Employee Assistance

Summary Plan Description

windstream

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EMPLOYEE ASSISTANCE PROGRAM (EAP) AT A GLANCE

BENEFIT	The Windstream Employee Assistance Program (EAP) is a professional, confidential service you can use to get help whenever you or an eligible dependent needs assistance in dealing with personal pressures.
ELIGIBILITY	All employees of Windstream and its subsidiaries are eligible for the benefits provided in this Summary Plan Description beginning on the first date of employment. Temporary, seasonal, leased, or independently contracted employees are not eligible.
ENROLLMENT	Enrollment is automatic. There is no election required for the EAP.
COSTS	The cost of the EAP is paid by Windstream.
LIMITATIONS	There are certain consultation time and topic limits for legal assistance, core identity theft services, and in-person EAP provider sessions. Please refer to the plan details for more information.
CLAIMS	All claims for in-person EAP provider sessions are filed by Magellan.
TERMINATION	Your coverage ends on the last date of the month in which your employment terminates. You may elect to continue coverage through COBRA.

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

EMPLOYEE ASSISTANCE PROGRAM (EAP) SUMMARY PLAN DESCRIPTION

The Windstream Employee Assistance Program (EAP) is a professional, confidential service you can use to get help without charge to you whenever you or an eligible dependent needs assistance in dealing with personal pressures. Counselors are available 24 hours a day, seven days a week for crisis assistance. The program is administered by Magellan Behavioral Health, Inc. (Magellan).

This Summary Plan Description has been prepared specifically for employees of Windstream and its subsidiaries. Temporary, seasonal, leased, or independently contracted employees are not eligible.

Windstream Benefits maintains a web page at www.windstreambenefits.com. Summary Plan Descriptions (SPDs), Summaries of Benefits and Coverage (SBCs), and a Glossary of Medical Terms are available within that page to help you learn about the Windstream EAP. You may also obtain a copy of any SPD or SBC, free of charge, by contacting Coordinated Care by Quantum Health at 877-550-3255 or writing to EBS Inc., P.O. Box 11657, Pleasanton, CA 94588.

CONTACT INFORMATION

You have access to the EAP 24 hours a day, seven days a week, 365 days a year:

Magellan EAP Phone: 800-327-5569 (800-456-4006 TTY)
Online: **www.MagellanHealth.com/member**

- For your first online visit, click on “New or Unregistered Users”.
- Then, enter the Windstream EAP phone number (above) to create an account.

ELIGIBILITY

All regular and occasional employees of Windstream and its subsidiaries are eligible for the benefits provided in this Summary Plan Description beginning on the first date of employment. Temporary, seasonal, leased, or independently contracted employees are not eligible.

Eligible dependents include:

- All spouses and dependent children of eligible employees and any family member or individual who is included in Windstream’s Dependent Eligibility Guide,
- All household members of eligible employees (residing in employee’s home), and
- Dependent children attending school of eligible employees.

Household members include any individual who permanently, physically resides in the household of an Employee, or who meets the requirements of a “dependent” as defined by the U. S. Internal Revenue Code or the Patient Protection and Affordable Care Act.

ENROLLMENT

Your coverage and coverage for your eligible dependents is automatic; you do not need to take any steps to enroll.

COSTS

The Company pays the full cost of participation in the EAP for you and your eligible dependents. If you are on an approved leave of absence, your EAP coverage will continue at no cost to you. You have no obligation to pay any premium or fees for EAP coverage or to obtain EAP services; there are no premiums, co-payments, co-insurance, or deductible payments applicable to EAP services.

OBTAINING EAP SERVICES

To obtain EAP services, simply call the toll-free number: 1-800-327-5569. EAP representatives are available 24 hours a day, 7 days a week, to provide referral and emergency crisis intervention services. Spanish-speaking representatives and counselors are also available.

When you call the EAP, a Magellan representative will:

- Ask you questions to help identify the problem and how it is affecting you,
- Find out what solutions you have tried and explore other solutions and resources, and
- Help you develop a plan to solve the problem.

