

Dental Care Plan

Summary Plan Description



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DENTAL CARE PLAN AT A GLANCE

BENEFIT	You may obtain dental care, including limited orthodontics, from a dentist of your choice and receive reimbursement for eligible expenses. Two Plan Options are available: (1) High and (2) Low.
ELIGIBILITY	All non-bargaining and bargaining employees of Windstream and its subsidiaries are eligible to participate if they are regularly scheduled to work at least 30 hours per week. Temporary, seasonal, leased, or independently contracted employees are not eligible.
ENROLLMENT	Enrollment is voluntary; however, you must elect to enroll during your first 31 days of employment (hire date + 30 calendar days). If you enroll during the first 31 days of employment, your coverage will be effective the first of the month following 8 weeks (56 calendar days) of employment. Late enrollment at a future date is only allowed at limited times.
CHANGE IN STATUS	If you have a change in status during the year, you <i>must</i> request enrollment or changes to your enrollment within 31 days (event date + 30 calendar days) of the event (such as birth or adoption, marriage, divorce, death, etc.).
COSTS	You and the Company share the costs of your coverage.
LIMITATIONS	Predetermination of benefits is suggested before major dental work is done.
CLAIMS	Claims must be filed with Delta Dental within 12 months after completion of treatment for which benefits are payable. Any claims filed after that period will be denied.
TERMINATION	Your coverage ends on the last day of the month in which your employment is terminated. You may continue your dental insurance for a limited amount of time after your employment terminates or when you no longer meet eligibility requirements. See the COBRA section for details.

This Summary Plan Description is for informational purposes and is not legally binding. This Summary Plan Description does not contain all of the technical details and legal expressions contained in the formal Plan documents. Any discrepancies between this Summary Plan Description and the formal Plan documents will be resolved in favor of the formal Plan documents. The Plan Administrator shall have the 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.

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

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

Eligible family members are defined as:

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

*Children include the following persons:

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

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

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

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

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

IMPORTANT NOTICE

Your dependents will lose coverage if they do not meet eligibility requirements and you waive continuation of coverage under COBRA as explained later in this document. However, your premiums will not automatically be adjusted, so make sure you contact Coordinated Care by Quantum Health within 31 days of the qualifying event (event date + 30 calendar days) to avoid paying for coverage that is no longer provided. See the "Dental Plan Premiums and Costs" section for more information regarding when your requested changes would reflect on your paycheck. Coverage will cease at the end of the month in which the eligibility requirements are not met.

SPECIAL ENROLLMENT PROVISIONS AND COVERAGE CHANGES

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

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

During your online enrollment session, you will be asked to return certain event and/or dependent documentation before your changes are approved. **If you need assistance requesting changes to your benefits, contact Coordinated Care by Quantum Health at 1-877-550-3255.**

Your and your dependent's coverage will never begin before your waiting period is satisfied (e.g. new hire waiting period). Your change must correspond and be consistent with your event.

Enrolling During Your First 31 Days of Employment

If you are a new employee, you must enroll in the Dental Care Plan during your first 31 days (hire date + 30 days) of employment if you wish to have coverage.

Coverage for you and your dependents, if applicable, will begin on the first day of the month following 8 weeks (56 calendar days) of employment.

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

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

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

Change in Family Status

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

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

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

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

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

- You and/or your dependents were covered under a group plan or insurance policy at the time coverage under this Plan is offered; and the coverage under the other group plan or insurance policy was:
 - COBRA continuation coverage and that coverage was exhausted; or
 - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
 - Terminated and no substitute coverage is offered; or
 - Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or

- No longer receiving any monetary contribution toward the premium from the employer.

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

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

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

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

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

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

After a Change in Employment Classification

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

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

You are eligible to enroll you and your dependents in this Plan within 31 days of your change in employment classification (event date + 30 calendar days).

Enrolling or Changing Elections during the Annual Benefit Enrollment Period

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

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

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

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

Your election change must correspond with a change and must actually be made under your dependent's employer's plan.

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

Significant Changes in Cost of Coverage

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

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

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

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

Special Provisions Relating to a Judgment, Decree, or Court Order

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

Entitlement to Medicare or Medicaid

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

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

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISIONS

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

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

- In the case of marriage, on the date of the marriage; or

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

TERMINATION AND LOSS OF ELIGIBILITY

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

- The end of the period for which your last contribution is made, if you fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for your eligible class is canceled (for instance, a collective bargaining agreement change); or
- The last day of the Plan year if you voluntarily cancel coverage by not enrolling while remaining eligible during the Annual Enrollment Period; or
- The last day of the month in which you are no longer a member of a covered class (for instance, a collective bargaining unit), as determined by Windstream;

- The last day of the month in which your employment ends or you are temporarily laid off; or
- The last day of the month in which you retire; or
- The date you submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan; or
- In the case of Special Enrollment, the termination date will be the date prior to the effective date listed for any of the Special Enrollment events defined in the prior section, even if you voluntarily cancel coverage due to an event and remain eligible for the Plan.

