FRONTIER COMMUNICATIONS CORPORATION

HEALTH REIMBURSEMENT ARRANGEMENT SUMMARY PLAN DESCRIPTION

January 1, 2012

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ABOUT THIS SUMMARY PLAN DESCRIPTION

The Frontier Communications Corporation Health Reimbursement Arrangement (the "Plan") provides eligible employees of Frontier Communications Corporation ("Frontier") and any subsidiary or division designated by Frontier as a participating employer with reimbursements of qualifying medical expenses. Currently, Frontier is the only employer participating in the Plan.

The rules and operation of the Plan are described in this Summary Plan Description ("SPD") as clearly as possible with minimal use of the technical terms appearing in the official legal documents (including applicable insurance contracts). However, the official legal documents remain the final authority and, in the event of a conflict with this SPD, shall govern in all cases. You may request a copy of the official legal documents from the Plan Administrator.

You are encouraged to read this SPD carefully. If you have any questions about the benefits provided under the Plan, you should contact your employer.

ELIGIBILITY AND PARTICIPATION

ELIGIBLE EMPLOYEES

You are eligible for the Plan if you are classified as either a regular full-time employee or a regular part-time employee who is eligible for this Plan under the collective bargaining agreement between the International Brotherhood of Electrical Workers, AFL-CIO (IBEW), Local Unions 289, 986, 1106, and 1431 and, but only with respect to the National Buried Service Wire Group bargaining unit, IBEW Local Unions 21, 51, 89, 543, 702 and 723.

A regular full-time employee will be eligible to participate in the Plan after 90 days from the date of hire.

A regular part-time employee will be eligible to participate in the Plan after 12 months from the date of hire during which he/she worked an average of 25 hours or more per week. To maintain eligibility for each calendar year thereafter, the employee must work an average of 25 hours or more per week in the prior calendar year in order to participate in the Plan for the following calendar year.

INELIGIBLE PERSONS

You are *not* eligible to participate in the Plan if:

- You are paid from a non-U.S. payroll, either entirely or partly.
- You are classified by your employer as an intern, casual or temporary employee.
- You are classified by your employer as an independent contractor (without regard to how the individual may be classified by a court or administrative agency).
- You are not covered by the applicable collective bargaining agreement.

It is expressly intended that individuals not treated as eligible employees by their employer are to be excluded from participation in the Plan under all circumstances until the employer changes their classification. Therefore, an independent contractor or any other ineligible individual who is reclassified by a court, administrative agency or other party, as an eligible employee will not be considered an eligible employee for periods before his or her employer implements the reclassification decision, even if the decision applies retroactively.

The Plan Administrator, in its sole discretion and in accordance with the Plan documents and applicable collective bargaining agreements, will determine whether you are eligible to participate in the Plan.

RETURN FROM MILITARY SERVICE

If an employee returns to active employment in a position as an eligible employee following active military duty, any minimum age and service requirements and any waiting period applicable to new eligible employees will not apply. All benefits provided by the Plan will be restored to their status as of the eligible employee's last day worked provided the employee applies for reinstatement within the time period required by the Uniform Services Employment and Reemployment Rights Act (USERRA). Plan coverage will be effective on the date the employee returns to active employment in a position as an eligible employee.

SPOUSE AND DEPENDENT COVERAGE

As a Plan participant you can receive reimbursement for eligible claims for your eligible spouse, your eligible children (*e.g.*, biological, adopted, step and foster children) up to his or her 26th birthday, any dependent child for whom you are the legal guardian and any other eligible individual who qualifies as your Federal income tax dependent. In addition, you can receive reimbursement for eligible claims for a child who is covered by a qualified medical child support order (QMCSO) under ERISA Section 609.

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the Plan, if the order is determined to be “qualified.” You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

COMMENCEMENT OF PARTICIPATION

Your coverage will be effective on the date you satisfy the eligibility requirements described above.

LEAVES OF ABSENCE

Family and Medical Leave

Eligible employees will receive up to 12 weeks of unpaid, job-protected leave during any 12-month period for certain family and medical reasons. In general, you will be eligible to take FMLA leave if:

- You have worked for your employer at least 12 months before the leave;
- You have worked at least 1,250 hours during the 12 months immediately before the leave; and
- You have worked at a worksite where your employer employs at least 50 employees in a 75-mile radius.

