as mail order through your local Walgreens pharmacy.

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# SUPPLEMENTAL MEDICAL

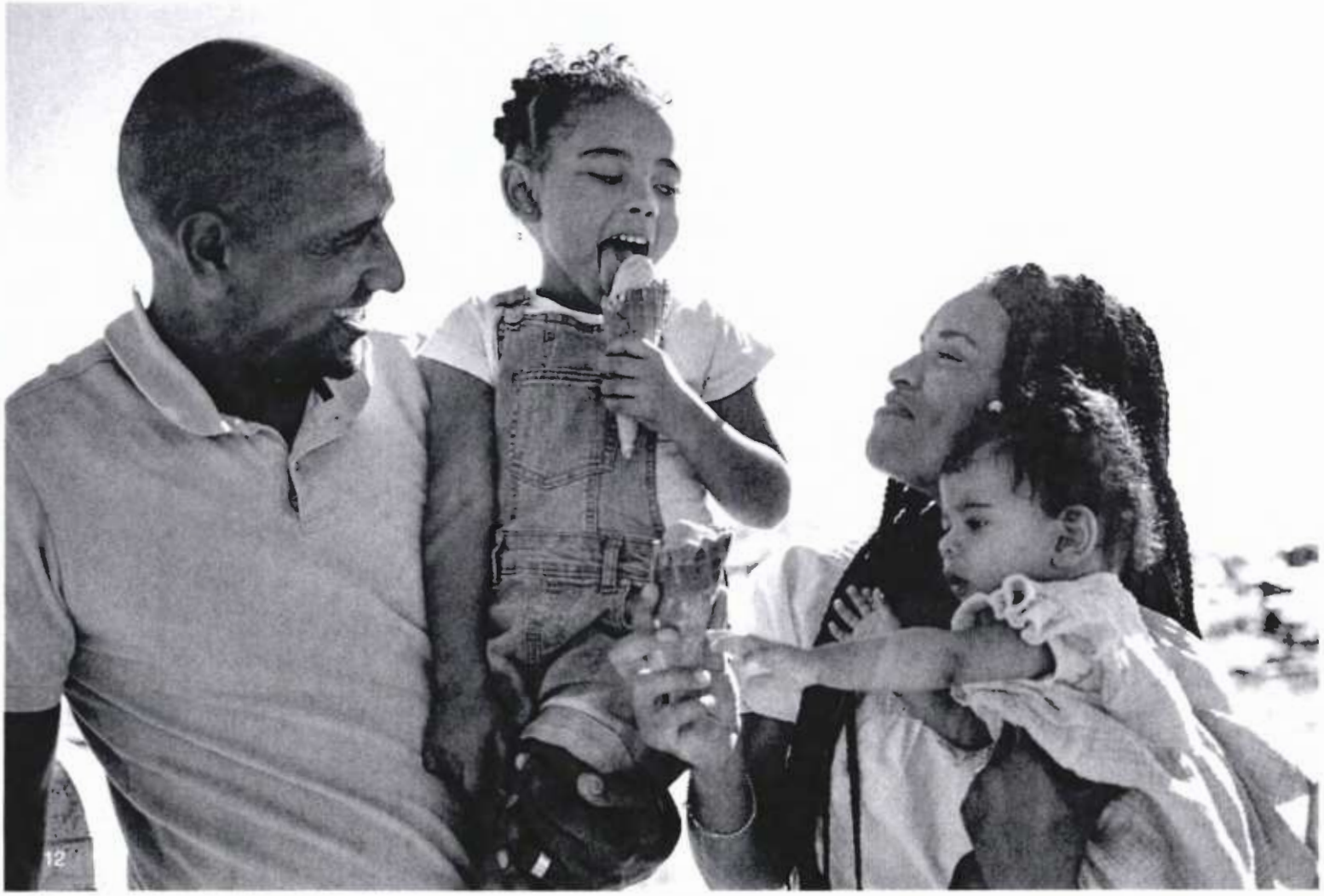
## VOLUNTARY INSURANCE OPTIONS THROUGH AETNA

Supplemental medical plans help protect you from certain expenses, which may not be covered by your primary medical plan. You pay the full cost of coverage through after-tax payroll deductions. Be sure to consider your anticipated medical needs for the coming year – for example, a major surgery – when deciding if supplemental coverage is right for you.

**Keep in mind:** Supplemental medical plans are intended to work with a primary medical plan. They do not provide medical coverage and do not, on their own, meet health care reform requirements.

Windstream offers three different types of supplemental medical plans. You can choose any combination of the following and enrollment in a Windstream medical plan is not necessary to enroll in a supplemental medical plan:

- **Hospital indemnity insurance**. Provides cash payments for hospital stays (due to childbirth, illness, injury, etc.) that you can use to cover expenses your medical plan does not cover, such as deductibles, coinsurance and other out-of-pocket costs.
- **Accident insurance**. Provides cash benefits in cases of eligible accidental injuries to help pay for uncovered medical expenses, such as your deductible or coinsurance, or for ongoing living expenses.
- **Critical illness insurance**. Protects against the financial impact of certain illnesses, such as a heart attack or cancer. You receive a lump-sum cash benefit, which can be used to pay for your treatment costs or for everyday living expenses like housekeeping services, special transportation services and daycare.



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# SUPPORTING YOUR PHYSICAL WELL-BEING

For Windstream, healthy employees equal a healthy company. To meet the needs of our diverse workforce, we provide enhanced support to those with specific care needs such as fertility, diabetes, weight management, back and joint pain and more. These programs help make it easier to take care of your health and financial well-being.

*Note: If you are enrolled in the Surest Choice Plan, these health programs may be offered by different providers through your medical plan.*

## Clickotine

Clickotine is a digital tobacco cessation program that can help you gradually master the habits you'll need to quit smoking and sustain long term healthy living. It includes helpful tools like quit aids, mindful breathing and journaling, as well as:

- Eight weeks of Nicotine Replacement Therapy (gum, patch or lozenge)
- Support tools
- Trigger tracking
- Vaping module

## Hinge Health

Hinge Health is a no cost digital physical therapy program that helps you overcome chronic back, knee, hip, neck or shoulder pain without drugs or surgery. Hinge Health accomplishes this by uniquely delivering education and exercise therapy to promote long-term success and to avoid unnecessary surgeries – all from the comfort of your home. Hinge Health provides access to a free tablet, wearable sensors and a personal coach in addition to exercise therapy tailored to your condition and a personal care team of experts. You can get help for:

- Conquering pain or limited movement
- Recovering from a recent or past injury
- Preparing for and recovery from surgery
- Getting a second opinion on your treatment plan

Visit ***hingehealth.com/windstream*** to get started.

## Livongo

Livongo offers no cost diabetes and hypertension support for employees and spouses who are enrolled in a Windstream medical plan and meet clinical requirements. When you enroll in either program you will receive:

- The latest technology to simplify living with diabetes and/or hypertension
- Real-time support from health coaches
- Unlimited test strips and lancets with the diabetic program

## Omada

A clinical weight management program is available at no cost to employees, spouses and dependents who are enrolled in a Windstream medical plan and meet clinical requirements. Get started by calling Omada at **888.409.8687**.

## Progyny

Progyny specializes in offering families a variety of options in fertility treatment – with proven success. With over 600 clinics, Progyny offers a wide network of specialists. Available to those who enroll in a Windstream medical plan, Progyny will coordinate with your medical and pharmacy benefits. Coverage is subject to the deductible and coinsurance, or copay based on your Windstream medical plan. See ***page 8*** for more details.

## Quest Biometric Screening

A biometric screening helps you track changes in your health each year and detect potential health risks such as diabetes, high blood pressure and heart disease. Know your numbers — including blood pressure, cholesterol, glucose and BMI — by visiting local designated labs or through your doctor's office if you are enrolled in a Windstream medical plan. Employees and spouses who enroll in a Windstream medical plan are encouraged to complete the confidential biometric screening. Visit ***windstreambenefits.com*** to learn more.

# WELL-BEING (CONTINUED)

## SUPPORTING YOUR MENTAL WELL-BEING

We recognize that emotional well-being is a cornerstone of living a balanced life. Everything from making plans for big life changes to managing day-to-day issues can impact our well-being. At Windstream, we look beyond traditional benefits and experiences to provide you with innovative support to manage your life, cope with stress, and make getting help more convenient.

These virtual resources are aimed at normalizing the need for professional help and making support more accessible for you and your family — whether it's learning new strategies to improve your mental health, setting you up with a licensed counselor you can talk to one-on-one, or connecting you to like-minded people simply to remind you that you're not alone.

### Your Windstream medical plan

Your BCBS, UMR or Surest medical plan provides comprehensive coverage for behavioral health concerns and support for dealing with certain conditions, through in-person and telemedicine providers. You can schedule visits with a therapist or psychiatrist for challenges like depression, anxiety, stress, and many others. You also have access to high-quality facilities for substance use and/or eating disorders. If you're enrolled in a BCBS or UMR plan, visit ***arkansasbluecross.com/members/behavioral-health/behavioral-health-resources*** and ***teladoc.com*** for more information. If you're enrolled in the Surest Choice Plan, visit ***join.surest.com/windstream*** (the first time you log in, you will need to enter code: Windstream2024).

### Expert medical guidance

Your BCBS, UMR, or Surest medical plan connects you to a team of specialists who will personally help you find trusted, in-network providers focused on mental health, answer questions about care or your Windstream benefits, and provide the support and advocacy you need and deserve. See page 25 for contact information for your medical plan carrier.

### Employee Assistance Plan (EAP)

EAP provides confidential support, online information and counseling on topics like well-being services, suicide prevention, legal assistance, financial coaching, identity theft resolution and work-life services. EAP services are available to all employees and family members regardless of enrollment in a Windstream medical plan. For more information visit ***member.magellanhealthcare.com***.

### BetterHelp

This app provides you access to a counselor by text message, phone, chat or video conference. Through this program, you have access to 5 pre-paid counseling sessions lasting 30-60 minutes. Text messaging is in addition to live, scheduled sessions for continuity of care in between sessions. Download the BetterHelp app from your app store.

### myStrength

The self-care program through the myStrength app can help you reduce stress, manage depression, control anxiety, be more mindful, and more. The app provides support through personalized self-guided tools, content and videos. To get started, visit ***member.magellanhealthcare.com***, click on "Explore," then find the "Self Care Programs" icon. Click on the "Get Started" button to register, then you can download the myStrength app.



# DENTAL

## DELTA DENTAL

You have a choice of three dental plans through Delta Dental. While you can choose any dental provider you want, you will save through reduced contract fees when you see an in-network dentist. Delta Dental will not mail you an ID card. Your provider can find your coverage online. To search for providers in the Delta Dental network, go to ***deltadentalar.com***. You can also download an ID card if you like to carry one with you.

| 2024 DENTAL PLANS | | | |
|---|---|---|---|
| | **Basic Plan** | **Standard Plan** | **Enhanced Plan** |
| Calendar Year Maximum | $750 | $1,500 | $2,000 |
| Annual Deductible (individual/family) | $50/$150 | $50/$150 | $50/$150 |
| **Plan coverage for in-network services** | | | |
| Preventive & Diagnostic Care | 90% | 100% | 100% |
| Basic Restorative Care | 70% | 80% | 80% |
| Major Restorative Care | Not covered | 50% | 50% |
| Orthodontia Expenses | Not covered | Not covered | 50% (up to $2,000 lifetime maximum) |
| TMJ Expenses | Not covered | 50% | 50% |
| Surgical Implants | Not covered | 50% | 50% |

| 2024 DENTAL PREMIUMS – Per Bi-Weekly Pay Period | | | |
|---|---|---|---|
| **Delta Dental** | **Basic** | **Standard** | **Enhanced (Orthodontia)** |
| Employee Only | $5.71 | $12.71 | $13.48 |
| Employee & Spouse | $10.69 | $25.80 | $29.18 |
| Employee & Children | $10.15 | $22.21 | $25.05 |
| Family | $16.93 | $39.67 | 44.61 |

*Due to rounding, some costs may vary by a cent in the enrollment system versus what's printed above. The premium cost in the enrollment system will be the amount that is payroll deducted.*



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# VISION



## VSP

You have the choice of two vision plans through VSP – a Materials Only Plan and an Enhanced Plan. You will not receive an ID card from VSP. Your provider can find your coverage online. To search for providers in the VSP network, go to *vsp.com*.

| 2024 VISION PLANS | | |
|---|---|---|
| | **Materials Only** | **Enhanced** |
| **Your in-network costs** | | |
| Exam (once every 12 months) | Not covered | $10 copay |
| Materials | $10 copay | $10 copay |
| Lenses | Every 12 months | Every 12 months |
| Frames | Every 12 months | Every 12 months |
| Contact Lenses (in lieu of glasses) | Every 12 months | Every 12 months |
| Frame Allowance | $200 | $200 |
| Contact Lens Allowance (in lieu of glasses) | $200 | $200 |
| Non-Prescription Eyewear Allowance (in lieu of glasses or contacts, from a VSP network doctor) | $200 | $200 |

**The Materials Only Plan does not cover exams.** As the name implies, the Materials Only Plan covers either contact lenses or frame lenses.

| 2024 VISION PREMIUMS – Per Bi-Weekly Pay Period | | |
|---|---|---|
| **VSP** | **Materials Only** | **Enhanced** |
| Employee Only | $2.35 | $5.47 |
| Employee & Spouse | $3.63 | $8.45 |
| Employee & Children | $3.70 | $8.63 |
| Family | $5.97 | $13.92 |

*Due to rounding, some costs may vary by a cent in the enrollment system versus what's printed above. The premium cost in the enrollment system will be the amount that is payroll deducted.*

*Information in this document pertains to all full-time, U.S.-based employees. Participation in Windstream's benefit plans by employees in bargaining units is subject to the terms of their collective bargaining agreement. Canadian employees should refer to Canada Life for coverage information and windstreambenefits.com for supplemental information.*

# HEALTH SAVINGS AND SPENDING ACCOUNTS

Windstream offers you opportunities to use tax-free dollars to pay for eligible health care and dependent care expenses. When you put money into these accounts, you don't pay taxes, so you keep more of your paycheck. Your savings and spending account options depend on which medical plan you choose.

## Health Savings Account (HSA)

The Health Savings Account (HSA) is a helpful, tax-advantaged tool to save on healthcare expenses—now or in the future—and the HSA is always yours, even if you leave Windstream.

- **Get a company contribution.** Windstream will contribute up to $600 tax-free to your HSA if you enroll in a Windstream HDHP medical plan and HSA for 2024. Windstream's contribution will be deposited over the course of the year (per pay period) and will be prorated for those starting medical coverage or HSA enrollment after Jan. 1, 2024, or for those who end coverage or enrollment before Dec. 31, 2024.

  **Even if you aren't planning to contribute, you must actively enroll in the HSA in order to receive Windstream's contributions.**

- **Important reminders:**
  - If you are moving from an FSA, use your FSA by Dec. 31. If you are moving from a Health Care FSA to an HSA, you will need to incur all claims for FSA dollars by Dec. 31, 2023, or forfeit the remaining balance.
  - Know if you're HSA-eligible. Some people are disqualified from contributing to an HSA per IRS regulations. For example, those enrolled in TriCare or any part of Medicare are ineligible for an HSA but can enroll in a Health Care FSA.

## Health Care Flexible Spending Account (FSA)

The Health Care Flexible Spending Account (FSA) is available to those not enrolled in an HSA. You do not have to be enrolled in a Windstream medical plan to enroll in a Health Care FSA. Keep in mind that a Health Care FSA is a "use it or lose it" account, and any remaining balance over the IRS defined carryover amount will be forfeited when the plan year ends.

## Daycare/Eldercare FSA

You can contribute up to $5,000* a year to help cover your qualified dependent care expenses, such as child daycare or eldercare. This does not apply to health care expenses. Unused money does not carry over at the end of each year – use it or lose it.

## Commuter FSA

Use before-tax money to save on parking and transit expenses. You can contribute up to $280* a month for parking and up to $280* a month for transit, and unused money carries over at the end of each year. Contributions are deducted directly from your paycheck, and you can change or cancel your contribution month by month.

** Most recent IRS limit available at the time of publishing.*

**MORE INFORMATION**

Visit ***windstreambenefits.com*** for more detailed benefits information, summary plan descriptions, provider contacts and important legal notices.

## COMPARING THE HSA AND FSA

Depending on which medical plan you choose, you have access to an account to help you pay for health care expenses: the HSA and the Health Care FSA. Each type of account offers tax advantages, but there are some key differences between the two accounts.

| Key features | HSA | Health Care FSA |
|---|---|---|
| Eligible medical plans | 1850 HDHP Plan, 3200 HDHP Plan, 6550 HDHP Plan | 4000 Copay Plan, Surest Choice Plan<br>1850 HDHP Plan, 3200 HDHP Plan, 6550 HDHP Plan—as long as you're not enrolled in an HSA |
| Eligible expenses | • Eligible medical, dental, vision, and prescription out-of-pocket expenses, over-the-counter medications<br>• COBRA and retiree insurance premiums<br>• Long-term care premiums | • Eligible medical, dental, vision, and prescription out-of-pocket expenses and over-the-counter medications |
| Windstream contributions | $600 ($23.08 per pay period) | No company contribution |
| Your contribution*<br>2024 IRS maximum annual contribution includes employee and Windstream contributions | • Up to $4,150 employee-only<br>• Up to $8,300 employee + family<br>• If you are age 55 or older, you may contribute an additional $1,000<br>You can change your contribution amount at any time during the year and it will be effective on your next paycheck, subject to payroll processing deadlines. | • Up to $3,050<br>Outside of Annual Enrollment, you can only make changes to your contribution during the year with a qualified life event. |
| When funds become available | Windstream and employee contributions are deposited per pay period, and funds are available as soon as money is in your account. | The total amount is available at the beginning of the year. |
| Using your funds | You will receive a debit card after you open your account, which you can use for direct payment at a doctor's office, pharmacy, or other health care facility. Your debit card can also be used to pay a bill you receive in the mail from a doctor's office or facility. You will receive a debit card only when you first enroll in an HSA or FSA or your existing card expires; otherwise, you will use the same card from year to year. | |
| Rollovers | Balance in your account rolls over year after year, with no limit on the amount you can accumulate.<br>There is no deadline to submit claims for reimbursement. | Up to $610 can be rolled over to the next plan year if you again have a Health Care FSA; all other unused funds will be forfeited.<br>The deadline to submit claims and receipts from the previous year (January 1 through December 31) is March 31. |
| Ownership and portability | You own the account, so you can take it with you if you leave or retire from Windstream. | You cannot take your FSA with you if you leave or retire from Windstream. |
| Growing your balance | Your account earns interest, and once you reach a $1,000 balance, you can invest your money. | FSAs do not earn interest or allow for investment. |
| Tax benefits** | • No federal tax on money contributed<br>• No federal tax on interest or investment earnings<br>• No federal tax on money withdrawn to pay for eligible healthcare expenses | • No federal tax on money contributed<br>• No federal tax on money withdrawn to pay for eligible healthcare expenses |

* *Most recent IRS limit available at the time of publishing.*

** *Money in an HSA can be withdrawn tax-free as long as it is used to pay for qualified health-related expenses. If money is used for ineligible expenses, you will pay ordinary income tax on the amount withdrawn, plus a 20% penalty tax if you withdraw the money before age 65.*

# BASIC LIFE AND AD&D INSURANCE

## BASIC LIFE AND AD&D INSURANCE

Windstream provides basic life insurance through The Standard Insurance Company at no cost to you. A death benefit equal to 50% of your annual eligible compensation is provided. Accidental death and dismemberment insurance (AD&D) is automatically included in the plan and provides an additional benefit if you die or suffer serious injuries as a result of a covered accident.

## SUPPLEMENTAL LIFE INSURANCE

As a full-time employee, you can choose to purchase optional life insurance for yourself, your spouse and your child(ren). You pay the full cost of any supplemental life insurance coverage. You must purchase coverage for yourself first to purchase coverage for your dependents.

- Employee life insurance coverage, in increments of your annual earnings up to a maximum benefit of $1.5 million, may be purchased, subject to the Statement of Health (SOH) process.
- Spouse life insurance coverage up to a maximum benefit of $250,000 (not to exceed 100% of employee coverage) may be purchased, subject to the SOH process.
- Please note that if you choose to increase your coverage, you will not see that premium increase until the increase has been approved by The Standard.

Windstream's Group Number for SOH submission is **755555**.

## SUPPLEMENTAL AD&D INSURANCE

As a full-time employee, you can also choose to purchase supplemental AD&D insurance for yourself and your family. You pay the full cost of supplemental AD&D insurance coverage. You must purchase coverage for yourself first to purchase coverage for your dependents.