If you desire to work on your problem through in-person sessions with an EAP counselor or if it appears that your problem cannot be adequately addressed in a telephone consultation, the Magellan representative will refer you to an EAP counselor or another resource in your community, as appropriate.

You can also visit Magellan's website for confidential, anonymous access to educational materials, self-help tools, a directory of EAP counselors, guidance in preparing for a session with a counselor, and other resources. You can reach this website directly at **www.MagellanHealth.com/member**.

The EAP counselor directory can be searched by name or by ZIP Code. To access the directory of EAP counselors directly:

- Enter the URL **www.providerfind.magellanhealth.com/Member**
- Click on "Find a Provider"
- Follow the online directions
- Under "Provider Search," select "Employee Assistance Program" and "Continue"
- Enter search criteria (zip code, etc.)

Make sure that the box for "Employee Assistance Providers" is selected. At your request, Magellan will send you a hard copy of the directory information; contact Magellan at 1-800-327-5569.

COVERED SERVICES

Personal Consultation Services
The EAP provides confidential assessment, counseling, and referral services to help with issues or problems that could potentially affect your health, relationships, and job performance. You and each of your eligible dependents are eligible to participate in up to five (5) in-person sessions per problem each calendar year (as considered clinically necessary by the EAP). If you obtain in-person counseling for a problem together with an eligible dependent, such as your spouse, the total number of in-person sessions for which you and the other person are eligible for that problem is still five (5) total. The number of sessions does not double simply because two persons participate in counseling or triple because three persons participate. There is no lifetime maximum on the number of sessions.

The EAP will help you develop solutions for problems such as:
- Marital and family problems (marital tension, parental concerns, etc.)
- Emotional concerns (anxiety, depression, stress, etc.)
- Substance abuse or misuse (drug, alcohol, etc.)
- Emotional stress
- Conflicts at work or home
- Other personal problems

In-person EAP services are available only through the network of independent EAP counselors with whom Magellan contracts. You may select an EAP counselor (i) by calling Magellan at 1-800-327-5569 or (ii) through the online EAP self-referral process at **www.MagellanHealth.com/member**.

To use the online self-referral process:
- Enter the URL **www.MagellanHealth.com/member** and sign in with your user name and password (or follow the instructions for creating a user name and password)
- Follow the online directions.
- Under "Providers/Caregivers," select "Get an EAP Referral"
- Follow the online directions.

The EAP counselor will help you evaluate and work through your problem. In many cases, the problem is resolved within the five (5) in-person sessions available through the EAP. However, if more sessions or other health care services are needed, you may be referred to an outside source for assistance; such referral may take place as soon as the EAP counselor recognizes that handling your problem through the EAP is not appropriate.

Legal and Financial Consultation Services
The EAP also provides you and your eligible dependents with free initial legal and financial consultations for such matters as:
- Wills and inheritance concerns
- Divorce, custody, adoption matters
- Consumer issues
- Real estate questions
- Criminal matters

- Debt management
- Basic financial planning/retirement, savings, investments
- insurance,
- Budgeting/family financial issues
- Identity theft

You may access the legal or financial consultation services through the EAP toll-free number at 1-800-327-5569. Legal consultation services are available telephonically and in-person and may be limited to up to sixty (60) minutes per separate legal matter per year; financial consultation services are available only telephonically and may be limited to one telephone consultation per separate financial matter per year. If you need continued legal assistance after the initial consultation, you can choose whether to retain the attorney at your expense, seek alternative counsel, or adopt an alternative plan of action. If you retain the consulting attorney, you will be entitled to a twenty-five percent (25%) reduction in fees from the consulting attorney's normal fees. You are fully responsible for payment of these fees. The EAP offers simple will preparation through its Legal Consultation Services, but this service may require you to pay a fee of fifty dollars ($50) or more, as determined by Magellan; you are fully responsible for this fee if you choose to use this service.

You may also access an online library of articles on legal issues, legal forms that can be downloaded for your use, and other resources for legal and financial guidance through Magellan's website, which may be accessed as described above under Personal Consultation services.

There is no restriction on the number of times you may use the legal and financial consultation services; however, legal services may be limited to up to sixty (60) minutes per separate legal matter per year. You may not access legal consultation services on a continuing basis in order to undertake your own representation.

