SUMMARY PLAN DESCRIPTION

OF THE

EME MEDICAL BENEFIT

FOR RETIREES

UNDER THE

FRONTIER COMMUNICATIONS HEALTH CARE PLAN

Summary Plan Description of the
EME Medical Benefit under the
Frontier Communications Health Care Plan

TABLE OF CONTENTS

Summary Plan Description of the
EME Medical Benefit under the
Frontier Communications Health Care Plan

INTRODUCTION

Frontier Communications (the "Employer") established the Frontier Communications Health Care Plan (the "Plan") effective November 1, 1935 to provide health benefits for its eligible employees. This Summary PIan Description ("SPD") presents a brief description of the Plan. It is not meant to interpret, extend, or change the official Plan documents. If there is any conflict between this SPD and the Plan documents, the Plan documents will govern your rights to benefits. Copies of the Plan documents are available for inspection in the Plan Office at the Frontier Benefits Center, Frontier Communications, 401 Merritt 7, Norwalk, Connecticut, 06851, during regular business hours.

The information in this SPD may be modified by a "Summary of Material Modification" ("SMM") attached. Check to see if there are any SMMs attached when you refer to this SPD.

Summary Plan Description of the
EME Medical Benefit under the
Frontier Communications Health Care Plan

IMPORTANT PLAN INFORMATION YOU SHOULD KNOW

Plan Name: Frontier Communications Health Care Plan

Plan Number: 505

Plan Type: Welfare Plan

Plan Year: The Plan Year begins on January 1 and ends on December 31

Employer and Plan Sponsor:
Frontier Communications
401 Merritt 7
Norwalk, Connecticut 06851
(203) 614-5600

Employer Identification Number: 06-0619596

Plan Administrator:
Frontier Communications
401 Merritt 7
Norwalk, Connecticut 06851
(203) 614-5600

Type of Plan Administration: The Plan is self-funded by the Employer, which means that all benefits are paid from the general assets of the Employer. Frontier Communications processes benefit claims and pays benefits. The Employer is responsible for determining the type(s) of benefits available under the Plan, deciding requirements for eligibility to participate in the Plan, and setting participants' cost for coverage. The Human Resources Department is the primary source for information about these aspects of the Plan.

Plan Agent for Service of Legal Process:
Frontier Communications
401 Merritt 7
Norwalk, Connecticut 06851

Summary Plan Description of the
EME Medical Benefit under the
Frontier Communications Health Care Plan

1. Who is eligible to be a participant in the Plan?

An employee must have been a participant in the EME Plan at the time of retirement to retain eligibility. Once retired, new spouses or dependents cannot be added to your coverage.

Employees are eligible for retiree medical based upon the terms of their collective bargaining agreement. In order to enroll for and to continue eligibility in the retiree medical program, employees must begin collecting their pension immediately following active employment. For further information, contact Milliman at 1-(866)-333-2074.

Please note, expenses that are considered ineligible under a retiree's basic medical plan are also considered ineligible under EME.

Once retired, you cannot add dependents or new spouses to your coverage. If covered at the time of retirement, your coverage could include:

Child. A participant's natural or legally adopted child (or child placed for adoption with a participant), a stepchild dependent on a participant for support, a child for whom a participant is the legal guardian, or other child who lives with a participant and is claimed as a dependent on the participant's federal income tax return.

Dependent. A participant's: (i) Spouse; (ii) unmarried child under the age of 19; (iii) unmarried child under the age of 23 who either is a full time student in an accredited college or university recognized and approved by the insurance company providing health insurance for the child under the Plan or resides with the participant or the participant's ex-spouse; or (iv) unmarried child who is unable to support himself because of mental retardation, mental illness, or developmental disability as defined in the New York State Mental Hygiene Law, or because of physical handicap (provided such condition occurred before the child reached the age at which his coverage under the Plan would otherwise terminate). The Plan reserves the right to require proof that a child qualifies as a dependent as defined above.