*Information in this document pertains to all full-time, U.S.-based employees. Participation in Windstream's benefit plans by employees in bargaining units is subject to the terms of their collective bargaining agreement. Canadian employees should refer to Canada Life for coverage information and* ***windstreambenefits.com*** *for supplemental information.*

**Supplemental Employee Life Rates**

| Age-Band | Bi-Weekly (per $1000 of coverage) | Sample Premium (per $50,000 of coverage) |
|---|---|---|
| <25 | $0.02 | $1.06 |
| 25-29 | $0.03 | $1.25 |
| 30-34 | $0.03 | $1.48 |
| 35-39 | $0.03 | $1.66 |
| 40-44 | $0.04 | $1.89 |
| 45-49 | $0.06 | $2.93 |
| 50-54 | $0.07 | $4.27 |
| 55-59 | $0.16 | $8.12 |
| 60-64 | $0.24 | $11.88 |
| 65-69 | $0.46 | $22.96 |
| 70-74 | $0.74 | $37.13 |
| 75-79 | $0.74 | $37.13 |
| 80+ | $0.74 | $37.13 |

**Supplemental Spouse Life Rates**

| Age-Band | Bi-Weekly (per $1000 of coverage) | Sample Premium (per $50,000 of coverage) |
|---|---|---|
| <25 | $0.02 | $1.15 |
| 25-29 | $0.03 | $1.38 |
| 30-34 | $0.04 | $1.85 |
| 35-39 | $0.04 | $2.08 |
| 40-44 | $0.05 | $2.31 |
| 45-49 | $0.07 | $3.46 |
| 50-54 | $0.11 | $5.31 |
| 55-59 | $0.20 | $9.92 |
| 60-64 | $0.31 | $15.23 |
| 65-69 | $0.59 | $29.31 |
| 70-74 | $0.95 | $47.54 |
| 75-79 | $0.95 | $47.54 |
| 80+ | $0.95 | $47.54 |

# BASIC LIFE AND AD&D INSURANCE *(CONTINUED)*



## SHORT-TERM DISABILITY

Windstream provides short-term disability coverage at no cost to you, allowing income continuance in the event of an illness or injury. You will receive six weeks at full pay and up to 20 weeks at 66% of your pay.

## LONG-TERM DISABILITY

Windstream provides long-term disability insurance through New York Life that begins after the conclusion of your short-term disability benefits. LTD benefits replace a percentage of your lost income if your illness or injury causes you to miss work for more than 26 weeks. Your company-paid long-term disability insurance coordinates with other Windstream and government-sponsored benefits to provide a payment of 60% of your basic monthly earnings.

### IMPORTANT REMINDERS

- Life and AD&D coverage provided by Windstream is term insurance from The Standard Insurance Company. The coverage lasts as long as you are employed by Windstream. You have the option to convert or port your coverage should you leave the company.
- Enrolling in life insurance over a certain amount may require Evidence of Insurability by submission of a Statement of Health (SOH), which involves answering questions about your health. After electing coverage, you will receive more information if SOH is required. SOH is not required at any time to enroll in AD&D insurance.
- It is important to choose a beneficiary or beneficiaries to receive the policy's benefit payment in the event of the insured person's death. Make plans to designate your beneficiary(ies) during Annual Enrollment.

# ADDITIONAL BENEFITS

## VARIETY OF OPTIONS

Windstream offers you additional benefits to make everyday life easier and provide financial protection.

### MetLife® Legal Plan

The MetLife® Legal Assistance Plan offers economical access to attorneys for legal services such as will preparation, financial matters, real estate and certain traffic offenses.

- Give yourself, your spouse, your dependents, and your parents access to a nationwide network of 18,000 attorneys.
- Legal advice is a phone call away, and representatives will help you find an attorney in your area.
- You can choose between the High Plan and Low Plan based on your needs.
- Only available to enroll during Annual Enrollment.

### Identity theft protection

MetLife Identity Protection provides industry-leading, proactive identity and credit monitoring, offering you the most comprehensive solution to fight today's identity fraud issues.

- Get peace of mind with its identity and credit monitoring alerts to uncover fraud quickly.
- A digital wallet for securely storing documents and credit cards with a lost wallet replacement service.
- You can choose between the Protection Plan and Protection Plus Plan based on your needs.
- Only available to enroll during Annual Enrollment.

### Pet insurance

My Pet Protection through MetLife provides coverage for veterinary expenses related to accidents, illnesses and hereditary problems. Policies are available for dogs, cats, birds, reptiles and other exotic pets. Optional wellness coverage is also available for dogs and cats, providing reimbursement for the preventive care necessary to keep pets healthy year after year.

### Choice Auto & Home Program

Choice Auto & Home Program is available with multiple carriers such as, Liberty Mutual, Farmer's GroupSelect℠, Kemper, Safeco, Travelers and Progressive. Save on your auto, home and renters insurance by comparison-shopping coverages, rates and discounts from up to six of the leading auto and home insurance companies in the nation.[1,2] You may enroll in either auto or home insurance at any time throughout the year. Get quick estimates online at *https://personal-plans.com/auto/Application?clientID=589*. Payment for auto and home insurance can be made through payroll deduction. Call **855.978.2934** to enroll or get more information on auto and home insurance.

## WINDSTREAM 401(K) PLAN

### Tax-advantaged savings for retirement

The Windstream 401(k) Plan is a tax-advantaged way for you to save for retirement through payroll deductions on a pre-tax and/or Roth basis and earn the company's matching contribution, if eligible. You can enroll in or change your 401(k) contributions anytime during the year, but Annual Enrollment is a good time to consider your savings to ensure your deduction rate and investment choices align with your financial needs in retirement. Go to ***benefits.ml.com*** to assess your current investments or call **800.228.4015**.

### 4% company matching contributions

Windstream matches non-bargaining participants' 401(k) contributions dollar-for-dollar on the first 3% of pay, and then $0.50 on the dollar on the next 2% of pay. For example, if you contribute 5% of your eligible pay, you'll get another 4% from Windstream (3% + half of 2% = 4%). Windstream (employer) matching contributions are made each pay period.

[1] *Home insurance is not available in FL from the carriers offered in this program and may not be part of MetLife Auto & Home's benefit offering in MA.*

[2] *Employee discounts are not available from all carriers and only available to those who qualify. Coverages, discounts and billing options are subject to state availability, individual qualification and/or the insuring company's underwriting guidelines. Individual savings may vary and are not guaranteed.*

# TAKE ACTION OCT. 4 – 18, 2023

## Before enrolling

- Visit ***windstreambenefits.com*** to learn more about your benefit options for 2024. This site can be viewed at work or at home and by employees and family members.
- **Be on the lookout** for emails and other communication in the coming weeks. You will also have access to a *2024 Benefits Overview* video available on ***windstreambenefits.com***.
- Carefully consider your family's needs for 2024 and how the selection of Windstream benefits may provide valuable financial protection and support for your well-being.

## Enroll online from Oct. 4 – 18, 2023

Beginning Oct. 4, the Businessolver website will guide you through the benefits enrollment process every step of the way. Start by visiting ***windstreambenefits.com***.

- Failure to enroll in Windstream medical, dental, vision or savings and spending account coverage will result in no coverage for 2024. Note that current supplemental medical plans and voluntary benefits will continue without enrolling.
- Review and save (or print) your Benefit Summary to make sure you enrolled yourself and intended family members in the plans you want.

## Log in

Visit ***windstreambenefits.com*** and click the button to enroll in your benefits. This will take you into the Businessolver enrollment platform. If you are coming from within the Windstream network, no login will be required. If you are coming from outside the Windstream network, you will be asked to enter your Windstream SSO username and password to log in to Businessolver. If you have issues logging in, please contact Businessolver at **888.850.1712** for assistance.

## Make your elections

To select your benefits, click the button found on the homepage of ***windstreambenefits.com***, and then follow the simple enrollment steps.

### 1. PROFILE

- Review your personal information.
- Enter information for any dependents you wish to cover, if needed. You will need to provide Social Security numbers and dates of birth for dependents who are not already enrolled in Windstream benefits.
- Answer a few questions about your health needs and personal priorities. This helps the enrollment tool guide you toward "best match" benefit options for your needs.

### 2. SHOP FOR BENEFITS

- Review plan features and costs.
- Use online tools and educational resources to learn more.
- While you enroll, you can use the MyChoice® Recommendation Engine which will make plan recommendations based on your answers to lifestyle questions.
- Select the benefits you want to enroll in. If you enroll in a Windstream medical plan, you will be asked to attest to tobacco status (for you and your spouse) and coverage availability (for your spouse). You will also be required to verify dependents you're enrolling for medical coverage if they were not enrolled in the plan in 2023.

### 3. CONFIRM & FINISH

- Once you are satisfied with your selections, review your benefits summary for accuracy, then click the **Complete Enrollment** button.
- Choose to print a summary of your enrollment details. Be sure to verify your enrollment details outlined on your Benefit Summary and download and save a copy for reference.

**IF YOU PREFER TO ENROLL BY PHONE:**

When you need to talk to a real person, call the Businessolver Benefits Center. They can help you review your coverage options, answer your benefit questions and walk you through the enrollment process. You can also reach them through secure, live online chat when you are logged in to Businessolver.

**888.850.1712** Monday through Friday, 7 am – 7 pm CT.

**Your action is required!**

Annual Enrollment is Oct. 4 – 18, 2023. **You must enroll during this window in order to have Windstream benefits coverage in 2024.** If you do not enroll, you will not have access to Windstream medical, dental, vision, or savings or spending accounts coverage in 2024. Once the enrollment window closes on Oct. 18, 2023, benefits enrollment will only be available following a life event, such as marriage, divorce, birth of a child, or change in status (such as gain or loss of non-Windstream coverage).

# BENEFITS ELIGIBILITY

## WHO CAN ENROLL

Windstream health benefits are available to all U.S.-based employees regularly scheduled to work at least 30 hours per week and their eligible dependents. Eligible dependents include spouses and dependent children.

When enrolling, you will need to have your dependents' Social Security numbers and birth dates available if they are not already enrolled in a Windstream plan. You will also need to provide required documentation, like birth certificates and marriage licenses, to enroll dependents who were not enrolled in 2023. You will have **30 days from the day you elect your benefits** to provide documentation. Documents will not be returned to you. Since you may need to order documents from vital records/your local clerk's office, please begin collecting these documents immediately. Windstream does not retain copies of documents submitted.

### What to do if you experience a life event

Qualifying events such as a marriage, death, birth or divorce are effective on the date of the event. Should you have a qualifying event before the end of 2023, you will need to make the change with your current 2023 benefits carrier **within 30 days of the event** and provide dependent eligibility documentation within 30 days of changing your benefits. Premium changes are made as of the effective date of the life event. Windstream does not provide refunds for premium differences.

Should the event occur during or after Annual Enrollment, you will need to update your benefits for **BOTH** 2023 and 2024. If you need to make benefit changes to your 2023 coverage as the result of a life event, visit the Businessolver website through ***windstreambenefits.com*** or call **888.850.1712**. Changes must be made **within 30 days of the life event**, and you must provide dependent eligibility documentation within 30 days of the new election.

**KEEP IN MIND**

When changing your benefits due to a life event, the changes you make must be consistent with that event. For example, you cannot add a spouse to your medical coverage after having a baby; you can, however, add your new child to your coverage.

**MORE INFORMATION**

Visit ***windstreambenefits.com*** for more detailed benefits information, summary plan descriptions, provider contacts and important legal notices.



# MEDICAL PLAN TERMS

**Coinsurance.** Your share of the costs after the deductible is met. You may receive an added coinsurance benefit for preventive prescriptions. See description below.

**Copay.** A copay is a fixed fee that you pay at the time of service, for doctor visits and prescriptions.

**Deductible**. The amount you owe before your health insurance plan begins to pay. The deductible may not apply to all services.

**Embedded Deductible**. For all plans except the 1850 HDHP Plan, this is equal to the employee only plan deductible for any covered person on an employee + family member plan. This means a single member of your family can meet the embedded deductible and enter the coinsurance phase without all covered members reaching the full plan deductible.

**In-Network.** A provider who has a contract with your health insurer or plan to provide services or prescriptions to you at a discount. You will likely pay extra for out-of-network usage and can be billed the balance by the provider.

**Out-of-Pocket Maximum.** The most you pay during the year before Windstream begins to pay 100% of the allowed amount.

**Preventive Medical Care**. Windstream medical plans cover a set of preventive services at no cost to you through an in-network provider even if you haven't met your deductible. Covered preventive care services include biometric screenings, mammograms, colonoscopies, vaccines, well-woman and well-child visits. Be sure to follow the recommended age guidelines outlined in the medical summary plan description when scheduling your preventive care. For a complete list, visit ***healthcare.gov/coverage/preventive-care-benefits***.

**Preventive Prescription Drugs**. Certain medications are defined by the IRS as preventive. A complete preventive medication list is available at ***express-scripts.com***. Preventive prescription medications are available at a coinsurance rate whether or not you have met the deductible on all plans.

*This brochure provides an informal overview of the benefits programs effective as of January 1, 2024, for eligible employees of Windstream. Program details are provided in the applicable Windstream practices, plans or document summaries (collectively, the "Plan Documents"). Windstream reserves the right to amend, modify, terminate or partially terminate any portion of its benefits programs at any time by action of its officers subject to applicable collective bargaining agreements. If there is any conflict between this brochure and the Plan Documents, the Plan Documents shall control.*



# WHO TO CONTACT

**Note:** Please visit ***windstreambenefits.com*** for a current list of services and providers.

| Benefit | If you need help with... | Provider | Contact |
|---|---|---|---|
| **Businessolver** | benefits enrollment, life events, leaving the company, retiring, COBRA, contact numbers | N/A | **888.850.1712**<br>***windstreambenefits.com*** |
| **MY HEALTH** | | | |
| **Expert medical guidance** | providing personalized medical support, connecting you with trusted doctors and specialists, giving you a list of questions to ask your physician, scheduling appointments for you and answering questions | Included Health | **855.524.8426**<br>***includedhealth.com/windstream*** |
| | | Surest | **866.683.6440**<br>***join.surest.com/windstream***<br>Enter code: Windstream2024 |
| **Medical** | finding in-network providers, understanding your medical coverage, etc. | BCBS and UMR | **855.524.8426**<br>***includedhealth.com/windstream***<br>Download Included Health app from your app store |
| | | Surest | **866.683.6440**<br>***join.surest.com/windstream***<br>Enter code: Windstream2024 |
| **Prescription Drug Program** | refilling your prescriptions and comparing prescription drug costs | Express Scripts | **866.804.7613**<br>***express-scripts.com*** |
| **Dental** | finding in-network dentists, understanding your dental plan coverage, etc. | Delta Dental | **800.462.5410**<br>***deltadentalar.com*** |
| **Vision** | finding in-network providers, understanding your vision plan coverage, etc. | VSP | **800.877.7195**<br>***vsp.com*** |
| **Hospital Indemnity** | supplementing your medical plan and covering expenses related to hospital stays | Aetna | **800.607.3366**<br>***myaetnasupplemental.com*** |
| **Accident** | supplementing your medical plan and covering expenses related to treatment/hospitalization from an accident | Aetna | **800.607.3366**<br>***myaetnasupplemental.com*** |
| **Critical Illness** | supplementing your medical plan and covering expenses for certain conditions, such as heart attack, stroke, cancer, organ transplant | Aetna | **800.607.3366**<br>***myaetnasupplemental.com*** |
| **Telemedicine** | getting convenient, 24/7 access to primary care, urgent care, and mental health treatment by phone, video or app | Teladoc – BCBS and UMR | **800.Teladoc (835.2362)**<br>***teladoc.com*** |
| | | Surest | **866.683.6440**<br>***join.surest.com/windstream***<br>Enter code: Windstream2024 |
| **Prescription Drug Savings Program** | saving money on prescriptions | RxSavings Solutions | **800.268.4476**<br>***myrxss.com*** |
| **Weight Management Programs** | managing your weight | Omada | **888.409.8687** |
| **Diabetes and Hypertension Program** | managing diabetes, hypertension | Livongo | **800.945.4355**<br>***welcome.livongo.com*** |
| **Fertility Benefits** | having a baby | Progyny | **833.505.6171**<br>***progyny.com*** |

# WHO TO CONTACT *(CONTINUED)*

| Benefit | If you need help with... | Provider | Contact |
|---|---|---|---|
| **MY HEALTH** | | | |
| **Physical Therapy** | chronic back, knee, hip, neck or shoulder pain | Hinge Health | **855.902.2777**<br>*hingehealth.com/Windstream*<br>*hello@hingehealth.com* |
| **Mental Health** | managing stress, depression, anxiety and more | BetterHelp<br>myStrength | **Download BetterHelp from your app store**<br>**800.327.5569 (TTY 711)**<br>*member.magellanhealthcare.com* |
| **MY WEALTH** | | | |
| **Health Savings Account (HSA)** | setting aside money for medical, prescription drug, dental and vision expenses and saving for retirement | Businessolver | **888.850.1712** |
| **Health Care Flexible Spending Account (FSA)** | setting aside money for medical, prescription drug, dental and vision expenses (if not enrolled in the HSA) | Businessolver | **888.850.1712** |
| **Daycare/Eldercare FSA** | setting aside money for dependent care or eldercare expenses | Businessolver | **888.850.1712** |
| **Commuter FSA** | setting aside money for transit and parking expenses | Businessolver | **888.850.1712** |
| **401(k) Plan** | saving for retirement | Merrill | **800.228.4015**<br>*benefits.ml.com* |
| **NextGen College Investing Plan** | saving for your children's or grandchildren's educational future | Merrill | **877.463.9843**<br>*benefits.ml.com* |
| **Financial Well-being** | assessing your current financial state | Merrill, Magellan | **800.228.4015**<br>*benefits.ml.com* |
| **MY LIFE** | | | |
| **Basic Group Life and Accidental Death & Dismemberment (AD&D) and Life and Accident Insurance** | getting protected and preserving your income from the unexpected | Standard Insurance Company | **800.997.1654** |
| **Short-Term and Long-Term Disability** | getting protected and preserving your income while disabled and away from work | New York Life | **888.842.4462**<br>*myNYLGBS.com* |
| **Employee Assistance Program (EAP)** | reducing stress, strengthening relationships, increasing productivity, improving quality of life and more | Magellan | **800.327.5569** |
| **Legal Plan** | getting legal advice | MetLife | **800.821.6400**<br>*members.legalplans.com* |
| **Identity Theft Protection** | protecting and restoring your identity | MetLife | **833.552.2123**<br>*https://my.aura.com/sign-in* |
| **Pet Insurance** | paying for your pet's medical expenses | MetLife | **800.438.6388**<br>*metlife.com/getpetquote* |
| **Choice Auto & Home Program** | saving on home or auto insurance with premiums taken through payroll | Liberty Mutual, Farmer's GroupSelect℠, Kemper, Safeco, Travelers, Progressive | **855.978.2934**<br>*https://personal-plans.com/auto/Application?clientID=589* |
| **Adoption Assistance** | adopting a child | Human Resources Solution Center | **855.411.MYHR** |
| **REACH Educational Assistance** | covering additional education | Human Resources Solution Center | **855.411.MYHR** |
| **Parental Leave** | bonding with a new child | Human Resources Solution Center | **855.411.MYHR** |

# LEGAL NOTICES

**WINDSTREAM RESERVES THE RIGHT TO CHANGE, AMEND OR TERMINATE ANY BENEFITS PLAN AT ANY TIME FOR ANY REASON SUBJECT TO APPLICABLE COLLECTIVE BARGAINING AGREEMENTS. PARTICIPATION IN A BENEFITS PLAN IS NOT A PROMISE OR GUARANTEE OF FUTURE EMPLOYMENT. RECEIPT OF BENEFITS DOCUMENTS DOES NOT CONSTITUTE ELIGIBILITY.**

The Benefits Decision Guide, combined with these legal notices, provides an overview of the benefits available to eligible employees and their dependents. In all cases, the official plan documents govern and this Benefits Decision Guide is not, and should not be relied upon as, a governing document unless specified as such in the official plan documents. In the event of a discrepancy between the information presented in the Benefits Decision Guide and official plan documents, the official plan documents will govern.

## STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) or Summary of Material Reductions (SMR), as applicable, to the Windstream Services, LLC Welfare Benefit Plan summary plan description (SPD). It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

## SUMMARY OF BENEFITS COVERAGE

A Summary of Benefits Coverage (SBC) for each of the employer-sponsored medical plans is available at *windstreambenefits.com*. You may also request a paper copy by calling Businessolver at **888-850-1712**.

## TAXATION OF BENEFITS

The taxation of certain benefits may vary at the local, state and federal level. You should consult your tax advisor if you have any questions about the proper treatment of any benefits.

## IMPORTANT NOTICE FROM WINDSTREAM ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Windstream medical plans is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2024. This is known as "creditable coverage."

**Why this is important:** If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2024 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Windstream and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

## NOTICE OF CREDITABLE COVERAGE

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Windstream prescription drug plans listed below, you'll be interested to know that the prescription drug coverage under the plan is, on average, at least as good as standard Medicare prescription drug coverage for 2024. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

- $1,850 Deductible Plan
- $3,200 Deductible Plan
- $4,000 Copay Plan
- $6,550 Deductible
- Surest Choice Plan

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Windstream plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Windstream coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the Windstream plan, assuming you remain eligible.

You should know that if you waive or leave coverage with Windstream and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if this Windstream coverage changes, or upon your request.

# LEGAL NOTICES *(CONTINUED)*

### FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit *www.medicare.gov* for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) or visit the program online at *https://www.shiptacenter.org*.
- Call **1-800-MEDICARE** (1-800-633-4227). TTY users should call **1-877-486-2048**.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at *www.socialsecurity.gov* or call **1-800-772-1213** (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Windstream Benefits Department
4005 N. Rodney Parham Road, Little Rock, AR 72212
**501-748-7000**
*windstreambenefits@windstream.com*

### HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) SPECIAL ENROLLMENT NOTICE

### NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR HEALTH PLAN COVERAGE

If you have declined enrollment in Windstream's health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under these plans without waiting for the next Open Enrollment period, provided you request enrollment within 30 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Windstream will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Windstream group health plan. Note that this 60-day extension does not apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for special enrollment rights, you may add the dependent to your current coverage or change to another medical plan.