Work-Life Services

The EAP also provides telephone consultation, information, education and referral services in connection with child care, elder care, parenting issues, children with special needs, schooling and education, teen and young adult issues and adoption assistance.

A Work/Life consultant will discuss your work/life needs with you telephonically and send you a packet of educational materials. If you are looking for dependent care or educational resources, the Work/Life consultant will research resources in your area and send you a list of at least three licensed, certified or registered dependent care providers with confirmed vacancies in your area that match your needs, to the extent available. The telephone consultation, educational materials, and referral list are provided to you at no charge. You will be financially responsible for the dependent care arrangement that you select. If you choose to obtain elder care or child care, it will be up to you to evaluate each dependent care resource to determine the right arrangement for your loved one and to monitor the quality and appropriateness of the arrangement. The EAP does not endorse or recommend any of the dependent care resources identified. While Magellan makes reasonable efforts to ensure the accuracy of the information provided about dependent care resources, the information is obtained from those resources and Magellan cannot guarantee the accuracy of the information. The final decision about your dependent care arrangements is yours.

An online library of articles and tools on work/life issues is also available through Magellan's website, which may be accessed as described above under Personal Consultation services.

SERVICES NOT COVERED

The EAP does not include any of the services listed below. Some of these services may be covered by the Windstream Medical or Prescription Drug Plan, if you are eligible for and enrolled in that Plan. Contact Coordinated Care by Quantum Health for benefits available under the Windstream Medical, Prescription Drug, or other Plans by calling 1-877-550-3255.

- Treatment by someone other than an EAP counselor for whom (i) a Magellan representative opened a case, or (ii) you completed an electronic referral request through Magellan's online EAP self-referral process
- Charge for failure to keep a scheduled visit
- Charges for completing claim forms
- Services or supplies not needed for treatment or not approved by your EAP counselor
- Services or supplies required or paid for under any government law, including workers' compensation or other federal, state or local law
- Services or supplies rendered by a family member or for which there is no charge
- Services rendered before coverage became effective or after coverage ends
- Treatments, procedures or devices considered experimental or investigational in nature as determined by the EAP administrator
- Treatment for any problem or condition that cannot be resolved in brief counseling (for example, a psychosis or any other condition that requires inpatient treatment or more than five (5) sessions)
- Psychiatric services or other medical care (including prescription drugs)
- Inpatient treatment
- Treatment for any physical illness
- Direct treatment for mental retardation, learning disabilities, or autism
- More than five (5) in-person EAP sessions per problem per year
- Psychological, psychiatric, neurological, educational, or IQ testing
- Remedial education services, such as evaluation or treatment of learning disabilities, developmental and learning disorders, behavioral training, and cognitive rehabilitation
- Medication, medication management, or treatment of any condition for which medication is required, unless you are seeing a doctor who prescribes medication for that condition and oversees your use of the medication
- Evaluations for fitness for duty of excuses for leaves of absence or time off
- Examinations and diagnostic services in connection with obtaining employment or a particular employment assignment, admission to or continuing in school, securing any kind of license (including professional licenses), obtaining any kind of insurance coverage
- Court-mandated counseling, evaluations required by a state or federal judicial officer or other governmental agency or to be used in legal actions of any kind (for example, child custody proceedings)
- Testimony in legal proceedings or preparation for legal proceedings
- EAP services when you sue, or threaten to sue, the Company
- Acupuncture
- Aversion therapy

- Biofeedback and hypnotherapy
- Sleep therapy
- Legal assistance for employment issues, commercial enterprise, second opinions or third-party advice, such as a relative's legal problem, matters considered frivolous or harassing by the consulting attorney, matters involving Magellan, Windstream, the legal services vendors or its plan attorneys, or any matter that would involve a violation of ethical rules
- Recommendation or endorsement of a specific attorney to represent you; the final decision regarding whether a particular attorney is suitable for your needs can only be made by you.
- Financial advice or instruction as to any course of action. The financial consultants are not responsible for any decisions you make about your financial planning.

CLAIMS

Magellan will generally make a determination on your request for EAP services and inform you of its determination in your initial telephone call to request services.