2. When can I change my health coverage?

In general, once you have enrolled in the Plan you may not change your decision. However, you may be able to drop coverage or change your level of coverage if either of the following events occurs during the Plan year:

- a change in legal marital status through divorce, legal separation, annulment, or death of spouse
- the coverage you chose is eliminated or is significantly curtailed

Contact Milliman at 1-(866) 333-2074 immediately if either of these events occurs and you want to change your enrollment decision and/or your type or level of coverage. Even if you can make the change you desire, you will have a limited period of time after the event (e.g., 30 days) to make it.

3. What benefits are available if I am a participant in the Plan?

The benefits available under the Plan are described in the Appendix at the end of this SPD.

4. When does my coverage end?

On the date you cease to be eligible, the date you voluntarily drop coverage or the date the Plan is terminated.

5. When does Plan coverage for my spouse or dependent end?

Unless your spouse or dependent is eligible for and elects COBRA coverage (see Question & Answer 14 for an explanation of this coverage), his or her coverage under the Plan will end on:

- the date your Plan coverage ends
- in the case of your spouse, upon divorce or legal separation
- in the case of a dependent, when he or she no longer qualifies as an eligible dependent

6. Who decides what benefits are available under the Plan and which employees are eligible to participate?

The Plan Administrator has the power and discretion to: change the terms of the Plan (including rules for eligibility to participate); establish, increase, decrease or eliminate specific Plan benefits; and administer the Plan in all of its details, including the authority to: (i) decide issues of fact relevant to the eligibility of any person to receive benefits, or the amount of time of payment of benefits; (ii) interpret the terms of the Plan; (iii) supply any omission, interpret any ambiguous or uncertain provision of the Plan, and reconcile any inconsistency that may appear in the Plan.

7. Can the Employer ever amend or terminate the Plan?

Yes. The Employer maintains the Plan on a voluntarily basis and has the right to amend or terminate the Plan, and terminate any health coverage provided under the Plan, at any time with respect to any individual, group, or class of employees, including retirees and employees eligible to retire and were participating. Employees and retirees never have a vested right to Plan coverage.

8. What if I have questions about coverage or benefits, or want to make a claim for benefits?

If you have questions about eligibility under the Plan or the cost of insurance coverage, you should contact Milliman at 1-(866) 333-2074. If you have questions about specific benefits, you should contact:

Claims for benefits should also be submitted to Frontier Communications 401 Merritt 7, Norwalk CT 06851

9. What additional rights do I have as a participant?

Federal law gives participants rights with regard to coverage and certain specific benefits.

10. Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

This includes the ability to:

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

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, arid copies of the latest annual report (Form 5500 Series), if applicable, 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, if applicable.

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 Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $1 10 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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 medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, US. 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 Pension and Welfare Benefits Administration.

Expenses that are considered ineligible under a retiree's basic medical plan are also considered ineligible under EME.

HOSPITAL INPATIENT SERVICES	
Hospital Services	Covered at 80% subject to deductible. Private room covered under private room allowance. No coverage for custodial care.
Skilled Nursing Facility	Covered at 80% subject to deductible. Private room covered under private room allowance. No coverage for custodial care.
Hospice	80% of coinsurance or co-pays subject to deductible. Private room covered under private room allowance. No coverage for custodial care.
HOSPITAL OUTPATIENT SERVICES	
Diagnostic X-Ray	Covered at 80%, subject to the deductible
Diagnostic Laboratory and Pathology	Covered at 80%, subject to the deductible
Chemotherapy	Covered at 80%, subject to the deductible
Radiation Therapy	Covered at 80%, subject to the deductible
Surgical Care	Covered at 80%, subject to the deductible
Pre-admission Testing	Covered at 80%, subject to the deductible
EMERGENCY SERVICES	
Emergency and Urgent Care	Emergency Room covered at 50%, subject to the deductible Physician charges covered at 80%, subject to the deductible
Accidental Injury	Covered at 80%, subject to the deductible
PHYSICIAN SERVICES	
Hospital Inpatient	