To request a HIPAA special enrollment based on the events described above or obtain more information, contact *windstreambenefits@windstream.com*.

### WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your medical carrier at the phone number listed on the back of your ID card.

### NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your medical carrier at the phone number listed on the back of your ID card.

### MICHELLE'S LAW NOTICE

### EXTENDED DEPENDENT MEDICAL COVERAGE DURING STUDENT MEDICAL LEAVES

The Windstream plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from a post-secondary educational institution (including a college or university).

Coverage may continue for up to a year, unless the child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary, and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If the coverage provided by the plan is changed during this one-year period, the plan will provide the changed coverage for the remainder of the leave of absence.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, call Businessolver at **888-850-1712** as soon as the need for the leave is recognized by Windstream. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

**NOTICE REGARDING WELLNESS PROGRAM**

Windstream offers a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a biometric screening, which will include height and weight measurements, waist measurement, blood pressure, and a blood test measuring cholesterol, triglycerides and glucose levels.

The information from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as diabetes management. You also are encouraged to share your results or concerns with your own doctor.

**PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION:**

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Windstream may use aggregate information it collects to design a program based on identified health risks in the workplace, Quest will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are those individuals who need the information in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

**PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) NOTICE**

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit ***www.healthcare.gov***.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or ***www.insurekidsnow.gov*** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at ***www.askebsa.dol.gov*** or call **1-866-444-EBSA** (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility.

# LEGAL NOTICES *(CONTINUED)*

| Alabama – Medicaid | Kansas – Medicaid |
|---|---|
| Website: **http://myalhipp.com**<br>Phone: 1-855-692-5447 | Website: **https://www.kancare.ks.gov/**<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |
| **Alaska – Medicaid** | **Kentucky – Medicaid** |
| The AK Health Insurance Premium Payment Program<br>Website: **http://myakhipp.com**<br>Phone: 1-866-251-4861<br>Email: **CustomerService@MyAKHIPP.com**<br>Medicaid Eligibility: **https://health.alaska.gov/dpa/Pages/default.aspx** | Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**<br>Phone: 1-855-459-6328<br>Email: **KIHIPP.PROGRAM@ky.gov**<br>KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx**<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website: **https://chfs.ky.gov/agencies/dms** |
| **Arkansas – Medicaid** | **Louisiana – Medicaid** |
| Website: **http://myarhipp.com**<br>Phone: 1-855-MyARHIPP (1-855-692-7447) | Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp**<br>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) |
| **California – Medicaid** | **Maine – Medicaid** |
| Health Insurance Premium Payment (HIPP) Program<br>Website: **http://dhcs.ca.gov/hipp**<br>Phone: 1-916-445-8322<br>Fax: 1-916-440-5676<br>Email: **hipp@dhcs.ca.gov** | Enrollment Website: **https://www.mymaineconnection.gov/benefits/s/?language=en_US**<br>Phone: 1-800-442-6003 TTY: Maine relay 711<br>Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms**<br>Phone: 1-800-977-6740 TTY: Maine relay 711 |
| **Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** | **Massachusetts – Medicaid and CHIP** |
| Health First Colorado website: **https://www.healthfirstcolorado.com**<br>Health First Colorado Member Contact Center: 1-800-221-3943/state relay 711<br>CHP+: **https://hcpf.colorado.gov/child-health-plan-plus**<br>CHP+ Customer Service: 1-800-359-1991/State Relay 711<br>Health Insurance Buy-In Program (HIBI): **https://www.mycohibi.com/**<br>HIBI Customer Service: 1-855-692-6442 | Website: **https://www.mass.gov/masshealth/pa**<br>Phone: 1-800-862-4840<br>TTY: 711<br>Email: **masspremassistance@accenture.com** |
| **Florida – Medicaid** | **Minnesota – Medicaid** |
| Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**<br>Phone: 1-877-357-3268 | Website: **https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**<br>Phone: 1-800-657-3739 |
| **Georgia – Medicaid** | **Missouri – Medicaid** |
| GA HIPP Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**<br>Phone: 1-678-564-1162, Press 1<br>GA CHIPRA Website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**<br>Phone: 1-678-564-1162, Press 2 | Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**<br>Phone: 1-573-751-2005 |
| **Indiana – Medicaid** | **Montana – Medicaid** |
| Healthy Indiana Plan for low-income adults 19–64<br>Website: **http://www.in.gov/fssa/hip**<br>Phone: 1-877-438-4479<br>All other Medicaid:<br>Website: **https://www.in.gov/medicaid**<br>Phone 1-800-457-4584 | Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**<br>Phone: 1-800-694-3084<br>Email: **HHSHIPPProgram@mt.gov** |
| **Iowa – Medicaid and CHIP (Hawki)** | **Nebraska – Medicaid** |
| Medicaid Website: **https://dhs.iowa.gov/ime/members**<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website: **http://dhs.iowa.gov/hawki**<br>Hawki Phone: 1-800-257-8563<br>HIPP Website: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**<br>HIPP Phone: 1-888-346-9562 | Website: **http://www.ACCESSNebraska.ne.gov**<br>Phone: 1-855-632-7633<br>Lincoln: 1-402-473-7000<br>Omaha: 1-402-595-1178 |

| Nevada – Medicaid | South Carolina – Medicaid |
|---|---|
| Medicaid Website: **http://dhcfp.nv.gov**<br>Medicaid Phone: 1-800-992-0900 | Website: **https://www.scdhhs.gov**<br>Phone: 1-888-549-0820 |
| **New Hampshire – Medicaid** | **South Dakota – Medicaid** |
| Website: **https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**<br>Phone: 1-603-271-5218<br>Toll-free number for the HIPP program: 1-800-852-3345, ext. 5218 | Website: **http://dss.sd.gov**<br>Phone: 1-888-828-0059 |
| **New Jersey – Medicaid and CHIP** | **Texas – Medicaid** |
| Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid**<br>Medicaid Phone: 1-609-631-2392<br>CHIP Website: **http://www.njfamilycare.org/index.htm**l<br>CHIP Phone: 1-800-701-0710 | Website: **https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program**<br>Phone: 1-800-440-0493 |
| **New York – Medicaid** | **Utah – Medicaid and CHIP** |
| Website: **https://www.health.ny.gov/health_care/medicaid**<br>Phone: 1-800-541-2831 | Medicaid **Website: https://medicaid.utah.gov**<br>CHIP Website: **http://health.utah.gov/chip**<br>Phone: 1-877-543-7669 |
| **North Carolina – Medicaid** | **Vermont – Medicaid** |
| Website: **https://medicaid.ncdhhs.gov**<br>Phone: 1-919-855-4100 | Website: **https://dvha.vermont.gov/members/medicaid/hipp-program**<br>Phone: 1-800-250-8427 |
| **North Dakota – Medicaid** | **Virginia – Medicaid and CHIP** |
| Website: **https://www.hhs.nd.gov/healthcare**<br>Phone: 1-844-854-4825 | Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select**<br>**https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs**<br>**Medicaid/CHIP Phone: 1-800-432-5924** |
| **Oklahoma – Medicaid and CHIP** | **Washington – Medicaid** |
| Website: **http://www.insureoklahoma.org**<br>Phone: 1-888-365-3742 | Website: **https://www.hca.wa.gov**<br>Phone: 1-800-562-3022 |
| **Oregon – Medicaid** | **West Virginia – Medicaid and CHIP** |
| Website: **http://healthcare.oregon.gov/Pages/index.aspx**<br>Phone: 1-800-699-9075 | Website: **https://dhhr.wv.gov/bms**<br>**http://mywvhipp.com**<br>Medicaid Phone: 1-304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **Pennsylvania – Medicaid and CHIP** | **Wisconsin – Medicaid and CHIP** |
| Website: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx**<br>Phone: 1-800-692-7462<br>CHIP Website: **https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx**<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**<br>Phone: 1-800-362-3002 |
| **Rhode Island – Medicaid and CHIP** | **Wyoming – Medicaid** |
| Website: **http://www.eohhs.ri.gov**<br>Phone: 1-855-697-4347 or 1-401-462-0311 (Direct RIte Share line) | Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility**<br>Phone: 1-800-251-1269 |

# LEGAL NOTICES *(CONTINUED)*

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
*www.cms.hhs.gov*
1-877-267-2323, Menu Option 4, Ext. 61565

## WINDSTREAM HIPAA PRIVACY NOTICE

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Windstream health plans. This information, known as protected health information (PHI), includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium or as an oral communication. This notice describes the privacy practices of the Windstream Services, LLC Welfare Benefit Plan (the "Plan") and its incorporated medical/pharmacy (including care management/ advocacy/navigation), dental, vision, health care flexible spending account, wellness, and employee assistance plans. The plans covered by this notice may share health information with each other to carry out treatment, payment or healthcare operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

## THE PLAN'S DUTIES WITH RESPECT TO HEALTH INFORMATION ABOUT YOU

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Windstream as an employer — that's the way the HIPAA rules work. Different policies may apply to other Windstream programs or to data unrelated to the Plan.

## HOW THE PLAN MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of healthcare treatment, payment activities and healthcare operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing healthcare by one or more healthcare providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for healthcare. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- Healthcare operations include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service and internal grievance resolution. Healthcare operations also include evaluating vendors; engaging in credentialing, training and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

## HOW THE PLAN MAY SHARE YOUR HEALTH INFORMATION WITH WINDSTREAM

The Plan, or its health insurer or Health Maintenance Organization (HMO), may disclose your health information without your written authorization to Windstream for plan administration purposes. Windstream may need your health information to administer benefits under the Plan. Windstream agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Windstream employees in the Corporate Benefits, Human Resources, Central Records, Informational Technology, and Payroll Departments are the only Windstream employees who will have access to your health information for plan administration functions. Certain employees in the Procurement department may conduct analysis using de-identified PHI data to determine global cost-saving opportunities for the Plan.

Here's how additional information may be shared between the Plan and Windstream, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Windstream, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants'

claims information, from which names and other identifying information have been removed.

- The Plan, or its insurer or HMO, may disclose to Windstream information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Windstream cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Windstream from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

**OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR HEALTH INFORMATION**

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative if you have provided the Plan with written notice or authorization and any supporting documents (i.e., healthcare power of attorney or designation of personal representative). The Plan may disclose PHI to its business associates to perform certain plan administration functions. For example, business associates may include claims administrators, consultants, accountants, and attorneys. Business Associates may receive, create, maintain, and/or discose your PHI without your authorization, but only after the Business Associate agrees in writing with the Plan to limit its uses and disclosures to proper purposes and to implement appropriate safeguards regarding your PHI. The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

- Workers' compensation: Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
- Necessary to prevent serious threat to health or safety: Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
- Public health activities: Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
- Victims of abuse, neglect, or domestic violence: Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
- Judicial and administrative proceedings: Disclosures in response to a court or administrative order, subpoena, discovery request or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
- Law enforcement purposes: Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
- Decedents: Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
- Organ, eye or tissue donation: Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
- Research purposes: Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
- Health oversight activities: Disclosures to health agencies for activities authorized by law (audits, inspections, investigations or licensing actions) for oversight of the healthcare system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
- Specialized government functions: Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
- HHS investigations: Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes

# LEGAL NOTICES *(CONTINUED)*

in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

### YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the Contact section at the end of this notice for information on how to submit requests.

### RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION AND THE PLAN'S RIGHT TO REFUSE

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or healthcare operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your healthcare provider) or its business associate must comply with your request that health information regarding a specific healthcare item or service not be disclosed to the Plan for purposes of payment or healthcare operations if you have paid out of pocket and in full for the item or service.

### RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF YOUR HEALTH INFORMATION

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

### RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a healthcare provider; enrollment, payment, claims adjudication and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested.
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint.
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

### RIGHT TO AMEND YOUR HEALTH INFORMATION THAT IS INACCURATE OR INCOMPLETE

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested.
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint.
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

### RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the Other Allowable Uses or Disclosures of your Health Information section earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment or healthcare operations.
- To you about your own health information.
- Incidental to other permitted or required disclosures.
- Where authorization was provided.
- To family members or friends involved in your care (where disclosure is permitted without authorization).
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

### RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM THE PLAN UPON REQUEST

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

### RIGHT TO RECEIVE NOTIFICATION OF A BREACH OF UNSECURED PHI

You have the right to receive notice if your unsecured PHI is disclosed in violation of HIPAA rules unless there is a low probability that the PHI has been compromised. If it is determined from the Plan's risk assessment that a breach has occurred, you will be notified without unreasonable delay. The notification will include information about what happened and what may be done to mitigate harm.

### CHANGES TO THE INFORMATION IN THIS NOTICE

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2024. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, the Plan will post its revised notice on ***windstreambenefits.com*** under the Resources/Important Notices section and distribute the revised version of this Notice or information about any material change to affected individuals.

### COMPLAINTS

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, send it in writing to the Plan's HIPAA Privacy Officer, Windstream Benefits, at 4005 N. Rodney Parham Road, Mailstop 1170-B1F02-93, Little Rock, AR 72212 or ***windstreambenefits@windstream.com***.

### CONTACT

For more information on the Plan's privacy policies or your rights under HIPAA, contact the Plan's HIPAA Privacy Officer at ***windstreambenefits@windstream.com***.

# EXHIBIT B

WINDSTREAM

# Frequently Asked Questions

## 2024 Annual Enrollment

The Annual Enrollment window opens Wednesday, Oct. 4 to make 2024 benefit elections.
Failure to enroll by Wednesday, Oct. 18 will result in no coverage for 2024.
Visit windstreambenefits.com to enroll. FAQ updated as of Sept. 5, 2023.

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## Enrollment System Tips

**Confirmation**
Our benefits partner, Businessolver, uses a confirmation statement and a confirmation number to confirm completion of your enrollment. Please download or save this information for your reference and records.

**Medical Plan Order**
The system orders medical plans alphabetically. Even if UMR is your lower cost provider, Blue Cross Blue Shield will show first in the list of plans. Please make sure you look at the cost of both plans and select the lower cost carrier, if desired.

**Medical Plan Recommendation**
The enrollment system will recommend a plan based on your answers to the guided-shopping questions. The medical plan design is the same for both BCBS and UMR. Please review your plan and carrier election carefully to ensure you have selected the lower cost carrier, if desired.

**Unverified Dependents**
Unverified dependents are those who are new to coverage for 2024 and/or were not enrolled in 2023 medical, dental, or vision. They will need to be verified within 30 days of making your enrollment selections. Your unverified dependents will not show as enrolled in medical, dental, and/or vision, and your medical, dental, and vision rates will not reflect the cost of those



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Sensitivity: Internal

dependents until the verification process is complete. After your dependents are verified, you may go back and update your HSA contribution up to the family maximum, if desired.

**Company Paid Benefits**
All eligible employees are automatically enrolled in Basic Life, Basic AD&D, Short-Term Disability, Long-Term Disability, and the Employee Assistance Plan. There are no changes to these plans and Windstream pays the full cost. Short-term disability will not show in the platform as it is a pay policy administered by Windstream payroll.

**Beneficiaries**
Beneficiary information from 2023 remains in the enrollment system for 2024 for each benefit plan that requires a beneficiary (basic, voluntary, AD&D, and supplemental). You can update your beneficiary information at any time, but it is a wise practice to review at least once a year during annual enrollment.

## Annual Enrollment

**Q. When is Annual Enrollment?**
A. This year's Annual Enrollment begins Wednesday, Oct. 4, 2023, and ends on Wednesday, Oct. 18, 2023. During this time, you must enroll to have health benefits starting January 1, 2024. Your current medical, dental, and vision coverage plus savings and spending accounts will not continue after Dec. 31, 2023; these benefits do not "roll over."

**Q. Do I need to enroll? What happens if I do nothing?**
A. Yes, action is required! Even if you were just hired and completed 2023 enrollment, you must make your 2024 health and welfare benefits elections between Oct. 4 and Oct. 18, which is the Annual Enrollment period. If you do not take action to enroll, you will not have Windstream benefits coverage in 2024.

**Q. How do I enroll?**
A. Starting Oct. 4, visit windstreambenefits.com to enroll. You can review enrollment information and link directly to the enrollment platform by going to windstreambenefits.com.

The enrollment website will guide you through the enrollment process step by step. As you go through the site, you will see the coverage details and costs for each plan clearly displayed. When you get to the end, you will have a chance to review your selections and see your total cost. It is that simple!

If you need assistance enrolling, you may contact Businessolver at **888.850.1712** from 7 a.m. – 7 p.m. CT, Monday through Friday.

**Q. Who is eligible to enroll in Windstream benefits?**
A. Health coverage is available to all U.S. based employees regularly scheduled to work at least 30 hours per week and their eligible dependents, including a legal spouse (not separated or divorced), dependent children, and dependent grandchildren.



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**Q. What information is required to enroll my dependent in coverage?**
A. If you are enrolling dependents in a Windstream plan for the first time, you will need to provide their name, date of birth and social security number. In addition, you will need to submit government-issued documentation showing your relationship, such as birth and marriage certificates. Since you may need to order documents from vital records/your local clerk's office, please begin collecting these documents immediately. Dependents who were verified for coverage in 2023 will not need to be re-verified.

**Q. How is dependent verification documentation submitted?**
You can upload the documents in the enrollment system.

**Q. How long do I have to provide proper documentation?**
If you newly enroll dependents on a Windstream medical, dental or vision plan, you will have 30 days from the day of your enrollment to submit documentation.

**Q. How long will it take to confirm my dependents are eligible?**
The standard turn-around time is 2-3 business days after receipt of documentation. However, with increased volume during annual enrollment, the time may increase to up to 30 calendar days.

**Q. I'm a Canadian employee, do I have access to Windstream's benefits?**
A: The benefits related to this annual enrollment are only available to U.S. based employees. Canadian benefits will remain as is. No action is required to continue coverage under Canadian health plans.

**Q. Does Windstream cover domestic partners?**
A: Since marriage equality and the opportunity to marry exists between same-gender and opposite-gender partners, Windstream does not offer insurance coverage to unmarried partners of any gender.

**Q. What should I consider before I enroll in my benefits?**
A. We encourage you to give some thought to these questions before you enroll:

- How much health care and what type of care did you and your covered family members use this past year?
- Will your needs be similar to last year? Do you foresee any changes?
- How do you prefer to handle costs? For instance, would you rather pay more from your paycheck for a medical plan that covers more of your costs when you need care, or pay as little as possible from your paycheck – even if that means bigger bills when you need care?
- How much life insurance do you need to feel comfortable and well protected?

Carefully consider all your enrollment decisions. After Annual Enrollment ends, you won't be able to change your benefits until the next annual enrollment period, unless you experience a qualified life event, like a marriage, divorce, birth of a child or a change in your spouse's work status.

**Q. What if I make a mistake when I enroll in my benefits?**



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A. We encourage you to review your benefits carefully after enrolling to ensure you have enrolled yourself and your intended dependents in the plan you choose. Please save your benefits confirmation as a record of your enrollment. If you realize you made a mistake after the enrollment window closes, you should contact Businessolver at 888.850.1712 before your 2024 benefits begin. Please note that you must have enrolled during the enrollment window to make changes. If you miss the enrollment deadline of Oct. 18, you will not be able to enroll unless you have a qualifying event.

**Q. What if I have a life event such as the birth of a child in October, November, or December 2023?**
A. You will need to enter the life event in the Businessolver platform and enroll in both 2023 and 2024 coverage.

## Benefit Plans

**Q. Where can I learn about my health and welfare benefit options?**
A. With many benefit choices, you have important decisions to make. We have education and resources to ensure you understand your options and feel confident about the enrollment process, including:

- **windstreambenefits.com** – Beginning in Sept., **windstreambenefits.com** will provide details you need to understand your options.
- **Annual Enrollment Decision Guide** – The guide provides an overview of your benefits and is available to view, download, or print on **windstreambenefits.com**.
- **Enrollment platform and mobile app** – You are able to access the enrollment platform and from there download the mobile app through **windstreambenefits.com**. This site provides education and decision-support tools to help you select the benefits that are right for you.

**Q: Is my medical insurance going to cost me more than last year?**
A: For 2024, medial rates are increasing. This increase is higher than our historical run rate due to inflation and the impact of delayed care from the pandemic.

**Q. Will there be medical surcharges?**
A. Yes, the following surcharges will remain in place.

- **Spousal Surcharge** – Windstream has a spousal surcharge of $100 per month ($46.15 per pay period) for any spouse who has coverage available through his/her employer and chooses to be on a Windstream medical plan. If your spouse is not offered coverage through his/her employer or is not employed, the surcharge does not apply. If your spouse is employed by Windstream, the surcharge does not apply.

- **Tobacco Use Surcharge** – A $50 monthly surcharge ($23.08 per pay period) will be applied to each medically enrolled employee and spouse who attest to using tobacco products during enrollment. If you or your spouse complete a tobacco cessation program or quit tobacco use, you can have the surcharge removed prospectively by



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- **BCBS and UMR Medical Insurance Questions and Claims Issues**– Windstream provides access to Included Health at no cost to you. Included Health can be reached at **855-524-8426**.

- **Surest Plan Questions and Claim Issues** – Surest Plan members can contact the Surest team at **866-683-6440** for all questions and issues.

- **Enrollment** – If you need help choosing your plan or have trouble navigating the enrollment system, Businessolver offers a team to provide you with personal support. Just pick up the phone or chat with them online if you need help. Assistance will be available by phone at 888.850.1712 or online at **windstreambenefits.com** starting when the enrollment window opens on Oct. 4.