If Magellan cannot decide while on the initial call, Magellan will decide within five (5) calendar days of your request for services or of notice to Magellan of a circumstance that affects the availability of further EAP services. Magellan will inform you by telephone of its determination within one (1) business day after it decides. If you consent to written notice, Magellan will send you written notice of its determination within one business day of the telephonic notice.

If you are receiving an ongoing course of EAP counseling, Magellan will notify you in advance if it intends to terminate or reduce the number of EAP sessions that can be provided so that you will have an opportunity to appeal the decision before the termination or reduction takes effect.

If Magellan determines that you need Urgent Care, Magellan will provide telephonic crisis counseling and make an appropriate referral to your benefit plan and/or emergency resources in the community. Magellan does not make Claim determinations relating to Urgent Care.

- **What is Urgent Care?**
  Urgent Care is care needed to avoid serious jeopardy to your life or health or to regain maximum function (or required to avoid severe pain), as determined by Magellan or your treating physician.

- **What is a Claim?**
  A Claim is a request for benefits made in accordance with the Plan's procedures. A Claim may be either a request for EAP services or a request for reimbursement of the cost of EAP counseling.

Because Magellan pays all EAP providers directly, you should not make any payment to a provider for EAP services. In the event that you mistakenly pay a provider for EAP services, Magellan will make a determination on your request for reimbursement within 15 days after receipt of the Claim (if EAP services have not yet been received) or with 30 days after receipt of the Claim (if the EAP services have already been received). Magellan will notify you of its determination telephonically, and, if you consent to written notice, in writing, within the 15 day or 30 day period, as applicable.

FILING AN APPEAL

If a Claim for EAP benefits is wholly or partially denied, and you authorize written communication to you, Magellan will provide written notice of the denial to you or your Authorized Representative.

This notice of the decision will:

- give the specific reason or reasons for the denial decision;
- identify Plan provisions on which the decision is based;
- describe any additional material or information necessary for an appeal review and an explanation of why it is necessary;
- explain the review procedure, including time limits for appealing the decision and to sue in federal court;
- identify your right to receive, free of charge, upon your request, any internal rule, guidelines, protocol or similar criterion relied on in making the decision; and
- identify your right to receive, free of charge, upon your request, an explanation of the clinical judgment on which the decision is based (if the denial is based on exclusion of experimental treatment services or because EAP services are not clinically appropriate).

If you do not authorize written notice, Magellan will furnish this information to you or your Authorized Representative by telephone.

- **Who is your Authorized Representative?**
  An Authorized Representative is a person you authorize, in writing, to act on your behalf or a person given authority by court order to request treatment or submit claims on your behalf.

Appeal of Adverse Determinations of Claims for EAP Benefits

If you believe your Claim for EAP benefits was denied in error, you may appeal the decision. Your appeal must be submitted in writing to Magellan within 180 days following your receipt of a denial notice.

Your appeal should state the reasons why you feel your Claim for EAP benefits is valid and include any additional documentation that you feel supports your Claim for EAP benefits. You can also include any additional questions or comments. You may submit written comments, documents, records and other information relating to your appeal, whether or not the comments, documents, records or information were submitted in connection with the initial Claim for EAP benefits. On your request, Magellan will make relevant documents available to you.

The review of the initial decision will consider all new information, whether or not it was presented or available for the initial decision. The person who conducts the appeal review will be different from the person(s) who originally denied your Claim for EAP benefits and will not report directly to the original decision maker or prior reviewer.

You or your Authorized Representative will be notified of the appeal decision within the following time frames:

- If the case involves an adverse determination on a request for EAP services or a pre-service adverse determination relating to reimbursement, within thirty (30) days of Magellan's receipt of the request for appeal;

- If the case involves a post-service adverse determination relating to reimbursement, within sixty (60) days of Magellan's receipt of the request for appeal.