If you take a leave of absence pursuant to FMLA, your coverage under the Plan will continue.

Short Term Disability and Long Term Disability

Your participation in the Plan will continue while you are disabled under the short term disability plan. If you become eligible for long term disability benefits, your participation in the Plan will continue for as long as such participation is allowed under your applicable collective bargaining agreement.

Other Approved Leaves

If you are on a leave of absence approved by your employer, your participation in the Plan will continue for as long as such participation is allowed under your applicable collective bargaining agreement.

TERMINATION OF PARTICIPATION

Your Plan coverage will terminate at the time when you no longer meet the criteria to be an eligible employee as listed above. For example, your Plan coverage will terminate based on certain events, including:

- Termination of employment, including retirement, layoff and otherwise; or
- When you are no longer considered an eligible employee.

In addition, your dependent children and spouse will cease to have Plan coverage when your participation as an employee terminates or earlier if your dependent children or spouse fail to satisfy the criteria as set forth above.

If your participation terminates, you may continue to participate to the extent necessary to provide you with payment for claims incurred while you were still covered and to allow you to exercise your right to spend down your balance following termination. Additional information regarding your spend-down rights is provided elsewhere in this SPD.

RESCISSION OF COVERAGE

The Plan shall not rescind coverage for a participant or qualifying dependent, unless the participant or dependent performs an act, practice, or omission that constitutes fraud or unless the participant or dependent makes an intentional misrepresentation of a material fact with respect to the Plan. If coverage may be rescinded under the foregoing provisions, the participant or dependent shall be provided with at least 30 days advance written notice of such rescission. A rescission is subject to the claims procedures.

A rescission of Plan coverage is a cancellation or discontinuance of such coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission (and not subject to the rescission of coverage rules) if:

- The cancellation or discontinuance of coverage has only prospective effect;
- The cancellation or discontinuance of coverage results from a participant's termination of employment from an Employer; or
- The cancellation or discontinuance of coverage of a dependent results from such dependent's failing to satisfy the applicable eligibility requirements to be a dependent.

BENEFITS

REIMBURSEMENTS

The Plan allows you to be reimbursed for Qualifying Medical Expenses. Qualifying Medical Expenses include the following, as determined by the Claims Administrator (unless excluded below), –

- Any expense that qualifies as a medical expense under Section 213(d) of the Internal Revenue Code for yourself and your eligible spouse and dependents; and
- Any premiums (or premium equivalents) for retiree health insurance or retiree health coverage that is paid for by you after-tax.

Qualifying Medical Expenses do not include the following –

- Any expense paid by another health plan (up to the dollar amount paid by the other health plan);
- Any expenses for over the counter medicines or drugs, unless you have a written prescription for such medicine or drug. Contact the Claims Administrator for additional information;
- Any expenses incurred before you begin to participate in the Plan;
- Any medical, dental or vision insurance premium (or premium equivalent) to the extent that you have paid for or could have paid for such premium (or premium equivalent) on a pre-tax basis through a Code Section 125 cafeteria plan;
- Any employee medical, dental or vision insurance premium (or premium equivalent) relating to coverage in a Frontier plan; and

- Any expenses or insurance premiums (or premium equivalents) for a domestic partner and his/her children, unless such individuals are your federal tax dependents.

Please keep in mind the following special rules regarding reimbursements and your Plan HRA Account –

- You must file any claims for eligible expenses by April 1 of the year following the year in which the eligible expense was incurred. Claims filed after April 1 of the year following the year in which the expense was incurred will not be paid. The April 1st deadline may be revised in the future by the Plan Administrator by communicating to Plan participants a different deadline date.

- Eligible expenses incurred for yourself may be reimbursed from the HRA Account. Expenses incurred for your spouse, your child or other dependent will only be reimbursed if your spouse, child or other dependent satisfies the provisions to be eligible for the Plan. Expenses for your domestic partner and your partner's children are not eligible for reimbursement from your HRA Account, unless they are considered your tax dependents for federal income tax purposes.

- If you are enrolled in a Frontier health flexible spending account (Health FSA), you will not be reimbursed for any Qualifying Medical Expenses from your HRA Account that are reimbursed by the Health FSA. Further, you will not be reimbursed from your HRA Account until the point in time when you have exhausted your Health FSA account for the year.
    - For example, if you elect to contribute $1,000 to your Health FSA for a year, you will not receive reimbursement from the HRA Account until you have received $1,000 in reimbursement from your Health FSA for that year. In the event that you only have $1,000 in unreimbursed expenses for that year, your HRA Account contribution will carry-over and be available in the following year for reimbursement.