Your Dependent's Coverage

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

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

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

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

The Employer or Plan has the right to rescind any coverage of the employee and/or dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under

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

Reinstatement of Coverage

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

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

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

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Employee Retirement Income Security Act of 1974 requires an administrator of a group health plan to determine whether a medical child support order presented to the plan is a Qualified Medical Child Support Order (QMCSO). If the order is a QMCSO, Windstream is obligated to provide benefits to an employee's child in accordance with the terms of such order. Written procedures for QMCSO's are available to employees and beneficiaries (including prospective alternate payees and alternate recipients), free of charge, upon request to Coordinated Care by Quantum Health at 1-877-550-3255.

CHOOSING YOUR DENTIST

You can use any dental provider you choose; however, Delta Dental has established a network of participating dentists who offer their services at negotiated rates to reduce your cost. If you choose a participating dentist, your claims will be filed automatically by the provider and the participating dentist will not bill you for any amount over the Maximum Plan Allowance (the dentist and Delta Dental have agreed upon the Maximum Plan Allowance). Since Delta Dental pays the

participating dentist directly, you don't have to pay the entire bill and wait to be paid back.

When you use a non-participating dentist, you may have to file claims for reimbursement of eligible expenses or pay a service charge. You may also have to pay the non-participating provider in advance for the entire bill. If so, Delta Dental will pay any benefits due to you after the claim is submitted. Since non-participating dentists have not agreed to accept the Maximum Plan Allowance that Delta Dental pays, you will be responsible for any difference between the dentist's fee and the Delta Dental payment. Your out of pocket costs will be greater if you use a non-participating dentist.

To find a network dentist, visit the Delta Dental web site at www.deltadental.com. Click on the Provider Directory link. Once at the website, select the "Search for a Dentist" icon. From the "Product Selection" menu, choose the network selected by Windstream: **Delta Dental PPO Plus Premier**.

You may also call Coordinated Care by Quantum Health at 1-877-550-3255 for assistance locating a participating dentist.

DENTAL PLAN PREMIUMS AND COSTS

The Windstream Dental Plan is a fully-insured plan, and the Company and employees pay for Plan benefits by sharing the premium costs of the Plan. Delta Dental processes claims and benefit payments, pursuant to an administrative services agreement between Windstream and Delta Dental. In addition to paying premiums, you are also responsible for paying your Plan deductible, co-payments, and costs of non-covered services, as described later in this document.

Premium Contributions

You pay 50% of the cost of the premiums for your Dental Plan coverage*. After you enroll in the Plan, your premium is deducted from your pay on a pre-tax basis. Periodically, this amount may change to adjust for the overall cost of the coverage.

*If you are a bargaining employee, refer to your Collective Bargaining agreement for Company premium sharing.

Because your contribution is on a pre-tax basis as governed by Section 125 of the Internal Revenue Code, you may not discontinue coverage during the calendar year, except upon your separation from service or due to a family status change (as described prior in this document).

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

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

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

Plan Options

The Dental Plan is designed to give you the flexibility to choose the coverage that best meets your needs. You can choose to enroll in one of two Dental Plan options. Both options cover preventive and diagnostic care. Both the High and Low Options have the same deductibles, although they have different co-payments and individual maximum benefits.

Deductible

Each year, you pay a set amount of your covered dental expenses before the Plan begins sharing the costs, or co-paying, with you. This initial amount is called a deductible. The Plan distinguishes between an Individual Deductible and a Family Deductible as follows:

- **\$50 Annual Individual Deductible** - Every year, each individual will pay \$50 of his/her dental costs before the Plan starts co-paying for that individual's expenses.
- **\$150 Annual Family Deductible** - After any combination of family members have made deductible payments of \$150, no further deductible assessments will be made against any member of the family.

Two special circumstances affect the payment of deductibles:

1. **Dental Preventive Benefits** - No deductible is required for diagnostic or preventive benefits (Coverage A).
2. **Three-Month Carryover** – If a charge is incurred for a covered service during the last three months of any calendar year (October, November,

December) and is applied to the deductible for that year, the charge will also be applied to the deductible for the next calendar year.

Co-Payments

After the deductible has been met (when applicable), the Plan makes co-payments according to the following schedule.