Physician Visits	Covered at 80% of the usual and customary charge, subject to the deductible.
Surgery	Covered at 80% of the usual and customary charge, subject to the deductible
Anesthesia	Covered at 80% of the usual and customary charge, subject to the deductible
Physician's Office	
Diagnostic Office Visits	Covered at 80% of the usual and customary charge, subject to the deductible
Routine Preventive Services (including GYN exams)	No coverage
Immunizations	No coverage
Allergy Tests and Injections	Covered at 80% of the usual and customary charge, subject to the deductible
Eye Exams	No coverage for routine exams or refractions. Diagnostic covered at 80% of the usual and customary charge, subject to the deductible.
Eye Wear	One pair of corrective lenses after cataract surgery covered at 80%, subject to the deductible.
Hearing Evaluations	No coverage for routine care. Diagnostic covered at 80% of the usual and customary, subject to the deductible.
Chemotherapy	Covered at 80% of the usual and customary charge, subject to the deductible.
Radiation Therapy	Covered at 80% of the usual and customary charge, subject to the deductible.
Diagnostic Laboratory and Pathology	Covered at 80% of the usual and customary charge, subject to the deductible.
Diagnostic X-ray	Covered at 80% of the usual and customary charge, subject to the deductible.
MATERNITY	
Hospital Charges for	Covered at 80%, subject to the deductible.

Mother	
Physician Charges for Mother	Covered at 80% of the usual and customary charge, subject to the deductible.
Newborn Nursery Care	Covered at 80%, subject to the deductible.
PSYCHIATRIC and CHEMICAL DEPENDENCE	Pre-certification required on all admissions for psychiatric and chemical dependence. A penalty of $500 will apply if pre-certification is not obtained.
<u>InPatient</u>	
Acute Psychiatric	Hospital: Unlimited days for semi-private/private room and all services for acute care covered at 80%, subject to the deductible. Doctor: Covered at 80% of the usual and customary charge, subject to the deductible, for unlimited days provided the patient is in an acute general hospital
Chemical Dependence	Hospital: Up to 45 days for semi-private/private room and all services for acute care covered at 80%, subject to the deductible. Doctor: Covered at 80% of the usual and customary charge, subject to the deductible, for up to 45 days provided the patient is in an acute general hospital
<u>Outpatient</u>	
Acute Psychiatric	Covered at 50%, subject to the deductible. This is a combined benefit (hospital and physician charges). Covered at 80%,subject to the deductible if employee is on psychiatric disability.
Chemical Dependence	Up to 60 days per person per calendar year covered at 80%, subject to the deductible.
OTHER SERVICES	
Home Care	Covered at 80%, subject to the deductible.
Physical Therapy	Covered at 80% of the usual and customary charge, subject to the deductible.

Occupational Therapy	Covered at 80% of the usual and customary charge, subject to the deductible.
Durable Medical Equipment (ME)	Covered at 80%, subject to the deductible.
Internal Prosthetics	Covered at 80%, subject to the deductible.
External Prosthetics and Orthopedic Braces and Supports	Covered at 80%, subject to the deductible.
Ambulance	Covered at 80%, subject to the deductible.
Prescription Drugs	Covered at 80%, subject to the deductible. Deductibles and prescription drug copayment after Basic covered at 80%,subject to the deductible.
Dental	Covered at 80% subject to the deductible for treatment of an accidental injury to sound and natural teeth. Services must be rendered within 12 months of the date of injury.
Chiropractic Services	Covered at 80%, subject to the deductible.
Out-of-Area Coverage	Coverage provided worldwide at 80% subject to deductible and basic plan provisions.
Dependent Coverage	To age 23 for unmarried children provide they are a full time student
Deductible, Coinsurance	Non Medicare participant Annual Deductible of $5,000 per member Medicare participant Annual Deductible of $5,000 Medical expenses per member, Annual Deductible of $5,000 Prescription Drug Expenses per member
Lifetime Benefit Maximum	Unlimited

This Is Not A Contract. It Is Intended To Highlight The Coverage Of This Program. Benefits Are Determined By The Terms Of The Contract. All Benefits Are Subject To Medical Necessity.

October 2009