## Health Savings and Spending Accounts

**Q. What is the difference between an HSA and a Health Care FSA?**
A. A Health Savings Account (HSA) offers you the ability to save tax-free money to pay your health care expenses. In addition to your own contributions, Windstream also provides up to a $600 tax-free company contribution if you enroll in a Windstream medical plan and elect an HSA. The company contribution will be deposited in prorated amounts throughout the year each pay period. With an HSA, the account is yours to keep – unused money rolls over year after year, and it can even be used to help plan for health care expenses in retirement.

A Health Care Flexible Spending Account (FSA) is a pre-tax benefit account that is also used to pay for eligible medical expenses. You cannot contribute an HSA and have a rollover to an FSA in the same plan year. Unlike an HSA, a Health Care FSA is a "use it or lose it" account. You are allowed to roll over an IRS defined amount of unused funds if you enroll in an FSA the following year. Your full annual election is available at the start of the plan year with a Health Care FSA, regardless of how much you have contributed thus far.

**Q. Can anyone enroll in a Health Savings Account (HSA)?**
A. No. This plan design is governed by federal regulations. You cannot contribute to an HSA if:

- You are enrolled in Medicare, TRICARE or TRICARE for Life,
- You are claimed as a dependent on someone else's tax return,
- You are covered by a Full Medical Flexible Spending Account, or
- You are covered by any other health plan that is not a federally qualified, high deductible plan.

If you are newly enrolling in an HSA, you'll be prompted to affirm the set-up of a health savings account during your online Annual Enrollment session while making your medical election. If you do not open an HSA or provide documentation per the US Patriot Act verification process if requested, Windstream will be unable to make its contribution.

**Q. What family members can I cover on a Windstream medical plan with an HSA?**
A. All eligible family members may be enrolled in a medical plan. However, federal law only allows your federal tax dependents to have claims paid from your HSA.



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Sensitivity: Internal

**Q. Can I have a Medical Flexible Spending Account and a Health Savings Account?**
A. No. Federal law does not permit you to participate in a Full Medical Reimbursement Flexible Spending Account (FSA) if you enroll in a Health Savings Account. You'll still be able to participate in Dependent Care Reimbursement, Mass Transit and Parking Reimbursement Accounts.

**Q. Can I enroll in a Flexible Spending Account (FSA) if I don't enroll in a Windstream medical plan?**
A. Yes. You can enroll in an FSA account without enrolling in a Windstream medical plan.

**Q. Can I enroll in a Health Savings Account (HSA) if I don't enroll in a Windstream medical plan?**
A. No. Enrollment in a Windstream HSA account is dependent on enrollment in a Windstream high-deductible medical plan.

**Q: Once I choose how much I want taken out of my paycheck for my HSA contribution, can I change it?**
A: Yes. You will be able to change your contribution throughout the year through the enrollment platform. However, you are responsible for making sure your annual voluntary contribution does not exceed the annual limits set by the IRS.

## Benefit Enrollment Tools

**Q. What is Benefitssolver, powered by Businessolver?**
A. Benefitssolver is an online benefits shopping and enrollment platform where you will enroll in your Windstream health and welfare benefits during Annual Enrollment. Through the platform, you will choose from a selection of benefits. The website has decision-support tools to help you see which plans best fit your unique needs.

**Q. How will Businessolver platform help me make decisions?**
A. As you enroll in the platform, you will find key information displayed for each plan, including coverage details and what it will cost. You will also find tools, tips, and other information to help you better understand your benefit options.

If you need help finding the right coverage, you can use the MyChoice "best match" feature. After you log in, you will be asked a few profile questions about your insurance usage, payment preference and ability to afford an unexpected medical expense. Then, the platform will show you the plans that may best match your situation. While the decision is yours, these suggestions may help you make an appropriate choice. Keep in mind that the "best match" may not always be the lowest cost carrier or plan but may most closely match your risk tolerance and savings strategy.

**Q. How will the enrollment platform help me stretch my health care dollars?**
A. The platform will help you take control of your health spending by:

- Clearly showing the costs associated with each plan.



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- Offering a range of options at different prices.
- Helping you find the most cost-effective plan for your needs.
- Offering valuable tax savings through health and dependent care accounts.
- Giving you access to group discounts on additional benefits such as auto and home insurance, pet insurance, and more.

## Other Benefits Questions

**Q. What do I do if I experience a qualifying life event during or after enrollment?**
A. Qualifying events such as a marriage, death, birth or divorce are effective on the date of the event. Should you have a qualifying event before the end of 2023, you will need to change your benefits within 30 days of the event to enroll for coverage for the remainder of the year and for 2024.

**Q. Are voluntary medical supplement plan premiums pre-tax or post-tax?**
A. Supplemental medical premiums are deducted on a post-tax basis. Claim payments made are not taxable.

**Q. I was recently hired, where do I enroll?**
A. If you were employed by Oct. 6, you will need to enroll in Windstream benefits for 2023 coverage. You will also need to enroll for 2024 benefits coverage during annual enrollment. Those with a start date of Oct. 7 or after will only need to enroll for 2024 benefits coverage.

## Preparing for Enrollment

**Q. What information do I need to enroll my dependents?**
A. Gather birth dates and social security numbers of dependents you plan to newly enroll. The law requires Security Numbers (SSN) for all family members enrolled in insurance. Please make sure that the SSN for each of your dependents is correct. Failure to update the SSN will result in a tax penalty for you and may cause issues with processing your claims. If your dependents were verified for 2023 coverage, you will not need to re-submit verification documentation.

**Q. What do I need to do to verify that my dependents are eligible for coverage?**
A. If you plan on enrolling a dependent, you will need to gather and submit government-issued documentation showing your relationship, like birth and marriage certificates. **Since you may need to order documents from vital records/your local clerk's office, please begin collecting these documents immediately.**

**Q. Where do I go when I need help enrolling?**
If have questions about enrollment or dependent verification, Businessolver benefits counselors will be available by phone (888.850.1712) Monday through Friday from 7 am to 7 pm CT. Chatbot Sofia is also available throughout the enrollment platform.



**Information in this document pertains to all full-time, non-bargaining, U.S. based employees. This brochure provides an informal overview of the benefits programs effective as of January 1, 2024, for eligible employees of Windstream. Program details are provided in the applicable Windstream practices, plans, or document summaries. Windstream reserves the right to amend, modify, terminate, or partially terminate, any portion of its benefits programs at any time by action of its officers. Participation in Windstream's benefit plans by bargaining unit employees is subject to the terms of their collective bargaining agreement.*

Sensitivity: Internal

# EXHIBIT C

# Windstream Services, LLC

# Windstream Services, LLC Welfare Benefit Plan

SUMMARY PLAN DESCRIPTION

Effective January 1, 2023

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# INTRODUCTION

This summary, together with the booklets, certificates and evidence of coverage documents listed in Appendix A (collectively, Benefit Booklets), is intended to serve as the Summary Plan Description (SPD), as required by the Employee Retirement Income Security Act of 1974 (ERISA). The SPD describes the benefits provided by the Windstream Services, LLC Welfare Benefit Plan (the Plan) for eligible employees and their eligible dependents.

Windstream Services, LLC and a number of related companies (Participating Employers, described in Appendix C) participate in this Plan. References to the "Company" in this summary may refer to either Windstream Services, LLC only or to Windstream Services, LLC and the Participating Employers, as applicable based on the context.

Windstream Services, LLC also sponsors the Windstream Services, LLC Cafeteria Plan intended to satisfy the requirements of Internal Revenue Code Sections 125, 129 and 105(e) to provide employees Health Care and Dependent Care Flexible Spending Accounts (FSAs) and the opportunity to make pre-tax contributions toward certain benefits. Windstream Services, LLC also offers employees enrolled in the high deductible health plan the opportunity to make pre-tax contributions to a Health Savings Account. The Windstream Services, LLC Cafeteria Plan has been fully incorporated into the Windstream Services, LLC Welfare Benefit Plan.

The Plan will provide benefits in accordance with applicable federal laws including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns' and Mothers' Health Protection Act (NMHPA), the Women's Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the Genetic Information Nondiscrimination Act (GINA), and the applicable provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (collectively referred to as Health Care Reform).

Notwithstanding any other provision in this SPD, Windstream Services, LLC intends to operate the Plan in compliance with the transparency, surprise billing and other applicable requirements in the relevant provisions of the Consolidated Appropriations Act, 2021 ("CAA") and the Transparency-In-Coverage Regulations as they become effective, based on a good faith, reasonable interpretation of the statute, existing regulations and other official guidance. As additional, final guidance becomes available and applicable, Windstream Services, LLC will modify this SPD accordingly and/or provide a Summary of Material Modifications.

The Medical, Dental, Wellness, FSA, and Severance plans are self-insured and provided under other contracts with service providers. All other benefits are provided under insurance or HMO contracts. All benefits are summarized in this document and in the Benefit Booklets (as defined below).

This summary should be read in connection with the Benefit Booklets (see Appendix A for a list of Benefit Booklets). The Benefit Booklets are provided by the insurance companies, HMOs and service providers and will be provided by Windstream Services, LLC. If there is ever a conflict or a difference between what is written in this summary and the Benefit Booklets with respect to **the specific benefits provided**, the Benefit Booklets shall govern unless otherwise provided by any federal and state law. If there is a conflict between the Benefit Booklets and this summary with respect to **the legal compliance requirements of ERISA and any other federal law**, this summary will rule. If there is a conflict between the Benefit Booklets and this summary with respect to the **eligibility of Retirees**, this summary will rule.

The applicable Benefit Booklets describe the use of network providers, the composition of the network, and the circumstances, if any, under which coverages will be provided for out-of-network services. A directory of participating network providers will be provided, automatically, at no cost to you. You may

also access provider directories on the insurance companies' and HMOs' websites or you can call the insurance companies or HMOs at the phone numbers indicated in the Benefit Booklets. You will also be informed about any conditions or limits on the selection of primary care providers or specialty medical providers that may apply under the Plan.

For additional information regarding the benefits provided under the Plan, please contact the Plan Administrator identified in the *Administrative Information* section. Windstream Services, LLC reserves the right to change, amend, suspend, or terminate any or all of the benefits under this Plan, in whole or in part, at any time and for any reason at its sole discretion.

Note that by adopting and maintaining these benefits, the Company has not entered into an employment contract with any employee. Nothing in the legal Plan documents or in the SPD gives any employee the right to be employed by the Company or to interfere with the Company's right to discharge any employee at any time.

Where a word or a phrase used in this summary is capitalized by not defined, that word or phrase shall have the same meaning assigned to it in the official document of the Plan. See also the Definitions section.

# DEFINITIONS

**HMO** means Health Maintenance Organization.

**Fertility benefits** mean the fertility benefits provided under the Medical plan.

**New Employee** means a common-law employee who is newly hired by a Participating Employer.

**Pharmacy benefits** mean the prescription drug benefits provided under the Medical plan.

# NONVESTED BENEFITS

Nothing in the Plan or this SPD, including but not limited to provisions addressing Retiree eligibility, shall be construed as creating any vested rights to continued eligibility or participation. Nor shall anything in the Plan or this SPD be construed as creating any vested rights in benefits in favor of any individual except with respect to claims that have actually been incurred by any such person that would otherwise be eligible for payment under the Plan, as it is in effect when the expense is incurred.

# ELIGIBILITY – EMPLOYEES AND DEPENDENTS OF EMPLOYEES

## EMPLOYEE ELIGIBILITY

Generally, for most Plan benefits, you are considered an "eligible employee" and are eligible to participate in the Plan on the first of the month following 8 weeks of continuous employment if you are:

- A regular full-time salaried or hourly employee of the Company regularly scheduled to work at least 30 hours per week or more.

You are eligible for the EAP benefit regardless of the number of hours you work.

You may also be eligible for Medical benefits if the Company otherwise determines that you worked at least 30 hours per week during a measurement period as defined in the applicable Affordable Care Act regulations. You will be informed by the Company if you are eligible for Medical benefits under this provision.

In addition, if you experience a period of 13 consecutive weeks (or longer) without an Hour of Service—either because you terminate employment or are absent for some other reason—you will have a Break in Service and you will be treated as a New Employee to the extent permitted by law (see the rules that apply to New Employees below).

Certain benefits are only available and/or are automatically provided when you enroll in other benefits. For example:

- The Pharmacy and Fertility benefits are included in the Medical coverage. In most cases, when this summary refers to Medical benefits, the information provided also applies to the included Pharmacy and Fertility benefits.
- The Care Management, Advocacy, and Navigation benefit is only provided to employees and dependents of employees who enroll in Medical coverage and does not require separate enrollment.

Other eligibility criteria apply to certain benefits. For example:

- Different eligibility rules apply for the long-term disability benefits. See Appendix B for eligibility.
- Eligibility for the Severance benefit is subject to the terms and conditions in the applicable Benefit Booklet in Appendix A.

Additional information regarding how and when you become eligible to participate in the benefits referred to in this summary and any conditions and limitations to eligibility are contained in the Benefit Booklets provided by the applicable insurance companies and/or service providers.

### Individuals not eligible for Plan benefits

For all Plan benefits other than Medical benefits, you are not eligible to participate in the Plan if you are:

- regularly scheduled to work fewer than 30 hours per week;
- an employee hired on *temporary* basis, with the classification temporary meaning any employee hired to fill a job vacancy for a limited time, as designated by the Plan Administrator;
- an employee who is hired on a *seasonal* basis, with the classification seasonal meaning any employee hired to fill a job vacancy relating to or occurring during a particular season, as designated by the Plan Administrator;
- an independent contractor;
- a consultant who is paid on other than a regular wage or salary by the Company;
- a non-employee director on the Windstream Services, LLC Board of Directors or a Participating Employer Board of Directors; or
- an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

A person the Plan Administrator determines is not an employee will not be eligible to participate in the Plan regardless of whether a court or tax or regulatory authority determines that the person is an employee.

### Medical 400 Plan Eligibility

Employees subject to a collective bargaining agreement applicable to the following union populations are eligible to enroll in the 400 Plan (as well as any other plans offered to employees not subject to a collective bargaining agreement), provided they are otherwise eligible to participate in the Plan, as described above:

- Communications Workers of America union (CWA) – Kentucky (if hired on or before December 31, 2018)
- CWA – Iowa (if hired on or before December 31, 2018)

## ELIGIBLE DEPENDENTS

### Medical, Dental, Vision, and Wellness Plan Benefits, Care Management, Advocacy, and Navigation

The following dependents are eligible for Medical, Dental, Vision, Wellness, Care Management, Advocacy, and Navigation coverage offered under the Plan:

- Your spouse, which means a person recognized as married to you by the state, possession, or territory of the United States in which you were married, regardless of where you live.
  - If you were married in a foreign jurisdiction, your spouse means a person recognized as your spouse under the laws of at least one state, possession, or territory of the United States, regardless of where you live;
- Your children through the end of the month in which they turn age 26, regardless of their marital status, regardless of student status and whether or not they live with you or you provide any of their support;
- Children for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); and
- Your mentally or physically disabled (as determined by the Social Security Administration) adult dependent children who live with you and who are primarily dependent on you for support (you must provide appropriate documentation) provided that the child was disabled prior to age 26.

Your eligible dependents can be enrolled in the Medical, Dental, Vision, and Care Management, Advocacy, and Navigation coverage under the Plan only if you (the employee) are enrolled.

If you are married to another Company employee (or Retiree), you may enroll as an employee or a dependent under the Plan, but you cannot enroll as both a dependent and an employee. Eligible dependents may be enrolled under one employee's coverage only under the Plan.

You are required to provide proof of your dependents' eligibility upon request. False or misrepresented eligibility information will cause both your coverage and your dependents' coverage to be irrevocably terminated (retroactively to the extent permitted by law), and could be grounds for employee discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation. If your coverage is terminated retroactively due to fraud or misrepresentation, you will forfeit any contributions made.

Your dependent children are:

- Your biological children,
- Stepchildren,
- Legally adopted children,
- Children who are placed in your home for adoption,
- Any other children who are your tax dependents, and
- Children for whom you are appointed as legal guardian who are chiefly dependent on you for support and maintenance.

Please see the applicable Benefit Booklets for additional eligibility requirements.

### Dependents Not Eligible

The following individuals are not eligible for Medical, Dental or Vision coverage, regardless of whether they are your tax dependents:

- A spouse or a child living outside the United States;
- A spouse who is enrolled as an employee or Retiree under the Plan;
- Your parent or spouse's parent.

### Dependent Life and Supplemental AD&D

The following dependents are eligible for Dependent Life and Supplemental AD&D coverage offered under the Plan:

- Your legally married spouse, whether of the same or opposite sex;
- Your, or your spouse's, unmarried natural child or stepchild, or legally adopted child under age 26.

Please see the applicable Benefit Booklets for additional eligibility requirements.

### Health Care FSA

For purposes of the Health Care FSA your dependents include:

- Your spouse, which means a person recognized as married to you by the state, possession, or territory of the United States in which you were married, regardless of where you live.
  - If you were married in a foreign jurisdiction, your spouse means a person recognized as your spouse under the laws of at least one state, possession, or territory of the United States, regardless of where you live;
- Your biological children, step children, legally adopted children, children placed in your home for adoption, and eligible foster children (which is defined as a child placed with you by an authorized

placement agency or by judgment, decree, or other order of any court of competent jurisdiction) until the end of the year in which they turn age 26, regardless of student status, whether they are married or live with you and regardless of whether you provide any support;
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support;
- Any other person who meets the Internal Revenue Service (IRS) definition of a tax dependent (without regard to the income limit) which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the qualifying child (as defined under the Internal Revenue Code) of the employee or any other individual. (Note, an employee can treat another person's qualifying child as a qualifying relative if the child satisfies the other requirements listed here and if the other person isn't required to file a tax return and either doesn't file a return or files one only to get a refund of withheld income taxes.)

### Childcare/Daycare/Eldercare FSA

Under IRS regulations, "eligible dependents" for the Childcare/Daycare/Eldercare FSA generally include (subject to additional rules imposed under the Internal Revenue Code):

- A child under age 13 who is your qualifying child (as defined under the Internal Revenue Code),
- A disabled spouse who lives with you for more than one half the year, and
- Any other qualifying child or qualifying relative (as both terms are defined under Internal Revenue Code Section 152, without regard to subsections (b)(1), (b)(2), and (d)(1)(B)) who receives more than one-half of their support from you, resides in your home, and is physically or mentally unable to care for themself, and is not the qualifying child of the employee or any other individual.

### Additional Eligibility Information

Additional information regarding how and when your eligible dependents become eligible to participate in the benefits referred to in this summary and any conditions and limitations to eligibility are contained in the Benefit Booklets provided by the applicable insurance companies and/or service providers.

### Qualified Medical Child Support Orders

The Plan may be required to cover your child due to a Qualified Medical Child Support Order (QMCSO) even if you have not enrolled the child. You may obtain a copy of Windstream Services, LLC's procedures governing QMCSO determinations, free of charge, by contacting the Windstream Benefits Committee, 4001 N. Rodney Parham Rd., Little Rock, AR 72212.

A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your Federal income tax return, and children who don't reside with you. However, children who are not eligible for coverage under the Plan, due to their age for example, cannot be added under a QMCSO.

# ELIGIBILITY – RETIREES AND DEPENDENTS OF RETIREES

## RETIREE ELIGIBILITY

A Retiree is (a) a former employee who retired on or before December 31, 2020 and is designated as an eligible Retiree by the Company or (b) subject to any applicable collective bargaining agreement, a person who retires from employment with the Company on or after January 1, 2021 and who:

- Is covered under the Plan immediately before retirement,
- Is not reemployed by the Company in a benefits-eligible position subsequent to retirement, and
- Meets the Company's eligibility rules for Retiree health benefits at the time of retirement, specifically:
  - Has attained age 55 with at least 20 years of Company service; or
  - Has attained age 60 with at least 15 years of Company service; or
  - Has attained age 65 with at least 5 years of Company service.

Years of Company service may include credited service with the Company and/or a related employer. The Plan Administrator has the discretionary authority to determine whether an individual has met the years of service requirement.

Retirees will be eligible for Medical, Dental, Vision, Life, AD&D, Supplemental Life, Dependent Life, and Supplemental AD&D coverage provided they meet any additional requirements for eligibility and participation set forth in the applicable Benefit Booklet(s). Once a Retiree becomes eligible for and, as applicable, elects to enroll in coverage as a Retiree, they must remain enrolled in order to stay eligible. If a Retiree's coverage terminates for any reason, including but not limited to failure to pay premiums or an election to drop coverage, such Retiree may not at any time reenroll in coverage under this Plan. Refer to your retirement program for more information.

### Medical Coverage Eligibility

Except as described below, only Retirees under age 65 are eligible for Medical coverage under the Plan. Once enrolled in the Company's Medical coverage, a Retiree may remain covered until the earlier of the following events:

- The first of the month in which the Retiree reaches age 65 (except as described below); or
- The Retiree experiences another termination event as described later in this summary.

*Age 65 Exception*:

Certain Retirees who are eligible for subsidized Medical coverage have been permitted to continue participation in the Medical coverage after turning 65. Effective as of 11:59 p.m. on December 31, 2021, the Company is limiting the scope of Retirees who will be eligible to participate after turning age 65. Beginning January 1, 2022, only GTE Agreement Retirees (as defined in the *Retiree Contributions* section of this summary) who are eligible to participate in the Company's Medical coverage at a reduced premium rate due to Company-provided subsidies will be eligible to continue participation in the Medical benefit after reaching age 65.