HIGH OPTION	<i>In-Network Plan Pays</i>	<i>Out-of-Network Plan Pays</i>
Diagnostic and Preventive Benefits (Coverage A)	100% up to the Maximum Plan Allowance	100% up to the Maximum Plan Allowance
Basic Restorative Services (Coverage B)	80% up to the Maximum Plan Allowance	80% up to the Maximum Plan Allowance
Major Restorative Services (Coverage C)	60% up to the Maximum Plan Allowance	60% up to the Maximum Plan Allowance
Orthodontic Benefits	60% up to the Maximum Plan Allowance	60% up to the Maximum Plan Allowance

LOW OPTION	<i>In-Network Plan Pays</i>	<i>Out-of-Network Plan Pays</i>
Diagnostic and Preventive Benefits (Coverage A)	80% up to the Maximum Plan Allowance	80% up to the Maximum Plan Allowance
Basic Restorative Services (Coverage B)	50% up to the Maximum Plan Allowance	50% up to the Maximum Plan Allowance
Major Restorative Services (Coverage C)	50% up to the Maximum Plan Allowance	50% up to the Maximum Plan Allowance
Orthodontic Benefits	None	None

Annual Maximum Benefit

High Option

The maximum annual amount the High Option will pay for dental benefits is \$1,500 per person. The maximum **lifetime** amount the Plan will pay for orthodontic benefits is \$1,250 per person. The orthodontic lifetime maximum does not count against your dental maximum.

Low Option

The maximum annual amount the Low Option will pay for dental benefits is \$750 per person. Orthodontia is **not** included in the Low Coverage Option.

Maximum Plan Allowance

Fees for eligible dental expenses will be paid up to the maximum plan allowance amount. The maximum plan allowance amount is the lesser of the following amounts:

- The usual charge of your dentist or provider for similar services or supplies.
- The actual charge submitted by your dentist or provider for the services or supplies.
- The customary charge for similar services or supplies of other dentists or other providers who have similar training and experience and are in the same geographic area as your dentist or provider. Customary charges are determined by Delta Dental based upon a statistical database maintained by Delta Dental that includes all claims occurring within the geographical area where services were supplied.

To make sure your dentist's fees do not exceed the maximum plan allowance amount, you may want to file a predetermination of benefits.

ELIGIBLE EXPENSES

If you have any questions regarding Plan coverage for a specific benefit (such as a particular treatment, test, device, or procedure), please call Delta Dental of Arkansas. Upon request, written verification of eligibility for coverage will be provided, free of charge.

The Plan covers four levels of treatment:

- Diagnostic and Preventative Services (Coverage A)
- Basic Restorative Services (Coverage B)
- Major Restorative Services (Coverage C)
- Orthodontic Benefits

Predetermination of benefits is suggested before major dental work is done.

Diagnostic and Preventative Services (Coverage A)

No deductible is required. Preventive Benefits are paid at 100% under the High Option and at 80% under the Low Option for the following procedures designed to prevent dental diseases and abnormalities:

- Routine periodic examinations not more than two (2) in any calendar year, inclusive of an initial oral examination.
- Bitewing x-rays two (2) sets of four (4) films in a calendar year.
- Intraoral-periapical and extraoral x-rays.
- Full-mouth x-rays one (1) in any thirty six (36) consecutive month period.
- Prophylaxis (cleaning) not more than two (2) in any calendar year. * **Please see information on Evidence Based Dentistry.**
- Topical application of fluoride two (2) per calendar year.
- Space maintainers for prematurely lost teeth of eligible dependent children to age nineteen (19).
- Minor emergency treatment for the relief of pain as needed by the participant once on the same date and only payable in conjunction with x-rays and /or diagnostic procedures.

Basic Restorative Services (Coverage B)

After the annual deductible has been met, Basic Restorative Services are paid at 80% under the High Option, and 50% under the Low Option for the following procedures designed to restore teeth:

- Sealants once per tooth on permanent maxillary and mandibular first and second molars with no caries (decay) on the occlusal surface for dependent children to age nineteen (19), limited to two (2) times per tooth every sixty (60) months.
- Amalgam (silver) and composite/resin (white) fillings.
- Sedative fillings.
- Simple extractions.
- Oral surgery, including pre- and post-operative care and surgical extractions.
- Consultations, but not more than two (2) in a twelve (12) month period.
- Root canal treatment is limited to once in any twenty four (24) month period for the same tooth.
- Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration).
- Pulp therapy and apexification/recalcification.

- Surgical periodontics, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery, but no more than one (1) surgical procedure per quadrant in any three (3) year period.
- Non-surgical periodontics. Periodontal scaling and root planing are limited to not more than once per quadrant in any twenty four (24) month period.
- Periodontal maintenance; limited to four (4) per calendar year, less the number of teeth cleanings received during the calendar year, following active periodontal treatment. * ***Please see information on Evidence Based Dentistry.***
- General anesthesia or intravenous sedation in connection with oral surgery and all extractions. Coverage will also be considered when oral surgery procedures are not performed if the patient has medically compromising condition. Injections of therapeutic drugs.
- Complete or partial denture reline, including chair side or laboratory procedures to improve the fit of the appliance to the tissue, if at least six (6) months have passed since the installation of the existing removable denture; and not more than once in any thirty six (36) month period.
- Complete or partial denture rebase, including laboratory replacement of the acrylic base of the appliance if at least six (6) months have passed since the installation of the existing removable denture; and not more than once in any thirty six (36) month period.
- Recementing of cast restorations or dentures.
- Adjustments of dentures, if at least six (6) months have passed since the installation of the denture.
- Simple repairs of crowns, inlays, onlays or dentures.