Participants may be provided with a debit card by the Claims Administrator to pay for Qualifying Medical Expenses. Any debit card shall be subject to the debit card's terms of use and any other requirements established by the Claims Administrator for this purpose. If a debit card is used to pay for an expense that is not a Qualifying Medical Expense, the Claims Administrator shall apply correction procedures as set forth in guidance under Section 125 of the Internal Revenue Code.

MAXIMUM REIMBURSEMENTS

If a Plan participant is eligible for a Performance Award (as set forth below), such Plan participant's HRA Account will be credited with $600 each year at the time the Performance Award is otherwise paid. Whether a Plan participant is eligible for a Performance Award and the time that such Performance Award is paid, is determined by the Company pursuant to the applicable provisions of the governing collective bargaining agreement.

Any credits to the HRA Account will be reduced by Qualifying Medical Expenses that are properly reimbursed from the Plan participant's HRA Account. HRA Account credits will also be reduced, on a pro rata basis, by the administrative fees paid by Frontier to the Claims Administrator for processing claims under the Plan. These fees will be withdrawn from HRA Accounts at one or more times during the year. Plan participants can contact the Company or the Plan Administrator to obtain the current amount of the fees.

Unused amounts from the prior calendar year may be carried forward to subsequent calendar years. You may not be reimbursed for an amount of eligible expenses that is greater than your HRA Account balance at the time the reimbursement is to be made. Any excess amount will be carried over to the next reimbursement cycle.

After your Plan eligibility terminates, no additional amounts will be credited to your HRA Account, with respect to periods after your termination. However, a contribution may be made to your HRA Account after termination of employment, if the contribution is required by the applicable collective bargaining agreement.

REIMBURSEMENT REQUESTS

During the course of the calendar year, you may submit requests for reimbursement of expenses you have incurred. However, you must make your requests for reimbursements no later than April 1 following the year in which the expense is incurred. (The deadline of April 1 may be changed for future years by communicating a different date to you in advance.) The Claims Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the Claims Administrator proof of the expenses you have incurred and that they have not been paid by any other health plan or form of coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

TERMINATION OF EMPLOYMENT OR PARTICIPATION

Once your Plan participation terminates (such as at a termination of employment, retirement or death), you will not receive any additional HRA Account contributions, unless otherwise required by the applicable collective bargaining agreement. However, you do have the ability to spend down your remaining HRA Account balance following your termination, as follows –

- You may continue to submit claims for reimbursement based on the rules and procedures set forth in this SPD until the date your HRA Account balance is exhausted. Once your HRA Account is exhausted, any remaining rights you may have in the Plan will terminate.

- If you die while you are participating in the Plan, your eligible spouse and eligible dependents (at the time of your death) can continue to submit claims for reimbursement until the date the HRA Account balance is exhausted.

- For any month that there is an outstanding balance in your HRA Account, your HRA Account will be charged a monthly administrative fee by the Claims Administrator. This fee will be charged based on the rules and procedures of the Claims Administrator. You may contact the Claims Administrator regarding the current amount of the monthly fee.

CLAIM AND APPEALS

When you have a claim to submit for reimbursement, you must:

(1) Obtain a claim form from the Claim Administrator;

(2) Complete the Employee portion of the form; and

(3) Attach copies of all bills from the service provider for which you are requesting reimbursement.

A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances but no later than the time periods set forth below. "Days" means calendar days.

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of insufficient information	15 days
Required Response by Participant	45 days

The Claim or Plan Administrator will provide written or electronic notification of any claim denial. The notice will include, among other things, specific information regarding the denial of your claim, a description of any additional review procedures that may be available to you and a description of your rights with respect to the denial.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Once an appeal is filed, the Claims Administrator will notify you within 60 days thereafter.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

With respect to those matters that the Plan Administrator and the Claims Administrator have been authorized to handle, each such entity has the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority shall be upheld on judicial review, unless it is shown that the interpretation or determination was an abuse of discretion (*i.e.*, the arbitrary and capricious standard). Benefits under the Plan will be paid only if the Plan Administrator or Claims Administrator, as applicable, decides in its discretion that you are entitled to them.