*Medical 400 Plan Eligibility*: Only those Retirees who were eligible to participate in the 400 Plan immediately prior to their retirement will be eligible to participate in the 400 Plan as a Retiree (provided they remain otherwise eligible to participate).

### Eligible Dependents

In general, the same eligibility rules apply to dependents of Retirees as apply to dependents of employees, except as described below.

Spouses of Retirees who are subject to the age 65 limitation on Medical coverage also are only eligible for Medical coverage until age 65.

## NOTIFICATION OF CHANGE IN ELIGIBILITY STATUS

If you or your dependents experience a change in status (see *Making Changes to Coverage During the Year* section), you must notify the Plan within 30 days in order to make a change in your election during the year. This notice may be done by calling 1-888-850-1712 or by making your election changes via the web at www.windstreambenefits.com.

In order to preserve your dependent's COBRA rights, you must notify the Plan, as noted above, in writing within 60 days in the event of divorce or in the event your child ceases to meet the eligibility requirements for benefit coverage. For more information about your duty to notify the Plan in such an event, see the *COBRA* section of this summary.

## ENROLLMENT

### New Employees

When you begin working at the Company, you will receive the information necessary to enroll in the Plan. If you satisfy the criteria for eligibility, you will automatically be enrolled in the following:

- Basic Life
- Basic AD&D
- Employee Assistance Plan
- Long-Term Disability

You must affirmatively enroll yourself and your eligible dependents within 30 days of the date your information is loaded into the benefits enrollment platform, or eligibility date for:

- Medical (including Pharmacy and Fertility Coverage (see *Medical Fertility Benefits* section below))
- Dental
- Vision
- Supplemental Life
- Dependent Life
- Supplemental AD&D
- Health Care FSA
- Childcare/Daycare/Eldercare FSA
- Group Pre-Paid Legal
- Voluntary Accident Insurance
- Voluntary Critical Illness Insurance
- Voluntary Hospital Indemnity Insurance
- Wellness Benefits

If you elect Medical coverage under a high deductible health plan and are otherwise eligible, the Company allows you to make pre-tax contributions towards a Health Savings Account (HSA). The Company may also make a contribution to your HSA if you are enrolled in a high deductible health plan as described in your enrollment materials.

Employees (and their dependents) who elect Medical coverage will also be covered under the Care Management, Advocacy, and Navigation benefit.

You may also be able to participate in certain Wellness programs that are described in your enrollment materials.

**What Happens if You Don't Enroll When You Are First Eligible?**

If you and your eligible dependents do not enroll in Medical, Dental, Vision, Supplemental AD&D, Health Care FSA or Childcare/Daycare/Eldercare FSA coverages within 30 days of the date your information is loaded into the benefits enrollment platform, you will have to wait until the next Open Enrollment period to enroll, unless you experience a change in status.

If you do not enroll in Supplemental Life or Dependent Life coverage when you are first eligible, you may enroll mid year but you will have to provide evidence of insurability OR you may enroll mid year if you have a change in status OR you will have to wait until the next Open Enrollment period.

If you do not enroll in Group Pre-Paid Legal, Voluntary Accident Insurance, Voluntary Critical Illness Insurance or Voluntary Hospital Indemnity Insurance coverage when you are first eligible, you may enroll mid year if you have a change in status OR you will have to wait until the next Open Enrollment period.

**When Does Coverage Begin?**

Your coverage under the Plan will begin the first of the month following 8 weeks of full-time continuous employment. Your eligible dependents' coverage under the Plan will begin on the same date if you make the necessary elections within the time period required.

**Please refer to the Benefits Booklets for additional details on eligibility and enrollment. Although enrollment in certain plans may be automatic, coverage may not be automatic.** For example, you may be enrolled but will need to take steps to finalize your coverage.

### CURRENT EMPLOYEES

Open Enrollment is held before the start of the plan year. This is your opportunity to enroll, change, or drop coverage. Changes are effective on January 1 following Open Enrollment. You'll receive information, including instructions on how to enroll, before Open Enrollment each year.

## CONTRIBUTIONS

### EMPLOYEE CONTRIBUTIONS

Windstream Services, LLC has established the Windstream Services, LLC Cafeteria Plan, a premium conversion plan under Internal Revenue Code Section 125, so that you will be able to pay your share of certain Plan benefits on a pre-tax basis. You pay your share of the cost of Medical, Dental, and Vision coverage you elect for yourself, your spouse, and any tax dependents on a pre-tax basis. If your enrolled eligible dependents are not eligible for tax-free coverage, you pay contributions for them on a

pre-tax basis, but will be subject to imputed income on the value of coverage. The level of contribution is determined by the Company.

Contributions to the Health Care FSA and Childcare/Daycare/Eldercare FSA are also on a pre-tax basis. If you wish to enroll, you will be required to agree to have your salary reduced by your elected contribution amount. If you are enrolled in the high deductible health plan you may make pre-tax contributions to a Health Savings Account.

If you are enrolled in Supplemental Life, Supplemental AD&D, Dependent Life, Group Pre-Paid Legal, Voluntary Accident Insurance, Voluntary Critical Illness Insurance and Voluntary Hospital Indemnity Insurance coverage, you pay the cost for coverage on an after-tax basis. Contributions are deducted from your paychecks based on your elected level of coverage.

You do not pay Social Security taxes on the pre-tax dollars you use to pay for coverage under the Plan. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these contributions. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the Plan will normally be greater than any eventual reduction in Social Security benefits.

Employees who are on leave and not receiving regular paychecks will be required to make any required contribution directly to Windstream (c/o BUSINESSOLVER.COM, INC) Address: PO Box 850512, Minneapolis, MN 55485-0512, 888-850-1712.

## RETIREE CONTRIBUTIONS

Except as described below, Retirees are expected to pay the full cost of any coverage elected for themselves and their dependents. In other words, while employees often are required to pay only a portion of the premium or contribution required to participate in the Plan benefit, with the Company paying the other portion, Retirees in most cases are responsible for the full premium or the full contribution amount required for participation.

In some cases, the Company subsidizes the cost of Medical and Basic Life coverage for certain eligible Retirees and/or dependents. Effective as of 11:59 p.m. on December 31, 2021, the Company eliminated those retiree coverage subsidies for all but a limited number of Retirees (and dependents). Beginning January 1, 2022, Retirees and their dependents are eligible to receive subsidies only if they fall into one of the groups described in the table below, are otherwise eligible for the Plan benefits for which the subsidies are provided, and are determined by the Plan Administrator to be subsidy-eligible.

| Group | Potentially Eligible For: |
|---|---|
| Retirees provided a subsidy for Basic Life coverage pursuant to one of the following:<br>• Agreement Between Windstream Kentucky LLC and Communications Workers of America Local Union 3371 and Local Union 3372 dated June 8, 2018<br>• Agreement Between Windstream Carolina, LLC and Communications Workers of America Local Unions 3683 and 3716 dated April 3, 2020 | Subsidized Basic Life Insurance |

| | |
|---|---|
| "GTE Agreement Retirees," which refers to individuals identified in:<br>• Schedule 11.2.3(b)(i) of the Asset Purchase Agreement Between GTE Southwest Incorporated and dba Texas Operating Co., LP dated September 3, 1999<br>• Schedule 11.2.3(b)(i) of the Asset Purchase Agreement Between GTE Southwest Incorporated and dba New Mexico Operating Co., LLC dated September 3, 1999<br>• Schedule 11.2.3(b)(i) of the Asset Purchase Agreement Between GTE Southwest Incorporated and dba Oklahoma Operating Co., LLC dated October 22, 1999 | Subsidized Basic Life Insurance |
| Certain former Communications Workers of America ("CWA") Local Union 6171 and Local Union 7019 bargained employees who retired prior to January 1, 2021 and who have been designated by the Company as eligible for subsidies. | Subsidized Basic Life Insurance |
| GTE Agreement Retirees who are designated by the Company as eligible for Medical and/or Retiree-Only Health Reimbursement Arrangement subsidies based on age and years of service and/or certain dependents of those Retirees. | Subsidized Medical |

Retirees are required to make any required contribution directly to Windstream (c/o BUSINESSOLVER.COM, INC) Address: PO Box 850512, Minneapolis, MN 55485-0512, 888-850-1712. All payments are made on an after-tax basis.

## MAKING CHANGES TO YOUR COVERAGE DURING THE YEAR

In general, the benefit plans and coverage levels you choose when you are first enrolled remain in effect for the remainder of the Plan Year in which you are enrolled. Elections you make at Open Enrollment generally remain in effect for the following plan year (January 1 through December 31). However, there are some circumstances that trigger mid-year enrollment rights or election change windows, as described below.

If, due to a HIPAA special enrollment event or change in status, you make a timely mid-year request to enroll yourself or a dependent in the Medical, Dental, Vision, Health Care FSA and/or Childcare/Daycare/Eldercare FSA benefits or change the type or level of coverage you have under those benefits, coverage will generally be effective as of the event date. For example, if you have made a change to your Medical coverage due to the birth or adoption of a child, your election change will be effective as of the date of the birth or adoption (or placement for adoption).

If you timely request to cancel or drop coverage due to a special enrollment event or change in status, generally those cancelations are effective on the event date or the end of the month in which the coverage ends (for example, if a dependent child turns 26 mid-month, his or her Medical coverage is canceled at the end of that month).

**What happens if you return to work with Windstream Services, LLC?**

If you were a former Employee of Windstream Services, LLC who returns to work within 30 days of termination of employment, your prior benefits will be reinstated. If you return to work within a 13-week

break-in-service (i.e., after 30 days but no later than 91 days), you will remain eligible for benefits and can either have your prior elections reinstated or can elect new benefits; such coverage, if elected within 30 days of your return to service, will be effective the first of the month following return. All employees rehired later will be considered new hires, subject to the Plan's waiting period. For more information, see *Eligibility* above.

## HIPAA Special Enrollment Events

If you decline enrollment for Medical benefits for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the Medical benefits provided under this Plan if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your eligible dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and your new eligible dependent children. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

The Plan recognizes a HIPAA special enrollment window for employees and dependents who are eligible but not enrolled if they lose Medicaid or CHIP coverage because they are no longer eligible, or they become eligible for a state's premium assistance program. Employees have 60 days from the date of the Medicaid/CHIP event to request enrollment under the Plan. Specific restrictions may apply, depending on federal and state law.

To request special enrollment or obtain more information, call 1-888-850-1712 or make your election changes via the web at windstreambenefits.com.

## Changes in Status

### Dependent Life, Supplemental Life, and Supplemental AD&D Mid-Year Changes

You cannot make changes to your Supplemental Life and Dependent Life or Supplemental AD&D elections during the Plan Year, unless you have a change in status.

### Voluntary Benefits Mid-Year Changes

In general, you cannot drop your Group Pre-Paid Legal coverage during the Plan Year unless your employment with the Company terminates. You may be able to enroll in Group Pre-Paid Legal coverage during the Plan Year if you experience certain changes in status.

You cannot make changes to your Voluntary Accident Insurance, Voluntary Critical Illness Insurance or Voluntary Hospital Indemnity Insurance elections during the Plan Year, unless you have a change in status, except that you can drop coverage at any time.

## Medical, Dental, Vision, and FSA Mid-Year Changes

You may be able to change your Medical, Dental, Vision, Health Care FSA or Childcare/Daycare/Eldercare FSA elections during the Plan Year if you experience a change in status.

If you experience one of the events described below and want to make a change to your coverage due to such event, you must notify Windstream Services, LLC within 30 days of the event (or 60 days for certain events as described under the *HIPAA Special Enrollments* section). If you do not notify Windstream Services, LLC within the 30-day period, you will not be able to make any changes to your coverage until the next Open Enrollment period.

Please note that in order to change your benefit elections due to a change in status where you are adding new dependents, you must show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, adoption decree, etc.) within 30 days of the date that the election change is processed. The following is a list of changes in status that may allow you to make a change to your elections (as long as you meet the consistency requirements, as described below).

- **Legal marital status:** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment;
- **Number of eligible dependents:** Any event that changes your number of eligible dependents including birth, death, adoption, legal guardianship, and placement for adoption;
- **Employment status:** Any event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage. Examples include:
  - Beginning or ending employment;
  - A strike or lockout;
  - Starting or returning from an unpaid leave of absence;
  - Changing from part-time to full-time employment or vice versa; and
  - A change in work location.
- **Dependent status:** Any event that causes your dependents to become eligible or ineligible for coverage because of age, student status, or similar circumstances;
- **Residence:** A change in the place of residence for you or your eligible dependents if:
  - the change results in your or your eligible dependents living outside your Medical, Dental, or Vision plan's network service area; or
  - you or your eligible dependent(s) move into the United States from outside of the country, as of the date of entry into the United States.
- **HIPAA Special Enrollment Events**: Events such as the loss of other coverage that qualify as special enrollment events under Health Insurance Portability and Accountability Act (HIPAA);
- **FMLA leave:** Beginning or returning from an FMLA leave;
- **Reduction in hours of service**: You and your dependents may drop your group health plan coverage under the Plan, even if you remain eligible for such coverage, if:
  - You were reasonably expected to work 30 hours per week and you experience a change in employment, after which you are reasonably expected to work less than 30 hours per week
  - You intend to enroll yourself and any dependents dropping coverage in another health plan (satisfying the Affordable Care Act's definition of minimum essential coverage) effective no later than the first day of the 2nd month after you drop Windstream Services, LLC coverage.
  - You are not permitted to change your health FSA elections because of a reduction in hours of service.
- **Enrollment in a health plan offered through the public Marketplace:**
  - If you are eligible for a special enrollment period to enroll in public Marketplace coverage, or you want to enroll in public Marketplace coverage during the public Marketplace's annual open

enrollment period, you may drop group health plan coverage under this Plan (including for any dependents, if applicable), even if you remain eligible for coverage under this Plan.
- If your enrolled dependent(s) become(s) eligible for a special enrollment period to enroll in public Marketplace coverage, or they want to enroll during the public Marketplace's annual open enrollment period, you may drop group health plan coverage for them under this Plan. However, you can retain enrollment for you and any covered dependents who do not intend to move to the Marketplace.
- Any individual whose coverage is dropped at this time must intend to enroll in public Marketplace coverage that is effective no later than the day immediately following the last day coverage under this Plan is dropped.
- You are not permitted to change your health Flexible Spending Account elections because you or your dependent(s) intend to enroll in a plan offered through the public Marketplace.

### Consistency Requirements for Changes in Status

Except for election changes due to a HIPAA special enrollment, changes as a result of a reduction in hours of service, and changes because of your enrollment in a health plan offered by the public Marketplace, the changes you make to your coverage must be "on account of and correspond with" the event. To satisfy this "consistency rule," both the event and the corresponding change in coverage must meet all the following requirements:

- **Effect on eligibility:** The event must affect eligibility for coverage under the Plan or under a plan sponsored by your dependent's employer. This includes any time you become eligible (or ineligible) for coverage or if the event results in an increase or decrease in the number of your dependent child(ren) who may benefit from coverage under the Plan.
- **Corresponding election change:** The election change must correspond with the event. For example, if your dependent child(ren) loses eligibility for coverage under the terms of the health plan, you may cancel health coverage only for that dependent child(ren). You may not cancel coverage for yourself or other covered dependents.

## Other Events that Allow You to Change Elections

### Entitlement to Government Benefits

If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid, or lose entitlement to certain other governmental group medical programs, you may make a corresponding change to your Medical, Dental, Vision, Supplemental AD&D, and Health Care FSA elections.

### QMCSOs

If a Qualified Medical Child Support Order (QMCSO) requires the Plan to provide coverage to your child, then the Plan Administrator may automatically change your election under the Plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of the QMCSO, if you desire. If the QMCSO requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan if you provide proof to the Plan Administrator that such other person actually provides the coverage for the child.

## Cost or Coverage Change Events

In some instances, you can make elections if the type of coverage or cost of coverage changes. These rules do not apply for purposes of a Health Care FSA. Please note that if the change occurs to another employer's plan, you may be required to show proof verifying these events have occurred.

### Cost Changes

If Windstream Services, LLC determines there is a significant increase or decrease in the cost of Medical, Dental and Vision coverages, you may be permitted to revoke your election and make a corresponding new election. If you previously declined coverage, you may also make a corresponding new election. In the event you elect a different plan administrator due to a significant increase or decrease in the cost of coverage, any amounts that were previously applied toward your annual deductible or out-of-pocket maximum will *not* apply to the new administrator.

Any change in the cost of your plan option that the Company determines is *not* significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.

### Coverage Changes

The following are additional situations in which you may change your current coverage.

**Restriction or Loss of Coverage** — If your coverage is significantly restricted or ceases entirely, you may revoke your elections and elect coverage under another option that provides similar coverage. Coverage is considered "significantly restricted" if there is an overall reduction in benefits coverage. If the restriction is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election.

**Addition to or Improvement in Coverage** — If Windstream Services, LLC adds a coverage option or significantly improves a coverage option during the year, you may revoke your existing election and elect the newly added or newly improved option.

**Changes in Coverage under Another Employer Plan** — If your spouse or dependent child(ren) is employed and their employer's plan allows for a change in your family member's coverage (either during that employer's Open Enrollment period or due to a mid-year election change permitted under the Internal Revenue Code), you may be able to make a corresponding election change under the Plan. For example, if your spouse elects family coverage during their employer's open enrollment period, you may request to end your coverage under the Plan.

**Loss of Other Group Health Plan Coverage** – If you or your spouse or dependent child(ren) lose coverage under another group health plan sponsored by a governmental or educational institution, including a state children's health insurance program (CHIP), medical care program of an Indian Tribal government, state health benefits risk pool, or a foreign government group health plan, you may enroll in coverage under this Plan.

### Childcare/Daycare/Eldercare FSA Cost or Coverage Changes

In addition to the changes described above, you may make mid-year election changes to your Childcare/Daycare/Eldercare FSA if you have one of the following events:

- An increase or decrease in dependent care provider fees (except for increases or decreases by a provider who is related to you);
- You choose a different dependent care provider who charges a different amount; or

- You make a change to your or your spouse's regular work schedule that increases or decreases your need for dependent care.

# COVERAGE DURING LEAVE OF ABSENCE

The sections below describe benefit continuation for two specific types of leave: Family and Medical Leave of Absence and Active Military Leave of Absence. For more information about any type of leave of absence, contact the Windstream Benefits Committee, 4005 N. Rodney Parham Rd., Little Rock, AR 72212, 501-748-7000.

## FMLA LEAVE

The federal Family and Medical Leave Act (FMLA) allows eligible employees to take a specific amount of unpaid leave for serious illness, the birth or adoption of a child, to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded while on active duty in the Armed Forces, or to deal with any qualifying exigency that arises from a family member's active duty or call to active duty in the Armed Forces or a military reserve unit from the National Guard, Military Reserve or retired status in the Armed Forces or Reserve. This leave is also available for family members of veterans for up to five years after a veteran leaves service if he or she develops a service-related injury or illness incurred or aggravated while on active duty. For additional information on FMLA leaves, please contact Windstream Services, LLC, 4005 N. Rodney Parham Rd., Little Rock, AR 72212, 501-748-7000.

If you take an FMLA leave, you may continue your group health coverage (Medical, Care Management, Advocacy, and Navigation, Dental, Vision, Employee Assistance Plan, Health Care FSA, and Wellness coverage) for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave. If you take a paid leave of absence, the cost of group health coverage will continue to be deducted from your pay on a pre-tax basis. If you take an unpaid leave of absence that qualifies under FMLA, you may continue your participation as long as you contribute the active employee share of the cost of group health coverage during the leave by pre-paying for your coverage on a pre-tax basis and/or catching up with pre-tax contributions upon your return from leave. You also have the option to suspend your health coverage during the leave.

If your Health Care FSA coverage terminates during your leave, you may be reinstated if you return to work in the same year that your leave began. You will have a choice to resume contributions to the spending accounts at the same level in effect before your leave, or you may elect to increase your contributions to "make up" for contributions you missed during your leave period. If you simply resume your prior contribution level, the amount available for reimbursement for the year will be reduced by the contributions missed during your leave. Regardless of whether you choose to resume your former contribution level, or make up for missed contributions, expenses incurred while your account participation is suspended will not be reimbursed.

If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections (for example, if you have a baby and want to increase your Health Care FSA coverage amount).

Your Basic Life, Basic AD&D and Long-Term Disability coverages will continue during an FMLA leave. Your Supplemental Life, Supplemental AD&D, Dependent Life, Group Pre-Paid Legal, Voluntary Accident Insurance, Voluntary Critical Illness Insurance and Voluntary Hospital Indemnity Insurance coverage will continue during FMLA leave if you continue to pay the required after-tax contributions during your leave. Your contributions to the Childcare/Daycare/Eldercare FSA will continue during a paid leave, but will be suspended if the leave is unpaid.

Any coverages that are terminated during your FMLA leave will be reinstated upon your return without any evidence of good health or newly imposed waiting period.

If you lose any group health coverage during an FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your group health coverage will start again on the first day after you return to work and make your required contributions.

If you do not return to work at the end of your FMLA leave you may be entitled to purchase COBRA continuation coverage (see *COBRA* section below).

## MILITARY LEAVE

If you take a military leave, whether for active duty or for training, you are entitled to extend your Medical, Care Management, Navigation, Dental, Vision, Employee Assistance Plan and Health Care FSA, and Wellness coverage for up to 24 months as long as you give the Company advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your total leave, when added to any prior periods of military leave from the Company, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit — including situations where service members are involuntarily retained beyond their obligated service date; additional required training; federal service as a member of the National Guard; and service under orders during war or national emergencies declared by the President or Congress. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the contributions required for active employees. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave.