Major Restorative Services (Coverage C)

After the deductible has been met, Major Benefits are paid at 60% under the High Coverage Option and 50% under the Low Coverage Option for the following more involved procedures and techniques designed to restore teeth:

- Initial installation of full, partial or fixed dentures or implants when needed to replace congenitally missing teeth or when needed to replace natural teeth that are lost while the person receiving such benefits was insured for dental insurance under this certificate.
- Replacement of a non-serviceable denture if such denture was installed more than sixty (60) months prior to replacement.
- Replacement of an immediate, temporary, full denture with a permanent, full denture, if the immediate temporary, full denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full denture.

- Initial installation of crowns, inlays, onlays and labial veneers.
- Replacement of any crowns, inlays, onlays with the same or a different type of cast restoration.
- Prefabricated stainless steel crown or prefabricated resin crown
- Core buildup.
- Posts and cores.
- Implants, but not more than once for the same tooth position in a sixty (60) month period.
- Repair of implants, but not more than once in a twelve (12) month period.
- Implant supported prosthetics, but no more than once for the same tooth position in a sixty (60) month period.
- Tissue conditioning once in a thirty six (36) month period.
- Non-surgical treatment of temporomandibular joint (TMJ) disorders. Services include appliance and x-rays related to the treatment and diagnosis of TMJ.

Orthodontic Benefits

If you are in the High Option, Orthodontic Benefits are paid at 60% (after the deductible has been met) for prevention and correction of improperly aligned teeth of a covered employee, spouse and eligible dependent children (dependent children are covered to the age of 26).

Limitations and Exclusions on Orthodontic Benefits

- Delta Dental shall make regular, quarterly payments for orthodontic benefits.
- Benefits end immediately with loss of eligibility, if treatment stops, or at the end of the service agreement between Delta Dental and Windstream.
- Benefits are not paid to repair or replace any orthodontic appliance.
- Orthodontic benefits are not paid for extractions or other surgical procedures.
- General limitations and exclusions in this Plan also apply to orthodontic benefits.
- The maximum **lifetime** benefit is \$1,250 per Plan participant. This orthodontic maximum will not count against your annual per person benefit for other dental benefits.

Orthodontic Payment

- The initial payment made by Delta Dental for comprehensive treatment can not be more than one-third (1/3) of the total fee for treatment. This is subject to the Plan co-payment percentage and lifetime maximum.

- Subsequent payment(s) will be issued on a regular basis for continuing, active orthodontic treatment. Payment(s) will begin the month after the beginning of treatment. Payments are subject to the co-payment and lifetime maximum of the Plan.

Prior to payment of benefits, you and your orthodontist should submit a treatment plan for approval for payment. The plan should include the following:

- the reason for the appliance;
- the amount and date of initial payment;
- the date the appliance is installed;
- the number of months required for treatment;
- the amount of monthly payments; and
- the total fee.

Note: Orthodontic benefits are not available in the Low Option.

(* Evidence Based Dentistry: Delta Dental covers additional routine cleanings or periodontal maintenance procedures up to four per calendar year for covered members with diabetes, heart disease, who are pregnant or have a history of periodontal disease. The additional benefits may not be combined by those with more than one of the above conditions.

INELIGIBLE EXPENSES AND OPTIONAL SERVICE LIMITS

If you have any questions regarding Plan coverage for a specific benefit (such as a particular treatment, test, device, or procedure), please call Delta Dental. Upon request, written verification of ineligibility for coverage will be provided, free of charge.

Services must be necessary and customary. Services must be provided following generally accepted dental practice standards as determined by the dental profession to be a paid benefit. Delta Dental will pay allowable benefits based upon the percentages and maximums listed in the Plan.

LIMITATIONS AND EXCLUSIONS ON DIAGNOSTIC AND PREVENTIVE BENEFITS

- Delta Dental will pay for two (2) oral examination(s) and two (2) cleaning(s) in a calendar year. *Please see information on Evidence Based Dentistry.
- Delta Dental will not pay for adult cleanings for participants(s) to age fourteen (14).
- Delta Dental will pay for full mouth x-rays one (1) time within any thirty six (36) consecutive month period. A combination of periapical and bitewing x-

rays (fourteen (14) or more films) or a panoramic film and additional x-rays make up a full mouth series.