Appeal Decision

- If you authorize written communication, Magellan will give you or your Authorized Representative the decision on the appeal in writing. If the denial is upheld on appeal, the notice will include the following information:
- the specific reason or reasons for the denial decision;
- identification of Plan provisions on which the decision is based;
- notice of your right to receive, free of charge, upon your request, any internal rule, guidelines, protocol or similar criterion relied on in making the decision;
- notice of your right to receive, free of charge, upon your request, an explanation of the clinical judgment on which the decision is based (if the denial is based on exclusion of experimental treatment services or because EAP services are not clinically appropriate);
- notice of your right to receive, free of charge, upon your request, reasonable access to, and copies of, all documents, records and other information relevant to the appeal; and
- notice of your right to bring a civil lawsuit under ERISA §502(a).

If you do not authorize written notification, Magellan will furnish this information to you or your Authorized Representative by telephone.

External Review

In addition to the appeal process through Magellan, if the adverse determination involves medical judgment, you may have the right to an external review by an independent review organization (IRO). You must submit your request for an external review to Magellan within four (4) months of your receipt of Magellan's appeal decision.

Magellan will determine your eligibility for external review and provide notice of acceptance as follows: immediate verbal notice of acceptance for an urgent external review and written notice within five business days for a standard external review.

External appeals are not available for adverse determinations pertaining to eligibility for coverage or other matters that do not require medical judgment.

Magellan assigns eligible external reviews to an IRO and provides the assigned IRO with all documents and information considered in Magellan's denial and appeal determinations. The IRO will notify you of its acceptance of the review and request any additional information needed; it will contact you directly to notify you of its decision within 45 days. The IRO's decision is final and binding. Magellan will implement the IRO decision immediately upon receipt of notice.

Neither the Plan, Magellan nor the IRO will charge you for pursuing an external review. If you choose not to request an external review, the Plan will not assert in any court proceeding that you failed to exhaust your administrative remedies because of that choice. If you do request an external review, the Plan will not make any claim that you were late in filing a lawsuit due to the time it takes to complete the external review.

A request for urgent external review must be submitted in writing following the completion of the Magellan appeal process. However, you may request external review before the appeal with Magellan is completed if Magellan fails to comply with requirements under federal regulations regarding denials and appeals (unless the failure to comply was a minor error that is not likely to cause prejudice or harm to you and was for good cause or a situation beyond Magellan's control).

Additional Rights
If you do not agree with Magellan's appeal decision and/or the decision of the external reviewer, you or your authorized representative may bring a civil action against the Plan under Section 502(a) of the Employee Retirement Income Security Act (ERISA) after you receive a final appeal decision from Magellan. You are excused from completing the Magellan appeal process before filing a lawsuit if Magellan fails to comply with requirements under federal regulations regarding denials and appeals (for example, the time frames described above).

TERMINATION OF COVERAGE

Normally, coverage under the Plan ends the earliest of:

- If your employment with the company terminates or you retire, coverage will end on the last date of the month in which your employment terminates.
- If you die, your eligible dependents will be covered through the last date of the month in which your death occurs.
- If you change employment status that affects your eligibility to participate in the EAP, your coverage ends on the last date of the month in which your change occurs.
- If you divorce, coverage for your ex-spouse continues through the last day of the month in which the divorce is final.
- If your children cease to be dependents (meaning you provide them with principal support), coverage continues through the last day of the month in which you are no longer responsible for principal support.
- If your family member loses his or her eligibility status, his or her coverage continues through the last day of the month in which he or she is no longer an eligible family member.
- If the plan is terminated, coverage for you and your eligible dependents ends on the date the EAP is terminated.
- If you leave employment or experience a COBRA qualifying event, you or your dependents may have the right to continue EAP coverage as required by COBRA (see COBRA section for details).

ASSIGNMENT OF BENEFITS

You may not assign, transfer, or convey any of the benefits provided by the EAP.

CONFIDENTIALITY

Discussions with the EAP counselor are confidential. The EAP will not share information identifying your use of the EAP without your permission, except as required or permitted by law. You will have an opportunity to evaluate the services provided by the EAP by completing a confidential survey.