All other coverages will continue to the extent such coverage is permitted under the applicable Benefit Booklet, and you make any applicable contributions during your military leave, if any.

If you take a military leave, but your coverage under the Plan is terminated — for instance, because you do not elect the extended coverage — when you return to work at the Company, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health plan coverages. USERRA permits a health plan to impose an exclusion or waiting period to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months (see *COBRA* section below). However, your military leave benefits continuation period runs concurrently with your COBRA coverage period, subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. (See *COBRA* section) Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

## WHEN COVERAGE ENDS

Your coverage will terminate on the earliest of the following dates:

- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, by termination of the insurance contract or agreement, or with respect to employees and their dependents, by discontinuance of contributions by the Company;
- For Medical, Care Management, Advocacy, and Navigation, Dental, Vision, EAP, Health Care FSA, Childcare/Daycare/Eldercare FSA, Commuter FSA, Basic Life, Supplemental Life, Dependent Life, Basic AD&D, Supplemental AD&D, Voluntary Accident Insurance, Voluntary Critical Illness Insurance and Voluntary Hospital Indemnity Insurance benefits, the end of the month in which you cease to satisfy the eligibility requirements due to reduction in hours or termination of active employment, unless eligible for and electing coverage as a Retiree (except that in the event of your death, all coverage will cease as of that date);
- For Long-Term Disability, Group Pre-Paid Legal benefits, the date you cease to satisfy the eligibility requirements for a particular Plan benefit; which may result from your death, reduction in hours, or termination of active employment;
- The end of the period for which you paid your required contribution if the contribution for the next period is not paid when due; or
- The date you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained in the *Military Leave* section above.

Other circumstances that can result in the termination, reduction, loss or denial of benefits (for instance, exclusions for certain medical procedures) are described in the Benefit Booklets.

Coverage for your spouse and other dependents generally terminates when your coverage terminates, except that if you are covered as a Retiree, subject to any different eligibility rules applicable to a fully-insured benefit:

- Depending on your Retiree classification, as determined by the Company, your covered dependent may be permitted to continue coverage as a primary covered individual or dependent, as appropriate, in the event of your death, as long as such dependent remains otherwise eligible.; and
- If your coverage ends because you reach the age limit for coverage (e.g., age 65 for Medical coverage), your covered spouse under age 65and/or your covered dependent children may remain covered until they reach the applicable age limit, provided they remain otherwise eligible.

Their coverage will also cease for other reasons specified in the Benefit Booklets. In addition, their coverage will terminate:

- For your dependent child, for Medical, Dental and Vision coverage, the end of month in which he or she attains age 26, unless he or she is mentally or physically disabled and primarily depends on you for support;
- In the case of divorce, coverage for your dependent(s) will terminate as of the date of divorce;
- In the case of the death of a dependent, his or her coverage will end as of that date;
- With respect to dependents of employees, the end of the pay period in which you stop making contributions required for dependent coverage,
- With respect to dependents of Retirees, the end of the period for which you or your dependents paid the required contribution if the contribution for the next period is not paid when due; or
- For children covered pursuant to a QMCSO, coverage will end as of the date that the child is no longer covered under a QMCSO.

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) might have the right to continue health coverage temporarily under COBRA (see *COBRA* section below) or under a conversion right under a particular benefit plan. Refer to your Benefit Booklets for more information on conversion.

# COBRA

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances (called "qualifying events") when coverage would otherwise end. The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children who lose coverage for certain specified situations.

The following paragraphs generally explain COBRA coverage, when it may become available to you and your spouse and dependent children, and what you need to do to protect the right to receive it. COBRA applies to Medical, Dental, Vision, EAP, Health Care FSA and Wellness benefits. COBRA does not apply to any other benefits offered under the Plan (such as Life, LTD, or Basic/Supplemental AD&D benefits). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Summary Plan Description is intended to expand your rights beyond COBRA's requirements.

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

## What is COBRA Coverage

COBRA coverage is temporary continuation of group health coverage under the Plan when coverage would otherwise end because of a "qualifying event". After a qualifying event occurs and any required notice of that event is properly provided to the COBRA Administrator (see Contact Information below), COBRA coverage will be offered to each person losing group health coverage under the Plan who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if group health coverage under the Plan is lost because of the qualifying event.

COBRA coverage is the same coverage that the Plan provides to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the Plan's group health coverage elected by the qualified beneficiaries, including Open Enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay the full cost for COBRA coverage.

The pronoun "you" in the following paragraphs regarding COBRA refers to each person covered under the Plan who is or may become a qualified beneficiary.

## Who Is Covered

### Employees

If you are an employee of the Company, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of either one of the following qualifying events:

- A reduction in your hours of employment with the Company or
- The termination of your employment with the Company (for reasons other than gross misconduct on your part).

**Retiree**

If you are a Retiree, or the spouse or a dependent child of a Retiree of the Company, you will have the right to elect COBRA if you lose your group health coverage under the Plan because the employer declares bankruptcy under Chapter 11.

**Spouse**

If you are the spouse of an employee of the Company, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of any of the following qualifying events:

- The death of your spouse;
- The termination of your spouse's employment with the Company (for reasons other than your spouse's gross misconduct) or reduction in your spouse's hours of employment with the Company; or
- Divorce or legal separation from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

If you are the spouse of a Retiree, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of any of the following qualifying events:

- The death of your spouse; or
- Divorce or legal separation from your spouse. Also, if your spouse (the Retiree) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

**Dependent Children**

If you are a dependent child of an employee, you will have the right to elect COBRA if you lose your group health coverage under the Plan because any of the following qualified events:

- The death of the parent-employee;
- The termination of the parent-employee's employment with the Company (for reasons other than the employee's gross misconduct) or reduction in the employee's hours of employment;
- The parent-employee's divorce or legal separation; or
- You, the dependent child, cease to meet the definition of a "dependent child" under the Plan.

If you are a dependent child of a Retiree, you will have the right to elect COBRA if you lose your group health coverage under the Plan because any of the following qualified events:

- The death of the parent Retiree;
- The parent Retiree's divorce or legal separation; or
- You, the dependent child, cease to meet the definition of a "dependent child" under the Plan.

### FMLA

If you take a leave of absence that qualified under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the leave, you (and your spouse and dependent children, if any) will have the right to elect COBRA if:

- you were covered by group health coverage under the Plan on the day before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and
- you lose group health coverage under the Plan because the employee does not return to work at the end of the leave.

COBRA coverage will begin on the earliest of the following to occur:

- when you definitively inform the Company that you are not returning at the end of the leave; or
- the end of the leave, assuming you do not return to work.

### Newly Eligible Child

If you, the former employee of the Company, elect COBRA coverage and then have a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Plan's eligibility and other requirements for group health coverage and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing the COBRA Administrator with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 30 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

If you fail to notify the COBRA Administrator within the 30 days, you will *not* be offered the option to elect COBRA coverage for the newly acquired child. Newly acquired dependent child(ren) (other than children born to, adopted by, or placed for adoption with the employee) will not be considered qualified beneficiaries, but may be added to the employee's continuation coverage, if enrolled in a timely fashion, subject to the Plan's rules for adding a new dependent.

### QMCSO

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by Windstream Services, LLC during the covered employee's period of employment with Windstream Services, LLC is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

## When is COBRA Coverage Available

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to the qualified beneficiaries. You do not need to notify the Plan Administrator or COBRA Administrator of any of these three qualifying events. Instead, in those cases, your employer will notify the Plan Administrator of the qualifying event no later than 30 days after the loss of coverage associated with the qualifying event.

For a qualifying event which is a divorce or legal separation of the employee/Retiree and spouse or a dependent child's losing eligibility for coverage, a COBRA election will be available to you only if you notify the Plan Administrator (see Contact Information below) in writing within 60 days of the later of the of the qualifying event or the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You or a representative acting on your behalf (such as a family member) are responsible for providing the required notice.

The notice must include the following information:

- The name of the employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiaries who lost (or will lose) coverage under the Plan due to the qualifying event;
- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the qualifying event, if the Plan Administrator or COBRA Administrator requests it. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s), driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail or hand deliver this notice to the Plan Administrator at the address listed below under Contact Information. If the above procedures are not followed or if the notice is not provided to the Plan Administrator within the 60-day notice period, you will lose your right to elect COBRA. In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any claims mistakenly paid.

## How to Elect COBRA

To elect COBRA coverage, you must complete the election form that is part of the Plan's COBRA election notice and mail it to the COBRA Administrator.

An election notice will be provided to qualified beneficiaries at the time of the qualifying event.

Under federal law, you must elect COBRA coverage within 60 days from the date you would lose coverage due to a qualifying event, or, if later, 60 days after the date you are provided with the COBRA election notice from the Plan. Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA.

If you return your election form waiving your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA coverage as long as it is within the original 60-day election period. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

### Separate Elections

Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the employee does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child may elect different coverage than the employee elects.

A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage.

### Coverage

If you elect COBRA continuation coverage, your coverage will generally be identical to coverage provided to "similarly situated" employees or family members at the time you lose coverage. However, if any changes are made to coverage for similarly situated employees or family members, your coverage will be modified as well. "Similarly situated" refers to a current employee or dependent child(ren) who has not had a qualifying event. Qualified beneficiaries on COBRA have the same enrollment and election change rights as active employees.

### Medicare and Other Coverage

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage. When you complete the election form, you must notify Windstream Services, LLC if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

## Health Care FSA COBRA Coverage

COBRA coverage under the Health Care FSA will be offered only to qualified beneficiaries losing coverage. COBRA coverage for the Health Care FSA, if elected, will consist of the Health Care FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-or-lose rule will continue to apply. All qualified beneficiaries who were covered under the Health Care FSA will be covered together for Health Care FSA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate Health Care FSA annual coverage limit and a separate COBRA premium.

## Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan. Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

All COBRA premiums must be paid by check, ACH debit or on-line credit card payment, as permitted by the COBRA Administrator. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the COBRA Administrator.

If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

COBRA coverage is not effective until you elect it *and* make the required payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

### Duration of COBRA

If you lose Plan coverage because of termination of employment or reduction in hours, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 18 months. For all other qualifying events, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 36 months. The maximum coverage period begins to run on the date that coverage would otherwise be lost due to the qualifying event.

When Plan coverage is lost because of termination of employment or reduction in hours, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE termination or reduction of hours.

The maximum COBRA coverage period for the Health Care FSA ends on the last day of the Plan Year in which the qualifying event occurred. COBRA coverage for the Health Care FSA cannot be extended under any circumstances.

If you lose Retiree Medical Plan coverage because of the bankruptcy of the employer, the law requires that you be given the opportunity to maintain COBRA coverage until the death of the Retiree, or in the case of a covered surviving spouse or children of a Retiree, for up to 36 months after the death of the Retiree.

COBRA coverage can end before any of the above maximum periods for several reasons. See the *Early Termination of COBRA* section below for more information.

### 29-Month Qualifying Event (Due to Disability)

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. The disability must have started at some time before the 61st day of COBRA coverage due to the covered employee's termination of employment or reduction of hours and must last until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

To continue coverage for the additional 11 months, you or a representative acting on your behalf must notify the COBRA Administrator in writing of the Social Security Administration's determination within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The name and address of the disabled qualified beneficiary;
- The date that the qualified beneficiary become disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- The signature, name and contract information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail or hand deliver this notice to the COBRA Administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no disability extension of COBRA coverage.

If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify the COBRA Administrator of this determination within 30 days of the date it is made and COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as described above, and include the same information required for, a notice of disability as described above.

### Second Qualifying Event

An extension of coverage will be available to the spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction in hours. Second qualifying events include an employee's death, divorce, or a child losing dependent status (if such qualifying event would have resulted in a loss of coverage under the plan for an active employee or dependent). If you experience a second qualifying event, COBRA coverage for a spouse or dependent child can be extended from 18-months (or 29 months in case of a disability extension) to 36 months, but in no event will coverage last beyond 36 months from the initial qualifying event or the date coverage would have been lost due to the initial qualifying event.

This extension is only available if you or a representative acting on your behalf notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would have lost coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the

qualified beneficiary was still covered under the Plan as an active participant). The notice must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The second qualifying event;
- The date of the second qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the Plan requests it. Acceptable documentation includes a copy of the divorce decree, death certificate or dependent child(ren)'s birth certificates, driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail this notice to the COBRA Administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

### Early Termination of COBRA

The law provides that your COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- The Company no longer provides group health coverage to any of its employees;
- The premium for COBRA continuation coverage is not paid on time (within the applicable grace period);
- The qualified beneficiary first becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee);
- The qualified beneficiary first becomes entitled to Medicare (under Part A, Part B or both) after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the Social Security Administration that the individual is no longer disabled. Coverage will end no sooner than the first of the month that is more than 30 days from the date Social Security determines that the individual is no longer disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant not receiving COBRA coverage (such as fraud). In addition, Windstream Services, LLC reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage. COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health coverage. Windstream Services, LLC, the insurance carriers and/or HMOs may require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice.

In addition, you must notify the COBRA Administrator in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled. See the *29-Month Qualifying Event (Due to Disability)* section above.

**Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

### Contact Information

If you have any questions about COBRA coverage or the application of the law, please contact:

COBRA Administrator:
Windstream (c/o BUSINESSOLVER.COM, INC.)
PO Box 850512
Minneapolis, MN 55485-0512
windstreambenefits.com
1-888-850-1712

Plan Administrator:
Windstream Benefits Committee
4005 N. Rodney Parham Rd., Little Rock, AR 72212
501-748-7000

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. For more information about the Marketplace, visit www.HealthCare.gov.

### Keep Your Plan Informed of Address Changes

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

## COVERED AND NON-COVERED SERVICES

Refer to the Benefit Booklets provided by your applicable insurance company and/or service provider for a specific listing of covered and non-covered services under your benefits.

### Special Rights for Mothers and Newborn Children

For the mother or newborn child, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or 96 hours following a Cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or newborn earlier than 48 hours (or 96 hours, as applicable) after the delivery. In any case, no authorization is required from the Plan or an insurance company for a length of stay that does not exceed 48 hours (or 96 hours).

### Women's Health and Cancer Rights Act

The Plan will provide certain coverage for benefits received in connection with a mastectomy, including reconstructive surgery following a mastectomy. This benefit applies to any covered employee or dependent, including you, your spouse, and your dependent child(ren).

If the covered person receives benefits under the Plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the covered person. Coverage may apply to:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Benefits for breast reconstruction are subject to annual Plan deductibles and coinsurance provisions that apply to other Medical and surgical benefits covered under the Plan.

# HEALTH CARE FSA BENEFITS

The Health Care FSA may be of interest to you if you are paying for health care expenses that are not fully reimbursed or not covered by your health coverage. You are not eligible to participate in the Health Care FSA if you are enrolled in Medical coverage paired with a health savings account.

This section explains how the Health Care FSA allows you to pay for certain health care expenses with pre-tax dollars. By participating, you will receive a portion of what would otherwise be your regular pay in health care expense reimbursement. This also reduces the amount of taxable income you receive and, therefore, reduces your taxes.

## COVERED DEPENDENTS

You may submit health care expenses incurred by you, your spouse, and your tax dependents as listed in the *Eligible Dependents* section above.

## CONTRIBUTION LIMITS

You may contribute any whole dollar amount of not more than $3,050, or, if different, the maximum allowed by the IRS per Plan Year of your own money to your Health Care FSA.

## ELIGIBLE EXPENSES

The Health Care FSA is an account that allows you to put money aside to reimburse yourself for "eligible" health care expenses. Expenses must be incurred during the Plan Year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill. You may submit bills for any expense for medical care, as defined in Section 213 of the Internal Revenue Code (except health insurance premiums, long-term care premiums and expenses associated with long-term care and other health care premiums), which you are obligated to pay and which are not covered by any plan.

This may include amounts that are not paid by your employer-sponsored health care plan, such as deductibles, coinsurance, co-payments, expenses in excess of plan dollar limits, or those which exceed customary and reasonable fees. You may also submit bills for Medical, Dental, and Vision expenses that are not reimbursed by another plan so long as they are medical expenses you could have claimed on your individual income tax return (Form 1040).

Expenses eligible to be reimbursed from the Health Care FSA include expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body. Expenses must be to alleviate or prevent a physical or mental defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person's general health (except

smoking cessation and physician-directed weight reduction programs) are not eligible for reimbursement.

Below is a partial list of expenses eligible for reimbursement under the Health Care FSA:

- Medical Expenses
  - Deductibles
  - Copayments
  - Coinsurance
  - Charges for routine check-ups, physical examinations, and tests connected with routine exams
  - Charges over the "reasonable and customary" limits
  - Expenses not covered by the Medical plan due to exclusion by the insurance company
  - Drugs requiring a doctor's written prescription that are not covered by insurance
  - Over-the-counter drugs and other over-the-counter items such as bandages, crutches, and other supplies, but only to the extent applicable regulations permit
  - Menstrual care products
  - Personal protective equipment (PPE) for the primary purpose of preventing the spread of COVID-19
  - Insulin (which may be reimbursed without a prescription)
  - Smoking cessation programs and related medicines
  - Weight loss programs which are at the direction of a physician to treat a medical condition such as hypertension (weight loss programs for general health improvement do not qualify)
  - Other selected expenses not covered by the Medical plan that qualify for a federal income tax deduction, such as special services and supplies for the disabled (such as seeing eye dogs for the blind, dentures and artificial limbs, wheelchairs and crutches).
- Dental Expenses
  - Deductibles
  - Coinsurance
  - Copayments
  - Expenses that exceed the maximum annual amount allowed by your Dental plan
  - Charges over the "reasonable and customary" limits
  - Orthodontia treatments that are not strictly cosmetic
- Vision and Hearing Expenses
  - Vision examinations and treatment not covered by insurance plan
  - Cost of eyeglasses, laser surgery, prescription sunglasses, contact lenses including lens solution and enzyme cleaner
  - Cost of hearing exams, aids and batteries
- Transportation - Amounts paid for transportation for health care can be claimed. Transportation costs do not include the cost of any meals and lodging while away from home and receiving health care treatment.

## INELIGIBLE EXPENSES

Below is a partial list of expenses ***not*** eligible for reimbursement under the Health Care FSA:

- Premiums
  - Premiums paid by the Employee, a spouse or other Dependents for coverage under any health plan
  - Premiums paid for Medicare
  - Premiums paid for Long Term-Care Insurance
  - Premiums paid for policies that provide coverage for loss of earnings, accidental death, loss of limbs, loss of sight, etc.

- Cosmetic Procedures that are strictly cosmetic, such as electrolysis, teeth bleaching, hair transplants or plastic surgery is not an expense for Medical care.
- Expenses Related to General Health - Expenses incurred must be primarily for the prevention or alleviation of a physical or mental illness or defect. Therefore, an expense which is merely beneficial to the general health of an individual (such as an expenditure for vacation or health club dues, even if prescribed by a doctor) is generally not an expense for Medical care. Generally, only foods prescribed by your doctor as supplements to the normal diet may qualify as a Medical expense. This exclusion does not include menstrual care products or PPE.
- Long Term Care Expenses

The IRS does not allow you to deduct the same expenses on your income tax return for which you are reimbursed under the Health Care FSA.

These are general examples of reimbursable expenses and ineligible expenses. Actual claims must satisfy the Internal Revenue Code rules for tax deductibility. For more information, contact the Claims Administrator.

## USE OR LOSE

IRS regulations stipulate that you must use the full amount of money in your Health Care FSA for expenses incurred during the applicable Plan Year, or forfeit what remains. Your request for reimbursement must be filed within 90 days after the Plan Year in which funds are allocated to your Health Care FSA for expenses incurred during that Plan Year. **Any funds remaining in your Account after that date will be forfeited.**

With this **"use or lose"** rule, it is extremely important that you carefully plan your contributions to your Health Care FSA. Set aside only as much as you expect to claim during the Plan Year, or you will lose it.

If you have a balance left in your Health Care FSA after the claim run out period, you may carry over up to $570 of any remaining balance. This carryover amount may be increased annually, as permitted under IRS rules and as communicated annually by Windstream Services, LLC. If you have less than the maximum permissible carryover amount remaining, you may carry over up to the amount of your unused balance. The unused balance cannot be cashed out. Any amounts in excess of the maximum permissible carryover amount will be forfeited. If you enroll in a Health Savings Account following for the subsequent Plan Year (after enrolling in a high deductible health plan), you are electing NOT to carry over any unused balance under the Health Care FSA; that is, any such remaining Health Care FSA balance shall be forfeited. If you do not elect a Health Care FSA for the following Plan Year, you will not be able to carry over any unused amounts as otherwise described in this paragraph.

You may not use money in your Health Care FSA to pay dependent day care expenses and vice versa. You may not switch money between the two accounts.

## FILING A CLAIM

When you incur eligible health care expenses, you may submit a claim form along with the invoice or receipt for such expense. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator. If your claim is greater than the amount of money in your account, you will still be reimbursed for the total amount of your claim up to the maximum amount you elected to contribute to your account. Thereafter, you must still continue making contributions on a regular basis.

All claims for a Plan Year must be submitted to the Claims Administrator within 90 days after the Plan Year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

The Claims Administrator for the Health Care FSA is Businessolver.

You may be able to use a debit card for your reimbursable expenses. Your vendor will send you instructions about how your debit card works.