- Preventative control programs (oral hygiene instructions, carries susceptibility tests, dietary control, tobacco counseling, etc.) are not a benefit.
- Delta Dental will pay for one (1) topical application of fluoride two (2) times in a calendar year. Fluoride rinses or self-applied fluorides are not a benefit.
- Pulp vitality tests are payable per visit, not per tooth, and only for the diagnosis of emergency conditions.
- A space maintainer is a benefit when used to replace prematurely lost or extracted teeth for children to age nineteen (19), Recementation of a space maintainer within six (6) months of the seating date is part of the original procedure. A space maintainer is not considered an orthodontic appliance.
- Palliative treatment is payable on a per visit basis, once on the same date and only payable when no other procedures are performed except for x-rays and/or diagnostic procedures.
- General limitations and exclusions found in this Plan also apply to Diagnostic and Preventive Benefits.

LIMITATIONS AND EXCLUSIONS ON BASIC RESTORATIVE BENEFITS

- A sealant is a benefit only on the unrestored, decay free chewing surface (occlusal surface) of the maxillary (upper) and mandibular (lower) first and second permanent molars. Sealants are a benefit twice in a sixty (60) month period for dependent children to age nineteen (19).
- Extractions, surgical extractions, root removal, alveoplasty, surgical exposure of impacted or unerupted tooth, tooth reimplantation and/or stabilization, transseptal fiberotomy, and oroantral fistula closure are limited to one (1) in a lifetime.
- Treatment of complications (post-surgical) or unusual circumstances are a benefit one (1) time in three (3) months (i.e., treatment of a dry socket).
- Payment for root canal treatment includes charges for temporary restorations. Retreatment of root canal by the same dentist or dental office will be considered after twenty-four (24) consecutive months have lapsed since initial treatment. Root canals on deciduous teeth are not a benefit and will be given the alternate benefit of a therapeutic pulpotomy, unless there is no permanent successor. Pulpal therapy is limited to primary teeth, and therapeutic pulpotomy is limited to once (1) in a lifetime.
- Full-mouth debridement.
- Payment for periodontal surgery shall include charges for three (3) months' post-operative care and any surgical re-entry for a thirty-six (36) consecutive month period. Root planing, curettage, and osseous surgery are not a benefit for participants(s) to age fifteen (15).

- Non-surgical periodontics will not be provided more often than one (1) time in a twenty-four (24) consecutive month period per quadrant.
- Periodontal maintenance is a benefit after three (3) consecutive months following active periodontal treatment.
- Charges for general anesthesia/intravenous sedation are covered when administered in conjunction with covered oral surgery.
- Analgesia, anxiolysis, inhalation of nitrous oxide, other drugs and/or medicines, and desensitizing medicines are not covered.
- Recementation of a bridge or crown within six (6) consecutive months of the seating date is part of the original procedure.
- Adjustments to complete or partial dentures made within the first six (6) consecutive month period after delivery are not covered.
- Relines and rebases are covered not more than once in any 36 month period and only after 6 months have passed since the installation of the existing full or partial denture.
- General limitations and exclusions found in this Plan also apply to Basic Restorative Services.

LIMITATIONS AND EXCLUSIONS ON MAJOR RESTORATIVE BENEFITS

- Delta Dental will not pay to replace any crowns, inlays, onlays, or veneers received in the previous sixty (60) months. Payment for crowns, inlays, onlays, and veneers shall include charges for preparations of tooth, gingival, and impression.
- Delta Dental will not pay for a crown, inlay, onlay, or veneer on a tooth that can be restored with an amalgam or composite restoration.
- Porcelain/ceramic or cast crowns for children to age thirteen (13) are not benefits.
- Delta Dental will not pay for the replacement of a stainless steel crown within a sixty (60) month period of the initial placement.
- Prefabricated resin crowns are not a benefit on molar teeth. A stainless steel crown allowance will be made with any fee difference the responsibility of the patient.
- Initial placement of an implant, full or partial removable dentures, fixed bridges (including crowns and inlays) which form a part thereof to replace a functioning natural tooth or teeth which are missing prior to the effective date of the individual's coverage, will not be covered unless the prosthetic appliance also includes the replacement of a natural tooth or teeth extracted while coverage was in effect.
- Delta Dental will not pay to replace any fixed bridges or partial or complete dentures that the participant received in the previous sixty (60) consecutive months, except where the loss of additional teeth requires the construction of

a new appliance. Delta Dental will not pay to replace a bridge or denture unless it cannot be made satisfactory.