AFFORDABLE CARE ACT PROVISIONS

External review may be available once you complete the regular claims and appeal process described above. However, external reviews are limited to only the following types of claims and appeals –

- Medical Judgment Claims and Appeals: External review procedures apply to adverse benefit determinations that involve medical judgments (including those based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a benefit or experimental or investigational determinations).
- Rescissions of Coverage: External review procedures apply to rescissions of coverage and whether a rescission has any effect on a particular benefit at the time of a rescission. (Subject to certain exceptions, generally a rescission is a retroactive termination of coverage.)

External review procedures do not apply to any other adverse determination (other than medical judgment and rescissions as set forth above), including eligibility appeals. Contact the Claims Administrator to determine if external review applies to your claim determination.

COBRA COVERAGE

GENERAL EXPLANATION OF COBRA RIGHTS

You and your dependents have the option to extend your Plan coverage at group rates in certain instances when coverage would otherwise end (or the cost of coverage would increase). This is called COBRA coverage. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. This section gives you a general description of your rights under COBRA.

COBRA PARTICIPATION

If one of the circumstances listed in the COBRA continuation chart below causes you or a dependent to lose health coverage, you may continue group health plan coverage for yourself and your dependents if you pay the entire cost of coverage, with an additional 2 percent to cover administrative expenses.

Continued coverage is available for a maximum of 18, 29, or 36 months, depending on the circumstances outlined in the chart. The maximum continuation period if multiple circumstances should occur during the 18-month COBRA period is a total of 36 months. For example, if you terminate your employment and then die, your dependents' coverage may continue for 36 months, as long as COBRA was elected at termination and in effect at your death.

It is the responsibility of you, your spouse, or your dependent children to contact your employer within 60 days of the event to request an application to continue participation due to your divorce or legal separation or a child no longer qualifying as a dependent. Also, to extend coverage beyond 18 months because of disability, you or your covered dependent must become disabled for Social Security purposes within 60 days of the qualifying event, and notice of the Social Security Administration's determination must be provided both within the initial 18-month period and within 60 days of when the determination is made.

If the disability ceases, notice should be provided within 30 days of the final determination that the disability has ended. You or your dependents must pay the full group rate for continued coverage, with an additional 2 percent for administrative expenses. In addition, if you (or a dependent) are disabled and coverage continues for 29 months, during the 19th through 29th month of COBRA participation, the cost for coverage will be greater than that usually charged for COBRA coverage.

If COBRA is elected, the coverage previously in effect will generally be continued. From time to time, some changes in coverage are possible. For example, coverage and cost will be modified as Frontier makes regular changes to the programs, and you will be given the opportunity to make a new election during annual enrollment or when you have a change in family status (if applicable). Any newly eligible dependents you may have may be covered under the same rules that apply to active employees.

You or your eligible dependents have 60 days after you receive a COBRA notice to elect continued participation under COBRA. An election by you or your spouse to continue coverage will apply to all the qualified beneficiaries losing coverage in the same qualifying event, unless the election specifies otherwise. Once you make your election, you will have up to 45 days to pay any make-up premiums you missed and the monthly premium for the current month. COBRA coverage will be effective the day after the qualifying event.

TERMINATION OF COBRA

COBRA coverage will terminate before the end of the indicated time period if:

- You or your dependent becomes covered under another group healthcare plan after electing COBRA (provided the plan does not have pre-existing condition exclusions affecting the covered individuals).

- You or certain of your dependents become entitled to Medicare after electing COBRA continuation coverage.
- The first required premium is not paid within 45 days or any subsequent premium is not paid within 30 days of the due date.
- If coverage is extended beyond 18 months because of disability, the date a final determination is made that the individual is no longer disabled.
- All health plans for active employees are terminated by your employer.