NOTICE OF PRIVACY PRACTICES (HIPAA)

In accordance with the privacy regulations issued by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Regulation), a complete notice of the Windstream privacy practices is available for your review on the My Benefits page of the WINtranet. The notice describes how medical information about you may be used and disclosed and how you can obtain access to the information. The notice also describes various rights you may have regarding your information. Upon request, a written copy will be provided to you by contacting your local Human Resources representative or by contacting Coordinated Care by Quantum Health at 877-550-3255.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that requires employers to offer continued access to group health care coverage to former members of a healthcare plan. Domestic partners are not eligible for COBRA coverage. The Company pays the full cost of your COBRA coverage under the Plan; however, you will need to elect coverage,

Plan benefits shall be identical to those the qualified beneficiary had immediately before the qualifying event that triggered the right to COBRA continuation. If the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a qualifying event (in other words, similarly situated non-COBRA beneficiaries).

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

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

maximum coverage period (for the spouse and dependent child) ends three years from the date the employee became entitled to Medicare.

The taking of leave under the Family and Medical Leave Act of 1993 (FMLA) does not constitute a qualifying event. A qualifying event occurs, however, if an employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a qualifying event occurs, it occurs on the last day of FMLA leave, and the applicable maximum coverage period is measured from this date.

If you need continued coverage because of a divorce or separation or because your child loses dependent status or for any other reason, contact Coordinated Care by Quantum Health at 877-550-3255. You or your dependents have up to 60 days after the date coverage would cease to elect continuation of coverage.

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

Children born or lawfully adopted during a period of COBRA coverage are eligible for coverage. For additional information, please contact Coordinated Care by Quantum Health at 877-550-3255.

A certificate of creditable coverage will be provided to you, free of charge, when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Events That End Continued Coverage

Extended coverage will end automatically upon the expiration of the 18-, 29- or 36-month continuation periods described earlier. In addition, extended coverage will end automatically if any of the situations listed below occurs:

- The Company ends the EAP.
- A person eligible for continued benefits becomes covered under any other EAP (unless the EAP has an enforceable preexisting condition clause).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

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

MISCELLANEOUS INFORMATION

No Employment Contract
The purpose of this Summary Plan Description is to provide you with information about the benefits available under the Plan. The benefits described are not conditions of employment, nor is the Summary Plan Description intended to create an employment contract between you and the Company. Nothing in this Summary Plan Description should be interpreted as a limitation on your right or the Company's right to terminate your employment at any time, with or without cause.

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

Reduction, Change, Termination, Forfeiture, or Suspension of Benefits
The following circumstances may lead to a reduction, change, termination, forfeiture, or suspension of benefits:

- amendment or termination of the Plan
- calculation errors discovered by subsequent audit
- becoming a member of a collective bargaining unit, if your collective bargaining agreement does not provide for participation in the Plan
- a marital situation resulting in a qualified medical child support order

AMENDMENT AND TERMINATION OF THE PLAN

There is no guarantee that the EAP will continue indefinitely. The program is voluntary on the part of the Company. The Company reserves the right to change the EAP Administrator at any time. There is also no guarantee that the number of EAP sessions will not be changed in the future.

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

STATEMENT OF ERISA RIGHTS

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

Receive Information about Your Plan and Benefits

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

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue EAP Coverage
Continue EAP coverage if there is a loss of coverage under the plan(s) as a result of a qualifying event. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

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

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file a suit in federal court. In such a case the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the

court may order the person you have sued to pay court costs and legal fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN DATA

Name of Plan: The Windstream Employee Assistance Program (EAP) is a component of the Windstream Comprehensive Plan of Group Insurance.

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

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

Plan Sponsor and Primary Agent for Service of Legal Process:
Windstream Services, L.L.C
4001 Rodney Parham Road
Little Rock, AR 72212

Plan Information may be obtained by writing to:
You may obtain Summary Plan Descriptions ("SPDs") about Windstream's benefit plans on the WINtranet. If you do not have access to a computer, you may also call 1-888-392-7597 or write to Windstream Benefits Center, P.O. Box 11657, Pleasanton, CA 94588 to request a copy of any SPD.

Collective Bargaining Agreements:
The Windstream Employee Assistance Program is maintained pursuant to one or more collective bargaining agreements. You may obtain a copy of the applicable collective bargaining agreement upon written request to the Plan Administrator, or you may examine a copy of the applicable agreement at the Plan Administrator's office.