- Payment for a partial or complete denture shall include charges for any necessary adjustment within a six (6) consecutive month period.
- A posterior, fixed partial denture and a removable partial denture in the same dental arch are not covered.
- The benefit is limited to the allowance for the partial, removable denture.
- Delta Dental limits payment for standard dentures to the maximum allowable fee for a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth. A standard denture is made by conventional means from acceptable materials. If a denture is constructed by specialized techniques and the fee is higher than the fee allowable for a standard denture, the patient is responsible for the difference.
- Delta Dental does not pay for fixed bridges or full or partial dentures for children to age seventeen (17).
- A fixed bridge where a partial denture is constructed in the same arch is not a covered benefit.
- Fixed partial denture retainers are a benefit one (1) time in any sixty (60) consecutive month period.
- Temporary and provisional crowns and partial dentures are not a benefit.
- Procedures for purely cosmetic reasons are not benefits.
- Cephalometric films are a benefit only if done for orthodontic purposes and covered under the orthodontic benefits.
- Diagnostic casts, intraoral and extraoral photographic images are not covered.
- Endosteal implants are covered but not more than once for the same tooth position in a sixty (60) month period.
- Implant abutments are covered one (1) time in every sixty (60) consecutive month period.
- An implant or abutment supported crown is covered one (1) time in every sixty (60) consecutive month period.
- An implant or abutment supported retainer is covered one (1) time in every sixty (60) consecutive month period.
- Repair of implant supported prosthesis or implant abutment is covered one (1) time in any twelve (12) consecutive month period.
- Recementation of implant /abutment supported crown or fixed partial denture is covered one (1) time in any twelve (12) consecutive month period after six (6) months have elapsed since initial placement.
- Implant maintenance procedure is covered one (1) time in any twelve (12) months.

- Implant removal is covered one (1) time in a lifetime per tooth.
- Tissue conditioning is limited to one (1) in a thirty six (36) consecutive month period. Tissue conditioning is not a benefit if performed on the same day a denture is delivered or a reline/rebase is provided.
- General limitations and exclusions found in this Plan also apply to Major Restorative Services.

GENERAL EXCLUSIONS

Ineligible expenses under both the High and Low Options include, but are not limited to the following:

- Benefits or services for injuries or conditions covered under Worker's Compensation or Employer's Liability laws. Benefits or services available from any federal or state government agency; municipality, county, other political subdivision; or community agency; or from any foundation or similar entity.
- Charges for services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
- Charges for services or supplies for which no charge is made that the patient is legally obligated to pay. Charges for which no charge would be made in the absence of dental coverage.
- Charges for treatment by other than a dentist except that a licensed hygienist may perform services in accordance with applicable law. Services must be under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
- Charges for the completion of forms and/or submission of supportive documentation required by Delta Dental for a benefit determination. A charge for these services is not to be made to a Delta Dental-covered patient by a participating dentist.
- Benefits to correct congenital or developmental malformations.
- Services for the purpose of improving appearance when form and function are satisfactory, and there is insufficient pathological condition evident to warrant the treatment (cosmetic dentistry).
- Benefits for services or appliances started prior to the date the patient became eligible under this plan, including, but not limited to, restorations, prosthodontics, and orthodontics.
- Services for increasing the vertical dimension or for restoring tooth structure lost by attrition, for rebuilding or maintaining occlusal services, or for stabilizing the teeth.
- Experimental and/or investigational services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards or a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time

services were rendered. Drugs are considered experimental if they are not commercially available for purchase and/or are not approved by the Food and Drug Administration for general use. Any prescriptions written by a dental physician and filled at a pharmacy are not covered.

- Charges for replacement of lost, missing, or stolen appliances/devices.
- Charges for services when a claim is received for payment more than twelve (12) months after services are rendered.
- Charges for complete occlusal adjustments, occlusal guards, occlusion analysis, enamel microabrasion, odontoplasty, bleaching, and athletic mouthguards, unless noted specifically in the Plan.
- Specialized techniques that entail procedure and process over and above that which is normally adequate. Any additional fee is the patient's responsibility.
- Behavior management.
- Those services and benefits excluded by the rules and regulations of Delta Dental including Delta Dental's processing policies.
- Removable appliances for control of harmful habits, including but not limited to tongue thrust appliances.
- Charges for general anesthesia/intravenous sedation are not covered except when administered in conjunction with covered oral surgery, excluding single tooth extractions (ADA procedure Code 7140) and for children three (3) and under, unless noted specifically in the Plan.
- Procedures that do not comply with Delta Dental's guidelines.
- Charges for precision attachments, provisional splinting, desensitizing medicines, home care medicines, premedications, stress breakers, coping, office visits during or after regularly scheduled hours, case presentations, and hospital-related services.
- All other benefits and services not specifically covered in the Plan.

OPTIONAL SERVICE LIMITS

- Services that cost more than the treatment usually provided under accepted dental practice standards are called Optional Services. Optional Services also include the use of specialized instead of standard procedures. Benefits for Optional Services will be based on the cost of the standard service. The participant will be responsible for the remainder of the fee.
- Payment made by Delta Dental for any surgical service will include charges for routine, post-operative evaluations or visits.
- If a participant transfers from one dentist to another during the course of treatment, benefits will be limited to the amount that would have been paid if one dentist rendered the service.

COORDINATION OF BENEFITS

Coordination of Benefits allows the Plan to share the cost of dental payments with other group plans. If in addition to the Windstream Dental Plan you or your dependents are covered by another group dental plan, Coordination of Benefits applies to you. That is, payments for your dental care and/or your dependents' care could be made by both plans.