### WHAT HAPPENS WHEN YOUR EMPLOYMENT ENDS

Unless you elect to continue your health FSA coverage under COBRA (see *COBRA* section above), your health FSA coverage ends on your date of termination of employment. Only claims incurred on or before your date of termination may be reimbursed from your health FSA. See *Eligible Expenses* above for a discussion of when claims are considered to be incurred. All claims must be submitted to the Claims Administrator within 90 days after your date of termination. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

## CHILDCARE/DAYCARE/ELDERCARE FSA BENEFITS

The Childcare/Daycare/Eldercare FSA may be of interest to you if you are paying for the care of a child or disabled member of your household in order for you or, if you are married, for you and your spouse to work.

This section explains how the Childcare/Daycare/Eldercare FSA allows you to pay for certain dependent care expenses with pre-tax dollars. By participating, you will receive in dependent care expense reimbursement a portion of what would otherwise be your regular pay. This also reduces the amount of taxable income you receive and, therefore, reduces your taxes.

### QUALIFIED DEPENDENTS

Your dependents who qualify for the dependent care reimbursement account include your children under age 13, your spouse and other tax dependents as listed in the *Eligible Dependents* section above.

### CONTRIBUTION LIMITS

The IRS limits the amount you may contribute to your Childcare/Daycare/Eldercare FSA. Under the Plan, there is an overall annual maximum of $5,000 (or $2,500 each if you and your spouse file separate income tax returns). But another limitation also applies due to IRS rules. If you or your spouse earns less than the above amounts, the maximum contribution you can make is the lesser of your or your spouse's annual earnings.

For example: During the calendar year, Mary will earn $41,500 from her job. Mary's spouse will earn $3,600 from their job. Mary's reimbursement from a Childcare/Daycare/Eldercare FSA will be limited to $3,600. Mary can choose to contribute no more than $300 a month ($300 x 12 = $3,600) to a Dependent Care FSA.

For purposes of the IRS limit, your spouse will have a presumed income if your spouse is a full-time student or disabled and incapable of self care. For each month that your spouse is a full-time student or is incapacitated, your spouse's income is presumed to be the greater of your spouse's actual income (if any) or $250. If you have two or more qualified dependents, the presumed income is the greater of your spouse's actual income (if any) or $500 a month.

## ELIGIBLE EXPENSES

Eligible expenses for reimbursement under the Plan include expenses incurred for the care of your qualified dependents:

- In your home;
- In another person's home;
- At a licensed nursery school, day camp (not overnight camp) or qualified day care center. A day care center will qualify if it meets state and local requirements and provides care and receives payment for more than 6 people who do not reside there; or
- At a specialty day camp (e.g., soccer camp, computer camp).

Expenses must be incurred in order to allow you – or if you're married, you and your spouse – to work or if your spouse is disabled and unable to care for him/herself or is a full-time student for at least 5 months of the year. To be eligible, expenses must have been incurred during the Plan Year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill. The Childcare/Daycare/Eldercare FSA will offer a "grace period" where you can continue to incur claims after the end of the Plan Year for reimbursement from unused Dependent Care Flexible Spending Account funds. This grace period allows you to incur expenses until March 15th following the Plan Year.

If the care is provided in your home or the home of another person, the care provider must not be claimed as a dependent on your tax return and must be age 19 or older (determined as of the close of the taxable year). An adult dependent must spend at least 8 hours a day in your home in order for expenses for caring for that person to be eligible. Services must be for the physical care of the child or adult dependent, not for education, meals, etc., unless incidental to the cost of care.

## INELIGIBLE EXPENSES

You cannot use the money in your Childcare/Daycare/Eldercare FSA to pay for:

- General "baby-sitting" other than during work hours
- Care or services provided by:
  - Your children under age 19 (whether or not they are your tax dependents)
  - Anyone you (or your spouse if you are married) can claim as a dependent for federal income tax purposes
- Nursing home care
- Overnight camp
- Private school tuition
- Expenses for education (kindergarten and above)
- Expenses that would not otherwise be eligible to be credited on your federal income tax return
- The cost of transportation between the place where day care services are provided and your home unless such transportation is furnished by the dependent care provider
- Expenses incurred while you are off from work for any reason. However, if you pay your dependent care provider on a weekly or longer basis, dependent care expenses incurred during a temporary absence from work for illness or vacation may be eligible
- Expenses for which you claim IRS child care credit when you file your tax return

The IRS does not allow you to claim a credit for the same expenses on your income tax return for which you are reimbursed under the FSA.

## USE OR LOSE

It is important that you not contribute more than the dependent care expenses that you are sure to incur. IRS regulations stipulate that you must use the full amount of money in your Childcare/Daycare/Eldercare FSA for expenses incurred during the Plan Year and within the 2-½-month grace period following the Plan Year (e.g., January 1st to March 15th), or forfeit what remains. You must incur eligible expenses by March 15th in order for them to be eligible for reimbursement. Your request for reimbursement must be filed within 90 days after the Plan Year in which funds are allocated to your Childcare/Daycare/Eldercare FSA for expenses incurred during the Plan Year. **Any funds remaining in your Account after that date will be forfeited.**

With this **"use or lose"** rule, it is extremely important that you carefully plan your contributions to your Childcare/Daycare/Eldercare FSA. Set aside only as much as you expect to claim during the Plan Year and within the 2-½-month grace period following the Plan Year or you will lose it.

You may not use money in your Childcare/Daycare/Eldercare FSA to pay health care expenses and vice versa. You may not switch money between the two accounts.

## FILING A CLAIM

When you incur eligible dependent care expenses, you may submit a claim form along with the invoice or receipt for such expense. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator.

If you have incurred claims during the grace period, but have also elected a Dependent Care Flexible Spending Account for the following Plan Year, your claims will be reimbursed first from any balance remaining in your prior Plan Year account, and then from your current Plan Year account.

All claims for a Plan Year and the 2-½-month grace period following the Plan Year must be submitted to the Claims Administrator within 90 days after the Plan Year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

The Claims Administrator for the Childcare/Daycare/Eldercare FSA is Businessolver.

## WHAT HAPPENS WHEN YOUR EMPLOYMENT ENDS

Only claims incurred on or before your date of termination may be reimbursed from your dependent care FSA. See *Eligible Expenses* above for a discussion of when claims are considered to be incurred. All claims must be submitted to the Claims Administrator within 90 days after your date of termination. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

## SPECIAL RULES AFFECTING DEPENDENT CARE ACCOUNTS

Several special rules apply to Dependent Care Spending Accounts. You should consider the following paragraphs, as they may affect the amount you choose to contribute to this account:

The IRS requires that the maximum amount you can take as a child care tax credit for dependent care expenses be deducted – dollar for dollar – by any reimbursements you receive from your Childcare/Daycare/Eldercare FSA. ***Some employees will receive more tax advantages by taking the dependent care tax credit, while others will do better by contributing to the Childcare/Daycare/Eldercare FSA. Please consult your tax advisor or carefully review your situation before making a choice.***

The money in your Dependent Care Spending Account must be used to pay for dependent care expenses that allow you and your spouse to work. However, this rule does not apply if your spouse is disabled and incapable of self-care or a full-time student at an accredited institution for at least five months each year. See Contribution Limits above for more information.

If you and your spouse are divorced and you have custody of your child(ren), you may be able to be reimbursed from the Dependent Care Spending Account even if you do not claim the dependent on your federal income tax return. See IRS Publication #503 for more information. A copy of that publication can be obtained at www.irs.gov.

## MEDICAL FERTILITY BENEFITS

Progyny is the premier fertility benefit designed to provide all-inclusive comprehensive coverage for cutting-edge fertility treatments to assist any employee wishing to have a child. Progyny's program includes a credentialed provider network and a personalized concierge-style member support team (Patient Care Advocates) who offer education, support, and coordinated care.

Through Progyny's benefit, members have access to a full suite of fertility treatment options, which may include (but may not be limited to):

- Artificial Insemination (IUI)
- Cryopreservation of oocytes and sperm
- FDA Bloodwork and Testing
- Fresh IVF Cycle
- Frozen Embryo Transfer (FET)
- Frozen Oocyte Transfer (includes fertilization of previously frozen oocytes and transfer)
- IVF Freeze-All
- Patient Care Advocate (PCA) Concierge Support
- Pre-authorized fertility medications (via Progyny Rx)
- PGT-A (PGS, or Pre-implantation Genetic Screening) to assess embryo viability
- PGT-M (PGD, or Pre-implantation Genetic Diagnosis)
- Pregnancy Gap Coverage (Pregnancy monitoring coverage until the in-network fertility clinic releases the member into the care of the member's OBGYN medical provider)
- Tissue Transportation (transportation of member's previously frozen reproductive tissue to in-network facilities)
- Purchase of donor tissue (eggs and sperm)

Progyny's benefit has the following standard exclusions:

- Home ovulation prediction kits
- Dependent child/children
- Services and supplies furnished by an out-of-network provider
- Treatments that are outside the standard of care and considered experimental by the American Society of Reproductive Medicine

## RETIREE-ONLY HEALTH REIMBURSEMENT ARRANGEMENT

This section explains how the Retiree-Only HRA helps eligible Retirees to pay for certain health care expenses after they turn 65, including but not limited to Medical insurance premiums, prescription drug premiums, Medicare Part B premiums, and Dental coverage premiums, and other eligible expenses as described below.

## Covered Dependents

You may submit health care expenses incurred by you or your spouse.

## Contributions

As discussed earlier in this summary, a very limited number of Retirees (and in some cases their dependent spouses) are eligible to receive Company contributions to a Retiree-Only Health Reimbursement Arrangement ("HRA") benefit. The Company determines the amount of the contribution or contributions it makes to an eligible Retiree's account.

A Retiree (and/or spouse) may be eligible for subsidized Medical coverage and Retiree-Only HRA contributions, but never for the same period of coverage. In other words, the Company will not provide subsidized Medical coverage for a Retiree and/or the Retiree's spouse and contribute to a Retiree-Only HRA for that Retiree (or spouse) at that same time.

Participants are not permitted to make any contributions to the HRA.

## Eligible Expenses

Expenses eligible for reimbursement under the Retiree-Only HRA are similar to the expenses eligible for reimbursement under the Health Care FSA (as previously described in this summary), except that the HRA funds may be used to reimburse health insurance premiums, including but not limited to Medical coverage, prescription drug coverage, Medicare Part B coverage, and Dental coverage premiums. You may request reimbursement for most expenses for Medical care as defined in Section 213(d) of the Internal Revenue Code (except expenses for qualified long-term care services) which you are obligated to pay and which are not covered by any other plan or coverage.

In order to be eligible for reimbursement, an otherwise eligible expense must have been incurred while you (or your spouse) is covered under the Retiree-Only HRA. You cannot request reimbursement for an expense incurred before your coverage began or after coverage ends.

## Unused Funds

Unlike the Health Care FSA, unused Retiree-Only HRA funds are not subject to a use or lose rule as long as you remain covered. Unused funds will roll over year to year. In the event of a married Retiree's death, the covered spouse retains access to and may continue to use the remaining funds.

## Filing a Claim

If you have funds available in your Retiree-Only HRA, you may submit a claim for reimbursement of eligible expenses. For information on how and where to file a claim, see the Reimbursement Instructional Guide, available at windstreambenefits.com. You may submit a claim for eligible expenses incurred during the Plan Year through the end of the "run-out period," which is January 1 – March 15 of the year following the Plan Year.

## What Happens When Contributions End

If the Company stops contributing to your Retiree-Only HRA, you may continue to participate and use the remaining funds as long as you remain otherwise eligible for coverage.

# CLAIMS AND APPEAL PROCESS

## FILING A CLAIM

The claims filing procedures are set forth in the Benefit Booklets, which are listed in Appendix A. In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claims Administrators. When the Claims Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan.

To ensure proper filing of claims, refer to the claims filing procedures that are set forth in the Benefit Booklets.

You may designate an authorized representative to handle the claim, or any subsequent appeal, on your behalf. To designate an authorized representative to act on a participant's or beneficiary's behalf with respect to a benefit claim, you (or your spouse or child) must submit a written request on a form approved by the Plan Administrator, which the participant or beneficiary signs and which authorizes the representative to act on their behalf with respect to the benefit claim. If a party is not properly designated as an authorized representative under Plan, the Plan Administrator will not communicate with that party with respect to any benefit claim or other exercise of a participant's or beneficiary's rights under the Plan. With respect to any urgent, pre-service, or concurrent care claim (discussed below), a participant's or beneficiary's treating physician or other health care professional may act as an authorized representative in exercising a participant's or beneficiary's rights under the Plan. The Plan will also recognize a court order giving a person authority to submit claims on a participant's or beneficiary's behalf. Any attempted assignment of benefits by a participant or beneficiary to a health care provider is void, and does not constitute a designation of an authorized representative for purposes of the Plan.

Claims Administrators – Fully Insured

Windstream Services, LLC provides the following benefits under the Plan through contracts with the insurance companies listed below. The Plan benefits listed below are guaranteed under contracts of insurance with the insurance companies listed below. The insurance companies administer claims for those benefits and are solely responsible for providing benefits.

| | |
|---|---|
| Care Management, Advocacy and Navigation | Included Health (formerly Grand Rounds)<br>https://includedhealth.com/windstream/<br>1-855-524-8426 |
| Fertility | Progyny<br>245 Fifth Ave., 4th floor<br>New York, NY 10016<br>1-833-505-6171 |
| Virtual Physical Therapy | Hinge Health<br>455 Market Street, Suite 700<br>San Francisco, CA 94105<br>1-855-902-2777 |

| | |
|---|---|
| Vision | Vision Service Plan (VSP)<br>Attention: Claims Services<br>P.O. Box 385018<br>Birmingham, AL 35238-5018<br>www.vsp.com<br>1-800-877-7195 |
| Basic, Supplemental & Dependent Life and Basic & Supplemental Accidental Death and Dismemberment (AD&D) | The Standard<br>Attention: Group Claims<br>P.O. Box 82622<br>Lincoln, NE 68501-2622<br>www,standard.com<br>1-800-547-9515 |
| Long-Term Disability | New York Life Group Benefit Solutions<br>Attention: Paper Intake Team<br>P.O. Box 709015<br>Dallas, TX 75370-9015<br>1-888-842-4462 |
| Employee Assistance Plan | Magellan<br>www.magellanhealth.com/member<br>1-800-327-5569 |
| Group Pre-Paid Legal | MetLife Legal<br>www.members.legalplans.com/home<br>1-800-821-6400 |
| Voluntary Accident Insurance | Cigna<br>P.O. Box 188028<br>Chattanooga, TN 37422<br>cignasupplementalhealthplans.com<br>1-800-754-3207 |
| Voluntary Critical Illness Insurance | Cigna<br>P.O. Box 188028<br>Chattanooga, TN 37422<br>cignasupplementalhealthplans.com<br>1-800-754-3207 |
| Voluntary Hospital Indemnity Insurance | Cigna<br>P.O. Box 188028<br>Chattanooga, TN 37422<br>cignasupplementalhealthplans.com<br>1-800-754-3207 |

Claims Administrators – Self-Insured

The Plan benefits listed below offered under this Plan are self-insured.

The Claims Administrators for the self-insured Medical, Pharmacy, Dental, and Retiree-Only HRA benefits offered under this Plan have the fiduciary responsibility for determining whether you are entitled to benefits and authorizing payment for benefits under those benefit program. Windstream Services, LLC has fiduciary responsibility for determining whether you are entitled to benefits and authorizing payment for benefits under the FSA programs offered under this Plan.

Self-insured benefits offered under this Plan are paid out of the general assets of Windstream Services, LLC and are not guaranteed under a contract or policy of insurance.

| | |
|---|---|
| Medical | BlueAdvantage Administrators of Arkansas<br>P.O. Box 1460<br>Little Rock, Arkansas 72203<br>1-844-662-2279 |
| Medical | UMR<br>P.O. Box 8033<br>Wausau, WI 54402-8033<br>www.umr.com<br>UMR-ClaimSubmission@UMR.com<br>Fax: 855-405-2189<br>Phone: 1-800-826-9781 |
| Pharmacy | Express Scripts<br>One Express Way<br>St. Louis, MO 63121<br>1-866-769-0052 |
| FSAs | Windstream (c/o BUSINESSOLVER.COM, INC)<br>Address: PO Box 850512, Minneapolis, MN 55485-0512<br>Website: windstreambenefits.com<br>Phone: 888-850-1712 |
| Dental | Delta Dental<br>P.O. Box 15965<br>N Little Rock, AR 72231-5965<br>www.deltadentalAR.com<br>1-800-462-5410 |
| Retiree-Only Health Reimbursement Arrangement | Windstream (c/o BUSINESSOLVER.COM, INC)<br>Address: PO Box 850512, Minneapolis, MN 55485-0512<br>Website: windstreambenefits.com<br>Phone: 888-850-1712 |

This section provides general information about the claims and appeals procedure applicable to certain Plan benefits under ERISA. (The *Administrative Information* section of this summary identifies which Plan benefits are *not* subject to ERISA. These claims and appeals rules do not apply to those

benefits.) Note that state insurance laws may provide additional protection to claimants under insured arrangements and if so, those rules will apply. See the Benefit Booklets for more information. **If there are any discrepancies between the claims and appeals procedures in this summary and the applicable Benefit Booklet, then the Benefit Booklet will govern.**

For Medical benefits, the Plan will comply with additional claim and appeal rules required under Health Care Reform. You will be notified if any of these new rules impact your claim. These rules will not apply to Dental or Vision claims or Health Care FSA claims.

## CLAIM-RELATED DEFINITIONS

### Claim

Any request for plan benefits made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved.

The Plan recognizes four categories of health benefit claims:

### Urgent Care Claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim for Medical benefits is urgent.

### Pre-service Claims

"Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

### Post-Service Claims

"Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

### Concurrent Care Claims

"Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim," or "post-service claim," depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

### Adverse Benefit Determination

If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision; and

- Certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at that time.

An adverse benefit determination for disability claims or Medical claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time. However, if the plan retroactively cancels coverage for failure to pay required contributions, that is not an adverse benefit determination.

## INITIAL CLAIM DETERMINATION

For each of the Plan benefits, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue. The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific Plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the Plan's review procedures and the time limits applicable to such procedures; and
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

In the event of an adverse benefit determination for a disability claim, the notice will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - the views of medical or vocational experts obtained by the plan, without regard to whether the advice was relied upon for the adverse benefit determination; and
  - any Social Security Administration disability determination regarding the claimant presented to the Plan;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request;
- Either the specific rule, guideline, protocol, standards, or other similar criteria relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and
- A statement that reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits are available free of charge, upon request.

In the event of an adverse benefit determination for a group health benefit claim (including but not limited to Medical benefit claims), the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- for adverse determinations involving urgent care, a description of the expedited review process for such claims (this notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice).

For Medical claims, the notice will include information sufficient to identify the claim involved. This includes:

- information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- a statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- a description of the Plan's standard used in denying the claim (e.g., a description of the "medical necessity" standard will be included) and the denial code and its corresponding meaning;
- in addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

## Time Frames for Initial Claims Decisions

Time frames generally start when the Plan receives a claim. (See the special rule for "concurrent care" decisions to limit previously-approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days. Health Care FSA and HRA claims are considered non-urgent "post-service" claims.

| | Medical,Care Management, Advocacy, and Navigation, Dental, Vision, EAP, Retiree-Only HRA & Health Care FSA Plans | | | | Long-Term Disability | Life, AD&D, Legal, & Voluntary Benefits |
|---|---|---|---|---|---|---|
| | Urgent Care Claims | Non-Urgent "Pre-Service" Claims | Non-Urgent "Post-Service" Claims | "Concurrent Care" Decision to Reduce Benefits | | |
| Time frame for Providing Notice | Notice of determination (*whether adverse or not*) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours.<br>If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours of receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. | Notice of determination (*whether adverse or not*) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days. | Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days. | Notice of adverse determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain decision before the benefit at issue is reduced or terminated. | Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 45 days. | Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 90 days. |

| | Medical,Care Management, Advocacy, and Navigation, Dental, Vision, EAP, Retiree-Only HRA & Health Care FSA Plans | | | | Long-Term Disability | Life, AD&D, Legal, & Voluntary Benefits |
|---|---|---|---|---|---|---|
| | Urgent Care Claims | Non-Urgent "Pre-Service" Claims | Non-Urgent "Post-Service" Claims | "Concurrent Care" Decision to Reduce Benefits | | |
| Extensions | If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan's receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination. | The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before initial 15-day period ends.* | The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.* | N/A | The Plan has up to 30 days, if necessary due to matters beyond the Plan's control. A second 30-day extension may also be permitted. The Plan must provide the extension notice before the period(s) ends.* | The Plan has up to 90 days for special circumstances and must provide the extension notice before the period ends. |
| Period for Claimant to Complete Claim | You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information). | You have at least 45 days to provide any missing information. | You have at least 45 days to provide any missing information. | N/A | You have at least 45 days to provide any missing information. | No rule. |
| Other Related Notices | Notice that your claim is improperly filed or that information is missing must be provided by the Plan as soon as possible (no later than 24 hours after receipt of the claim by the Plan). | Notice that your claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days after receipt of the claim by the Plan). | N/A | N/A | N/A | N/A |

| | Medical,Care Management, Advocacy, and Navigation, Dental, Vision, EAP, Retiree-Only HRA & Health Care FSA Plans | | | | Long-Term Disability | Life, AD&D, Legal, & Voluntary Benefits |
|---|---|---|---|---|---|---|
| | Urgent Care Claims | Non-Urgent "Pre-Service" Claims | Non-Urgent "Post-Service" Claims | "Concurrent Care" Decision to Reduce Benefits | | |

*15- or 30-day extension period (whichever is applicable) is measured from the time that the claimant responds to the notice from the Plan that the claim is missing information.