COBRA CONTINUATION CHART

CIRCUMSTANCES	MAXIMUM CONTINUATION PERIOD		
	EMPLOYEE	SPOUSE	CHILD
Employee loses coverage because of reduced work hours	18 months	18 months	18 months
Employee terminates for any reason (except gross misconduct)	18 months	18 months	18 months
Employee or covered dependent is disabled (as defined by Title II or XVI of the Social Security Act) during the first 60 days of COBRA coverage	29 months	29 months	29 months
Employee dies	N/A	36 months	36 months
Employee and spouse legally separate or divorce	N/A	36 months	36 months
Employee becomes entitled to Medicare	N/A	36 months	36 months
Child no longer qualifies as dependent	N/A	N/A	36 months

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that employers must meet for certain employees who are involved in the uniformed services. If your coverage under the Plan terminates due to your service in the uniformed services, you may elect special continuation coverage under USERRA for yourself and your covered dependents. Please contact your employer for additional information if you think these special rules apply to you.

AMENDMENT AND TERMINATION

The Plan has been established with a bona fide intention and expectation that it shall be continued indefinitely. However, Frontier shall not have any obligation whatsoever to maintain or continue the Plan or any level of Plan benefits for any length of time. Frontier reserves the

right to modify, reduce, suspend, amend or terminate (in whole or in part) this Plan at any time. Frontier does not promise any specific level of Plan benefits or Plan coverage.

Benefits for claims occurring after the effective date of a Plan amendment, modification or termination are payable in accordance with the revised Plan documents. All statements in this SPD and all representations by Frontier or its personnel are subject to the above right of amendment and termination. The right to modify, reduce, suspend, amend or terminate (in whole or in part) this Plan at any time applies, without limitation, even after an individual's circumstances have changed by retirement, termination or otherwise. Benefits do not become vested at any time.

The rights to amend and terminate this Plan as set forth above shall be limited by and shall be subject to the applicable collective bargaining agreement.

MISCELLANEOUS

OFFICIAL PLAN INFORMATION

Your coverage is an employee welfare benefit under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The Plan discussed in this SPD is the Frontier Communications Corporation Health Reimbursement Arrangement. The Plan is treated as a component of the Frontier Health Care Plan, Plan Number 505.

The financial and other records are kept on a plan year basis. The plan year ends on each December 31.

PLAN SPONSOR AND PLAN ADMINISTRATOR

The plan sponsor is –

Frontier Communications Corporation
3 High Ridge Park
Stamford, CT 06905-1337
EIN: 06-0619596
(203) 614-5114

The plan administrator is –

Frontier Communications Corporation
Attn: Plan Administrator
3 High Ridge Park
Stamford, CT 06905-1337

The Plan Administrator may be contacted by phone or in person through Frontier's Benefits Department at (203) 614-5114.

The Plan Administrator is the "named fiduciary" for the Plan under ERISA and has full discretion to exercise its duties hereunder. The Plan Administrator may adopt rules and procedures as to how the Plan operates and has authority to exercise discretion in performing its duties.

AGENT FOR SERVICE OF LEGAL PROCESS

Legal process may be served on –

Frontier Communications Corporation
Attn: General Counsel
3 High Ridge Park
Stamford, CT 06905-1337

It may also be served on the Plan Administrator.

THIRD-PARTY ADMINISTRATOR / CLAIMS ADMINISTRATOR

CompuSys of Utah, Inc. provides certain third-party administration services related to the Plan. Contact information is as follows –

CompuSys of Utah, Inc.
2156 West 2200 South
Salt Lake City, Utah 84119
877-282-8665

PLAN FUNDING

Contributions for Plan coverage are made by Frontier. Benefits are self-insured and paid out of Frontier's general assets. The Claims Administrator is not responsible for funding or insuring Plan benefits. Frontier pays an administrative fee to the Claims Administrator to process claims. This fee shall be deducted on a pro rata basis from each Participant's HRA Account at one or more times during the year. Information on the current amount of the administrative fee can be obtained by contacting the Plan Administrator.

NO GUARANTEE OF EMPLOYMENT

Nothing in the Plan or this SPD may or can be interpreted as a guarantee of future employment or continued employment for any duration.

YOUR RIGHTS UNDER ERISA

The following statement is required by federal law. As a participant in the group health plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to the following rights:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You may examine, without charge, at Frontier's office and at other specified locations, such as worksites, all documents governing the plans, 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.

You may obtain, upon written request to Frontier, 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 descriptions. Frontier may make a reasonable charge for the copies.

You will receive a summary of the plan's annual financial reports. Frontier is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You may continue coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights and 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 plans. The people who operate your plans, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a plan 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 the plan documents and/or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require Frontier 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 Frontier's control. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about a plan, you should contact your employer. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from your employer, you should contact the nearest 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, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.