If a participant is entitled to coverage under more than one insurance policy or benefit program, the benefits of this Plan will be subject to the following conditions:

- A. If the other program is not primarily a dental program, this program is primary.
- B. If the other program is for dental coverage, the following rules apply:
 - 1) The program covering the patient as an employee is primary over a program covering the patient as a dependent.
 - 2) Where the patient is a dependent child, primary dental coverage will be determined as follows:
 - o The coverage of the parent whose date of birth occurs earlier in the calendar year will be primary.
 - o Except for a dependent child of legally separated or divorced parents, the coverage of the parent with legal custody, or the coverage of the custodial parent's spouse (i.e., stepparent) will be primary, unless there is a court decree stating that one parent has financial responsibility for a child's health care expenses. If so, any Dependent coverage of that parent will be primary to any other dependent coverage.
- C. When primary coverage cannot be determined according to (A) and (B), the program that has covered the patient for the longer period will be primary.
- D. Coordination of Benefits within the same group will not be allowed.

If this coverage is primary, benefits will be provided without regard to any other coverage. If this coverage is not primary, benefits are limited to services which are benefits of this Plan that are not fully paid by any other coverage. However, benefits cannot exceed the amount of actual charges for any service(s).

The most that you will be reimbursed by both plans together will be the maximum amount paid by the plan with the most thorough coverage. For example, if Delta Dental receives a claim for an expense covered by another plan at 75% and the Windstream Plan would normally cover that claim at 80%, Windstream will pay the additional 5% (the difference between Windstream Plan's coverage and the other plan's coverage). If Delta Dental receives a claim for an expense covered by another plan at 80% and the Windstream Plan would also cover that claim at 80%, Windstream will not pay any additional amounts.

CLAIMS

If you visit a dentist that is in the Delta Dental network, your dentist's staff will file your claim for you. If you visit a non-network dentist, you may be required to complete the forms or pay a service charge and will need to insure that the dentist completes the provider section of the claim form. If needed, claim forms can be obtained by contacting Coordinated Care by Quantum Health at 1-877-550-3255. Information for filing a claim is listed on the claim forms.

If you have any questions during the claim process or appeal process, if applicable, please contact Coordinated Care by Quantum Health.

Claims Submission Deadline

All claims for dental expenses incurred during the calendar year must be submitted within twelve (12) months after completion of treatment for which benefits are payable. Any claims received after that date will be denied.

Initial Determination

Delta Dental will process your claim and make a determination within 30 days of the date the claim is received by Delta Dental, except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case Delta Dental may have an additional extension of 15 days to provide notification of the decision to approve or deny the claim. You will be required to furnish Delta Dental with information necessary to process the claim. If an extension is needed, Delta Dental will notify you prior to the expiration of the initial 30-day period, state the reason why the extension is needed, and state when the determination will be made. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of Delta Dental's notice requesting further information and an extension until Delta Dental receives the requested information does not count toward the time period Delta Dental is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from Delta Dental.

In the case of an urgent care claim, you will be notified within 72 hours of the benefit determination. An urgent care claim is a condition that could seriously jeopardize the life or health of the plan participant or the ability of the plan participant to regain maximum function or, in the opinion of a physician with knowledge of your medical

condition, would subject the plan participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Filing an Appeal

If Delta Dental denies your claim in whole or in part, the notification of the claim decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because Delta Dental did not receive sufficient information, the claim decision will describe the additional information needed and explain why the information is needed. Further, if an internal rule, protocol, guideline, or other criterion was relied upon in making the denial, the claim decision will state the rule, protocol, guideline, or other criteria or indicate that such rule, protocol, guideline, or other criteria was relied upon and that you may request a copy free of charge.

If Delta Dental denies your claim, you may appeal the decision. Upon your written request, Delta Dental will provide you free of charge with copies of documents, records, and other information relevant to your claim. You must submit your appeal to Delta Dental within 180 days of receiving Delta Dental decision to the following address:

**Delta Dental Claims Administrator
PO Box 15965
North Little Rock, AR 72231**

Appeals must be in writing and must include at least the name of the employee, name of the Plan, reference to the initial claim decision, and an explanation why you are appealing the initial determination. You may also submit any written comments, documents, records, or other information relating to your claim.

After Delta Dental receives your written request appealing the initial claim decision, Delta Dental will conduct a full and fair review of your claim. Deference will not be given to the initial denial of the claim, and Delta Dental review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether this information was submitted or considered in the initial claim determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgement, Delta Dental will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgement. This health care professional will not have consulted on the initial claim determination and will not be a subordinate of any person who was consulted on the initial determination.