## APPEALING A CLAIM

The following section generally describes the Plan's internal claim appeals process. The appeals processes of fully insured health plans may vary somewhat. Please see your Benefit Booklets for more information on fully insured health benefits.

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator as listed in the *Administrative Information* section below. If you don't appeal on time, you lose your right to later object to the decision.

Medical coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

For disability claims and for Medical claims, the Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

For disability claims and for Medical claims, prior to making a benefit determination on review, the Claims Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the Medical Plan (or at the direction of the Plan) in connection with the claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination

on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your disability or Medical claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets this exception.

For a disability claim, if the Plan fails to strictly adhere to all the requirements of the disability claims and appeals process with respect to your disability benefit claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. If a court rejects your demand for immediate review based on the exceptions above, your claim will be considered as refiled on appeal upon receipt of the court's decision, and the plan will notify you of the resubmission.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment under the Medical coverage, you may begin an expedited external review before the Plan's internal appeals process has been completed.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described in the *Time Frames for Appeals Process* section below. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review; and
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

For adverse benefit determinations concerning a group health benefit under the Plan (including but not limited to Medical benefit claims), the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; (for health and disability claims); and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; (for health and disability claims).

For Medical claim adverse benefit determinations, the notice will include information sufficient to identify the claim involved. This includes:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the Plan's standard used in denying the claim (e.g., a description of the "medical necessity" standard will be included) and the denial code and its corresponding meaning;
- In addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

For adverse benefit determinations on disability claims, the notice will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - the views of medical or vocational experts obtained by the plan, without regard to whether the advice was relied upon for the adverse benefit determination; and
  - any Social Security Administration disability determination regarding the claimant presented to the Plan;
- A description of any applicable contractual limitations period, including the date on which the claim expires;
- Either the specific rule, guideline, protocol, standards, or other similar criteria relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the following chart.

Except as described below with respect to the external review process, all decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

### External Review

For Medical benefits, you may have the right to request an external review of a claim involving medical judgment, as determined by the external reviewer or a coverage rescission; or, in the event there is a question as to whether the claim should have been subject to surprise billing protections, as required by the No Surprises Act provisions of the CAA. You must request the external review within four (4) months of the date you receive an adverse benefit determination. If your request for an external review is determined eligible for such a review, an independent organization will review the Claims Administrator's decision and provide you with a written determination, as described in the Benefits Booklets.

The external review decision is binding on you and the Plans, except to the extent other remedies are available under federal law.

The external review process does not apply to any other adverse benefit determination or final internal adverse benefit determination that is not related to medical judgment or coverage rescission.

## Legal Action

Before pursuing legal action for benefits under the Plan, you must first exhaust the Plan's claim, review and appeal procedures. Additionally, any lawsuit you bring for Plan benefits must be filed within 36 months of the date on which your claim is incurred under the Plan (unless the documents governing the particular plan benefit specify a shorter timeframe), and must be filed in the U.S. District Court for the Eastern District of Arkansas.

## Time Frames for Appeals Process

The claims appeals procedures for a specific benefit are set forth in the Benefit Booklets for that benefit. Please consult the Benefit Booklet for the specific benefit involved. Where not otherwise covered by the Benefit Booklets, the following procedures will apply. The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to "days" mean calendar days. The Plan can require two levels of mandatory appeal review.

| | Medical, Care Management, Advocacy, and Navigation, Dental, Vision, EAP, Retiree-Only HRA & Health Care FSA Plans | | | Long-Term Disability | Life, AD&D, Legal & Voluntary Benefits |
|---|---|---|---|---|---|
| | Urgent Care Claims* | Non-Urgent Care Pre-Service Claims* | Non-Urgent Care Post-Service Claims* | | |
| Period for Filing Appeal | You have at least 180 days. | You have at least 180 days. | You have at least 180 days. | You have at least 180 days. | You have at least 60 days. |
| Time frame for Providing Notice of Benefit Determination on Review | As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review. | Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal. | Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal. | Within a reasonable period of time, but not later than 45 days after receipt of request for review. | Within a reasonable period, but not later than 60 days from receipt of request for review. |
| Extensions | None. | None. | None. | Additional 45 days if special circumstances require extension (with period "tolled" until you respond to any information request from the Plan). | Additional 60 days if special circumstances require extension. |

* An appeal of a concurrent care decision to reduce or terminate previously-approved benefits may be an urgent care, pre-service, or post-service claim, depending on the facts.

## COORDINATION OF BENEFITS

### Coordination with Other Plans

Unless otherwise specified in the applicable Benefit Booklet, the Plan will coordinate benefits with any other health plan that covers you or your eligible dependents under the rules below.

Other health plans with which the Plan will coordinate include:

- Group or nongroup coverage, whether insured or uninsured, including HMOs;
- The medical care component of long-term care contracts, such as skilled nursing care;
- Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Coverage under federal government programs, except that coverage under a federal government program may be limited to hospital, medical, and surgical benefits of the government program. Coverage does not include Medicare supplemental policies or Medicaid policies; and
- The medical benefits coverage in group or individual automobile "fault" or "no-fault" coverage.

### Order of Benefit Determination

The rules below determine whether this Plan or another plan will pay primary (first) or secondary. In no case will you be entitled to benefits totaling more than 100% of the covered charges incurred or, where this plan pays primary, the covered charges otherwise payable under this Plan.

- COB/Non-COB Provision: The benefits of a plan which does not contain a coordination of benefits (COB) provision always shall be determined before the benefits of a plan which does contain a COB provision.
- No Fault Auto Insurance: The benefits of the plan which covers the person as a beneficiary under a no-fault automobile insurance policy required by law shall be determined prior to this Plan, regardless of whether the no-fault policy has been selected as secondary.
- Non-Dependent/Dependent: The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) shall be determined before those of the plan which covers the person as a dependent (unless "Medicare Coordination" below applies).
- Dependent Child/Parents not Separated or Divorced: When this Plan and another plan cover the same child as a dependent of different persons, called "parents":

  (1) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

  (2) if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

  However, if the other plan does not have the rule described in (1) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits. For a dependent who has coverage under either or both parents and also has coverage as a dependent under a spouse's plan, see "Longer-Shorter Length of Coverage" below applies.

- Dependent Child/Separated or Divorced Parents: If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

  (1) first, the plan of the parent with custody of the child;

  (2) then, the plan of the spouse of the parent with custody of the child;

  (3) the plan of the parent not having custody of the child, and

  (4) finally, the plan of the spouse of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any plan year starting before the Plan is given notice of the court decree.

  This Plan will not cover the expenses of any child who does not meet the definition of dependent as defined in this Plan except as may be required pursuant to a Qualified Medical Child Support Order under section 609(a) of ERISA.

- Active/Inactive Employee: The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- Continuation Coverage: If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law, and also under another group plan, the following shall be the order of benefit determination:

  (1) First, the benefits of a plan covering the person as an employee or retiree (or as the dependent of an employee or retiree);

  (2) Second, the benefits of coverage under the continuation plan.

  If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- Longer-Shorter Length of Coverage: If none of the above rules determines the order of benefits, the benefits of the plan which has covered the person longer are determined before those of the plan which has covered that person for the shorter time.

- Medicare Coordination

  (1) Employees and/or Spouses Entitled to Medicare Due to Age: Unless an active employee entitled to Medicare due to age gives the Plan notice (in the form and manner requested by the Plan Administrator) waiving his or her right to Plan benefits, the Plan is primary. With respect to the spouse of an active Employee who is entitled to Medicare due to the spouse's age, unless the employee gives the Plan notice (in the form and manner requested by the Plan Administrator) waiving Plan benefits, the Plan is primary.

(2) Medicare Disabled Covered Persons: If required by law, the Plan is primary with respect to a covered person who is also entitled to Medicare because of disability. Otherwise, the Plan is secondary.

(3) Covered Persons with End-Stage Renal Disease: For the period required by law, if any, the Plan is primary with respect to a covered person entitled to Medicare because of end-stage renal disease. Otherwise, the Plan is secondary.

**Disagreement on Order of Benefits**

If the Plan and the other health plan cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the Plan shall immediately pay half of the claim and will determine its liability following payment, except that the Plan shall be required to pay no more than it would have paid had it been the primary plan.

**Facility of Payment**

If another health plan provides or pays benefits that should have been provided or paid under this Plan, the Plan has the right to pay over to the other plan the amount the Plan Administrator determines is necessary to satisfy this coordination of benefit provision. These amounts are considered benefit payments under this Plan and will operate to discharge the Plan from liability to the extent of such payments.

## ACTS OF THIRD PARTIES

When you or your covered dependent are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (Medical, Dental and Vision) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid to (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid to (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and
- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses. Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and

- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Provide proof, if requested by the Claims Administrator and in the form requested by the Claims Administrator, that you have not and will not discharge or release a claim against a third party without the written consent of the Claims Administrator.
- Execute a written agreement assigning your rights against a third party to the Plan and/or authorizing the Plan to sue, compromise or settle a cause of action against a third party, if requested by the Claims Administrator.
- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including instituting a formal proceeding against a third party and/or setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this summary.
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the "Acts of Third Party" provisions in this summary conflict with provisions in a Benefit Booklet governing insured benefits, the Benefit Booklet will govern. If the Benefit Booklet for any self-insured benefit contains subrogation, reimbursement or recovery provisions, those provisions and the "Acts of Third Party" provisions in this summary will both apply, so that the Plan has the maximum subrogation, reimbursement, and recovery rights.

## Recovery of Overpayment

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

## Non-assignment of Benefits

Plan participants cannot assign, sell, transfer, pledge, borrow against, or otherwise promise any benefit payable under the Plan or the right to assert legal rights, including an administrative claim or lawsuit against any of the following: the Plan, the Plan Administrator, a Claims Administrator, or any Plan fiduciary, or the Company, or their officers, shareholders, or employees. For example, Plan participants may not assign their right to receive Plan benefits and legal rights relating to the Plan to any health care provider—such assignment is not permitted and is void. The Plan Administrator or Claims Administrator may make payment directly to the Plan participant or, at its discretion, make payment directly to a doctor, hospital, or other provider of care. When payment is made directly to a doctor, hospital or other provider of health care, such direct payments are solely at the discretion of the Plan Administrator or Claims Administrator—such payments do not create any enforceable assignment of benefits or the right

to assert any legal rights or to bring any administrative claim or lawsuit by any doctor, hospital, or other provider of care against the Plan (or the Plan Administrator, Claims Administrator, or any Plan fiduciary, or the Company, or officers, shareholders or employees thereof).

The Plan will, when required by law or applicable guidance, recognize an assignment of benefits to a state Medicaid program.

## MISSTATEMENTS AND MISREPRESENTATIONS

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

If you or your dependent(s) receive benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation, you may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. If you make any intentional misrepresentation or use fraudulent means concerning eligibility for coverage, changing your existing coverage, or benefits under the Plan, your coverage (and your dependents' coverage) may be terminated irrevocably (retroactively to the extent permitted by law), and could be grounds for discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

# ADMINISTRATIVE INFORMATION

Below is key information you need to know about your benefit plans:

| | |
|---|---|
| **Plan Name** | Windstream Services, LLC Welfare Benefit Plan |
| **Plan Number** | 501 |
| **Plan Sponsor** | Windstream Services, LLC<br>4005 N. Rodney Parham Rd.<br>Little Rock, AR 72212 |
| **Employer Identification Number** | 85-2049794 |
| **Plan Administrator** | Windstream Benefits Committee<br>4005 N. Rodney Parham Rd.<br>Little Rock, AR 72212<br>501-748-7000 |
| **Agent for Service of Legal Process** | Plan Administrator |
| **Plan Year** | January 1 through December 31 |
| **Plan Type** | Welfare benefit plan providing the following types of benefits:<br>▪ Medical (also including Pharmacy and Fertility benefits)<br>▪ Care Management, Advocacy, and Navigation<br>▪ Dental<br>▪ Vision<br>▪ Employee Assistance Plan<br>▪ Long-Term Disability (LTD)<br>▪ Basic Life Insurance<br>▪ Supplemental Life Insurance<br>▪ Dependent Life Insurance<br>▪ Basic Accidental Death and Dismemberment (AD&D)<br>▪ Supplemental AD&D<br>▪ Health Care FSA<br>▪ Group Pre-Paid Legal<br>▪ Voluntary Accident Insurance<br>▪ Voluntary Critical Illness Insurance<br>▪ Voluntary Hospital Indemnity Insurance<br>▪ Retiree-Only Health Reimbursement Arrangement<br>▪ Wellness<br>▪ Severance Pay<br><br>Although the Childcare/Daycare/Eldercare FSA and Health Savings Account are described in this summary, they are **not** subject to ERISA. |

| | |
|---|---|
| **Source of Contributions** | Depending on the benefits selected by the employee, the cost of contributions for certain of the benefits offered within the Plan will either be covered by contributions from the Company, contributions by the employee, or will be shared by the Company and the employee. The cost of Medical and Dental coverage is shared by the Company and its employees enrolled in those coverages. The Company pays 100% of the cost of the Care Management, Advocacy, and Navigation, EAP, Retiree-Only Health Reimbursement Arrangement, Long-Term Disability, Basic Life and Basic AD&D coverages. Employees pay 100% of the Vision, Supplemental Life, Dependent Life, Long-Term Disability, Supplemental AD&D Group Pre-Paid Legal, Voluntary Accident Insurance, Voluntary Critical Illness Insurance and Voluntary Hospital Indemnity Insurance coverages and contributions to the Health Care and Childcare/Daycare/Eldercare FSAs. Where the Company and employees share the cost of coverage, the Company shall contribute the difference between the amount employees contribute and the amount required to pay benefits under the Plan.<br><br>Except in limited circumstances in which Company subsidies are provided (as discussed earlier in this SPD), Retirees are responsible for paying 100% of the cost of coverage under any Medical, Dental, Vision, Life, AD&D, Supplemental Life, Dependent Life, and Supplemental AD&D coverage in which they and their dependents enroll.<br><br>The Plan Administrator will notify employees and Retirees annually as to what the contribution rates will be. The Company, in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time. Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be applied first to reimburse the Company for their contributions, unless otherwise provided in that group insurance contract or required by applicable law. |

## PLAN DOCUMENT

This document is intended merely as a summary of the official Plan document(s). In the event of any disagreement between this summary and the official Plan document(s), as they may be amended from time to time, the provisions of the Plan document(s) will govern.

## PLAN AMENDMENT AND TERMINATION

Windstream Services, LLC reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time. For example, Windstream Services, LLC reserves the right to amend

or terminate benefits, covered expenses, benefit coinsurance and copays, lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. Windstream Services, LLC also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by Windstream Services, LLC will be done in accordance with Windstream Services, LLC's normal operating procedures. Amendments will be effective at such date as Windstream Services, LLC determines, or upon the date of execution or adoption if no effective date is given. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of Windstream Services, LLC, the Plan shall terminate unless the Plan is continued by a successor to Windstream Services, LLC

If a benefit under the Plan is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Windstream Services, LLC to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document. If the entire Plan terminates, plan assets will be used for the benefit of participants and beneficiaries or to defray reasonable administrative expenses.

## PLAN ADMINISTRATION

The Windstream Benefits Committee is responsible for the general administration of the Plan, and will be the fiduciary to the extent not otherwise specified in this summary, the Plan document, or in a Benefit Booklet. The Windstream Benefits Committee has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and the Windstream Benefits Committee will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator nor Windstream Services, LLC will be liable in any manner for any determination made in good faith.

The Windstream Benefits Committee may designate other organizations or persons to carry out specific fiduciary responsibilities for the Windstream Benefits Committee in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping;
- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan; and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

The Windstream Benefits Committee will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

## Power and Authority of the Insurance Company

Certain benefit programs (identified in the *Filing a Claim* section of this summary) under this Plan are fully insured. Benefits may be provided under a group insurance contract entered into between Windstream Services, LLC and an insurance company. With respect to fully insured benefits, claims for benefits are sent to the insurance company. The insurance company is the fiduciary with respect to these claims and responsible for paying claims, not Windstream Services, LLC or the Plan Administrator.

The insurance company is responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan;
- Prescribing claims procedures to be followed and the claim forms to be used by employees and beneficiaries pursuant to the Plan;
- The insurance company also has the authority to require employees and beneficiaries to furnish it with such information as it determines is necessary for the proper administration of the Plan.

### Questions

If you have general questions regarding the Plan, please contact the Plan Administrator. However, if you have questions concerning eligibility for and/or the amount of benefits payable under the Plan, please refer to your Benefit Booklets or contact the applicable insurance company or Claims Administrator. If you have an ID card for a plan, you may also use the contact information on the back of that card.

# ERISA

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

### Receive Information about Your Plan and Benefits

You can:

Review at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, insurance contracts, Benefit Booklets, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.

Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Benefit Booklets and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

### Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse and/or dependent child(ren) if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to

pay for such coverage. Review the SPD and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

### Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on 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 Plan 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 (if any) from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which 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 medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and 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 any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or:

Office of Outreach, Education, and Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

# APPENDIX A — BENEFIT BOOKLETS

This summary should be read in combination with the insurance contracts, member handbooks, certificates of coverage or evidence of coverage documents (together and individually referred to as Benefit Booklets) provided by the insurance companies and service providers.

The Benefit Booklets are intended to describe the Plan benefits available to you as an employee of the Company, and, when read with this summary, are intended to meet ERISA's SPD requirements.

Please see the Benefit Booklets for details of Plan benefits. For additional information or for copies of the Benefit Booklets, please contact the Plan Administrator.

| Coverage | Benefit Booklet Name |
|---|---|
| Medical – BCBS, UMR, ESI (Rx) | Blue Cross Blue Shield Summaries of Benefits for Windstream Medical Plan<br>UMR Summary(ies) of Benefits<br>Progyny Benefit Member Guide<br>Rx Savings Solutions Benefit Flyer |
| Care Management, Advocacy and Navigation | Included Health Benefit Flyer |
| Virtual Physical Therapy | Hinge Health Benefit Flyer |
| Dental | Delta Dental Certificate of Coverage |
| Vision | VSP Vision Care Plan Evidence of Coverage |
| Employee Assistance Plan | Magellan Healthcare Benefit Flyer Employee Assistance Program |
| Basic Life Insurance | Standard Insurance Company Certificate and Summary Plan Description Group Life Insurance |
| Supplemental Life Insurance | Standard Insurance Company Certificate and Summary Plan Description Group Life Insurance |
| Dependent Life Insurance | Standard Insurance Company Certificate and Summary Plan Description Group Life Insurance |
| Long-Term Disability | New York Life Certificate of Insurance |
| Basic Accidental Death and Dismemberment | Standard Insurance Company Certificate and Summary Plan Description Group Life Insurance |
| Supplemental AD&D | Standard Insurance Company Certificate and Summary Plan Description Group Life Insurance |

| | |
|---|---|
| Group Pre-Paid Legal | MetLife Legal Benefit Summary |
| Voluntary Accident Insurance | Cigna Accident Plan Certificate |
| Voluntary Critical Illness Insurance | Cigna Critical Illness Plan Certificate |
| Voluntary Hospital Indemnity Insurance | Cigna Hospital Indemnity Plan Certificate |
| Wellness | Wellness Program Notice can be found at: http://windstreambenefits.com/my-health/summary-plan-descriptions/ |
| Retiree-Only Health Reimbursement Arrangement | Retiree-Only HRA Reimbursement Instructional Guide<br>Retiree-Only Health Reimbursement Arrangement Benefits Retirement Program information |
| Windstream Severance Pay Plan | Windstream Severance Pay Plan Document and Summary Plan Description |

# APPENDIX B — LONG TERM DISABILITY WAITING PERIOD

The waiting period for Long Term Disability (LTD) is as follows:

If you are in the following groups, you will be eligible for LTD after 180 days of employment:

- Iowa – IBEW
- Mississippi – CWA
- Valor – CWA
- Kentucky – IBEW
- Iowa – CWA
- Boston – IBEW
- Non-Union

If you are in the following groups, you will be eligible for LTD after 365 days of employment:

- Florida – CWA
- Kentucky – CWA
- North Carolina – CWA
- Newark, OH – CWA
- W Reserve Southern, OH – CWA
- Elyria/Kenton, OH – CWA
- Pennsylvania – CWA
- Nebraska – CWA
- New York – IBEW
- W Reserve, OH – IBEW
- Waynesburg, PA – IBEW
- New York – IBEW

If you are in Meadville, PA – IBEW, you will be eligible for LTD after 252 days of employment.

# APPENDIX C — PARTICIPATING EMPLOYERS

In addition to Windstream Services, LLC, the following entities are Participating Employers in this Plan:

Windstream Services, LLC
Windstream North Carolina, LLC
Windstream Mississippi, LLC
Windstream Florida, LLC
Windstream Western Reserve, LLC
Windstream Pennsylvania, LLC
Windstream New York, Inc.
Windstream Nebraska, Inc.
Windstream Ohio, LLC
Windstream Kentucky East, LLC
Valor Communications of TX LLC
Windstream Comm Kerrville, LLC
D&E Communications, LLC
Windstream Iowa Comm, LLC

Mailing address for all Participating Employers:

4005 N. Rodney Parham Road
Little Rock, Arkansas 72212

The list of Participating Employers shall be subject to modification without formal amendment of the Plan.