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

Employer Identification Number: 20-0792300

Type of Plan: The Comprehensive Plan of Group Insurance is a welfare benefit plan offering group health, dental, vision, life, long term disability, AD&D, wellness and EAP benefits, as well as medical and dependent care flexible spending accounts. The Employee Assistance Program is the component of the Comprehensive Plan of Group Insurance that offers confidential services for personal pressures.

Plan Identification Number: 501

Type of Administration: Some components of the Windstream Comprehensive Plan of Group Insurance use contract administration while others use insurers. The Employee Assistance Program uses Magellan as the administrator: Magellan Behavioral Health, 14100 Magellan Plaza, Maryland Heights, Missouri 63043, phone 1-800-327-5569.

The Plan Administrator is responsible for the administration of the EAP. The Plan Administrator has contracted with Magellan Behavioral Health to manage the services under the program. The Plan Administrator has delegated to Magellan Behavioral Health the authority to make final determinations regarding eligibility for benefits, claims for benefits, and procedures for obtaining benefits under the EAP. To the extent that a responsibility has not been delegated to another party, including Magellan, the Plan Administrator has the final discretionary authority to construe the terms of the Plan to resolve any ambiguities and to decide any question that may arise with the Plan's application or administration. Decisions of the EAP administrator are final and binding upon all parties.

Sources of Contributions and Funding Medium: Windstream pays the entire cost of the EAP from its general assets. There is no specific trust fund from which benefits or services under The Plan are paid. Active employees do not pay any contribution. However, if you are referred for treatment outside the EAP, you, together with your health care benefit plan, are responsible for paying for such treatment.

Plan Year: January 1 – December 31

DEFINITIONS

Certain terms and phrases used to describe the Employee Assistance Program (EAP) may not be familiar to you. It is important that you understand how the EAP works and your rights as a participant, so some important terms are defined below.

***Authorized Representative**: An authorized representative is a person you authorize, in writing, to act on your behalf or a person given authority by court order to request treatment or submit claims on your behalf.*

***Brief Counseling:** Brief counseling is outpatient counseling that is problem-focused, that emphasizes skills and strengths, and encourages practicing new behaviors; that involves setting goals achievable in a one (1) to five (5) month period; that involves interpretation, suggestions, and a framework provided by the counselor; that you may utilize alone or together with others who are important to resolution of your problem.*

***Claim:** A claim is a request for benefits made in accordance with the Plan's procedures. A claim may be either a request for personal consultation services or a request for reimbursement of the cost of EAP counseling.*

***Company:** Windstream Services L.L.C.*

***Employee Assistance Program (EAP) Administrator:** The EAP Administrator is Magellan Behavioral Health, the organization that has been engaged by the Company to provide the EAP.*

***Employee Assistance Program (EAP) Counselor:** An EAP Counselor is a psychologist, clinical social worker, marriage, family, and child counselor or other behavioral health professional who is licensed under state law to deliver counseling services and who is contracted with the EAP Administrator to provide EAP services.*

***Employee Assistance Program (EAP):** An EAP is a systematic program to help employees resolve personal problems, such as family conflict, drug or alcohol abuse, stress, marital discord, personal finances, and other personal problems, and to provide training, consultation, and other management services relating to the effective utilization of the EAP by an employer and its employees.*

***ERISA**: The Employee Retirement Income Security Act of 1974, the federal law that regulates group health plans and other employee plans.*

***Plan:** Unless otherwise stated, the term Plan refers to the Windstream Employee Assistance Program (EAP).*

***Urgent Care:** Care needed to avoid serious jeopardy to your life or health or to regain maximum function (or require to avoid severe pain), as determined by Magellan or your treating physician.*

CALIFORNIA EVIDENCE OF COVERAGE AND DISCLOSURE FORM, PRIVACY PRACTICES, AND GRIEVANCES

If you reside in California and are eligible for this Plan, the attached Employee Assistance Program Evidence of Coverage and Disclosure Form and Notice of Privacy Practices applies to you. If you reside outside of California, the terms do not apply to you.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-800-327-5569 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.