Delta Dental will notify you in writing of its final decision within a reasonable period of time, but no later than 60 days after Delta Dental's receipt of your written request for review. If an extension is needed because you did not provide sufficient information, the time period from Delta Dental's notice to you of the need for an extension to when Delta Dental receives the requested information does not count toward the time Delta Dental is allowed to notify you of its final decision.

For an expedited review of an urgent care claim, the request may be submitted orally (by telephone) or in writing (by fax or other expeditious method). If the care is an urgent care claim, Delta Dental will make an appeal determination within 72 hours.

If Delta Dental denies the claim on appeal, Delta Dental will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline, or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline, or other criteria or indicate that such rule, protocol, guideline, or other criteria was relied upon and that you may request a copy free of charge. Upon written request, Delta Dental will provide you free of charge with copies of documents, records, and other information relevant to your claim.

Overdue Bills

In most cases, your approved claim will be paid before it becomes overdue. This is usually true if you file within 30 days of the date you receive the bill. However, at times some claims might be delayed in processing or in the mail. If your bill does become overdue, call Delta Dental immediately.

Overpayment

Despite Delta Dental's best efforts, they may make a claim payment which is not for a benefit provided under this Plan, or they may make payment to you when payment should have gone directly to the provider of treatment or services instead. In the event of an erroneous or mistaken payment, you must refund the full amount of such payment to Delta Dental promptly upon request.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that requires employers to offer continued access to group health care coverage to former members of the plan. Employees or their dependents who elect this continued coverage must pay the entire premium plus a 2% administrative fee. Plan benefits shall be identical to those the qualified beneficiary had immediately before the qualifying event that triggered the right to COBRA continuation. If the coverage has been changed, the coverage must be identical to the coverage

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

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

- If you and your dependents are to lose coverage because you leave the Company or experience a reduction in work hours, you and your dependents may continue coverage for up to 18 months.
- If your dependents are to lose coverage because you die, become eligible for Medicare, or divorce or separate, they may continue coverage for up to 36 months.
- If one of your children is to lose coverage because he/she no longer fits the definition of "eligible dependent," he/she may continue coverage for up to 36 months.
- 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 and is subject to a 50% administration fee. The Social Security Administration must formally determine under Title II (Old Age, Survivors and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of determination of disability under the Social Security Act must be provided by the disabled individual to Windstream within the 18-month coverage period and within 60 days after the date of determination.
- If a second qualifying event other than the employer's Title II bankruptcy occurs (for example, the employee dies or becomes divorced) within the 18-month or 29-month coverage period, the maximum coverage period becomes three years from the date of the initial termination or reduction in hours.
- If the employee's employment terminates (other than for gross misconduct) or the employee's hours are reduced within 18 months after the employee becomes entitled to Medicare, the maximum coverage period (for the spouse and dependent child) ends three years from the date the employee became entitled to Medicare.

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

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 (unless coverage is lost on a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when coverage is lost). The covered employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during FMLA leave.

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

Children born or lawfully adopted during a period of COBRA coverage are eligible for coverage. For additional information, please contact Coordinated Care by Quantum Health at 1-877-550-3255 for assistance.

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.

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 windstreambenefits.com, "tab" My Health, Summary Plan Descriptions, Important Notices. The notice describes how medical information about you may be used and disclosed and how you can obtain access to the information. The notice also describes various rights you may have regarding your information. If you do not have access to a computer, you may also call 1-877-550-3255 or write to Windstream Benefits Center, P.O. Box 11657, Pleasanton, CA 94588 to request a copy of the policy.

MISCELLANEOUS INFORMATION

No Employment Contract

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

Administration

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

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

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

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

AMENDMENT AND TERMINATION OF THE PLAN

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

STATEMENT OF ERISA RIGHTS

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

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office, 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 Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan(s) as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or Elimination of Exclusionary Periods

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, 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 terminate you or otherwise discriminate against you because of exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 Dental Care Plan is a component of the Windstream Comprehensive Plan of Group Insurance.

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

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

Plan Sponsor and Primary Agent for Service of Legal Process:

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

Plan Information may be obtained by writing to:

You may obtain Summary Plan Descriptions (“SPDs”) about Windstream’s benefit plans at WindstreamBenefits.com. If you do not have access to a computer, you may also call 1-888-392-7597 or write to Windstream Benefits Center, P.O. Box 11657, Pleasanton, CA 94588 to request a copy of any SPD.

Collective Bargaining Agreements:

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

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

Employer Identification Number: 20-0792300

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

Plan Identification Number: 501

Type of Administration: Some components of the Windstream Comprehensive Plan of Group Insurance use contract administration while others use insurers. The Dental Care Plan uses insurer administration and has hired Delta Dental as the insurer.

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

Contributions for the Dental Care Plan are paid shared by the employee and the Company, and are remitted to Delta Dental. Bargaining employees share the cost of coverage with Windstream, per the respective Collective Bargaining Agreements.

Plan Year: January 1 - December 31