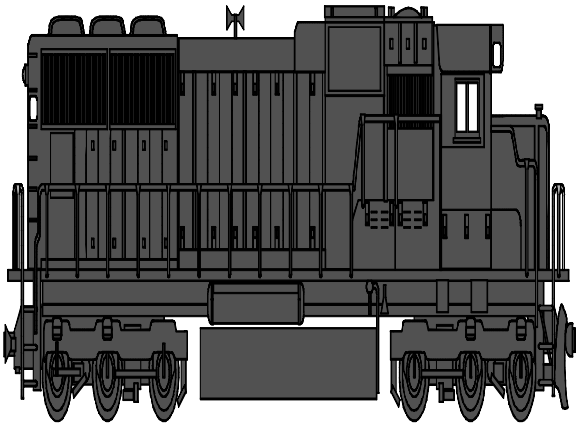
RAILROAD EMPLOYEES NATIONAL VISION PLAN 2003



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I
Important Notice to Employees

This booklet describes The Railroad Employees National Vision Plan ("Plan"). The Plan was established effective January 1, 1999.

The benefits provided by the Plan are fully insured by Mid-Atlantic Vision Service Plan, Inc. ("VSP"), 3333 Quality Drive, Rancho Cordova, California 95670.

Among other things, this booklet provides information about Plan benefits and how to file a claim. If you have any questions, or want further information about those benefits or claim-filing procedures, please call VSP toll-free at (888)-877-4782.

VSP chose United HealthCare to help with some of the Plan administration, including sending eligibility information on to VSP. Therefore, it is essential that the information about you and your dependents collected by United HealthCare be accurate and up-to-date. When you have any changes in marital or dependent status, please report them by calling the number on the back of your health plan identification card. *However, when you have an address change, you **must** report that change promptly to your employer.*

Some of the terms used in this booklet are in bold print. These terms have special meanings under the Plan that are set forth in the Definitions section of this booklet.

II
Plan Highlights

Here is a brief statement of the highlights of the Plan. The rest of this booklet provides a fuller explanation of the Plan provisions. You should, of course, read the entire booklet carefully.

The Plan provides benefits only for the particular vision services and supplies outlined below. The benefits are subject to various exclusions, conditions, limitations, and maximum amounts. These are described on pages 21 - 28 of this booklet.

Vision care services and supplies covered by the Plan may be obtained from any **VSP Doctor** or **Non-VSP Provider**. When covered services and supplies are obtained from a **VSP Doctor**, however, the benefits provided by the Plan are greater than when the services and supplies are obtained from a **Non-VSP Provider**.

The benefits are designed to help foster visual wellness; consequently, you may have to pay extra if you choose certain cosmetic or elective eyewear options. Before selecting your eyewear, ask your doctor about what is and is not covered by the Plan.

The chart below lists the Plan's benefits. This is only a short outline. See pages 21 - 26 for a more complete description.

Covered Services and Supplies	**VSP Doctor Benefit**	**Non-VSP Provider Benefit**
One eye exam every 12 months, counting from the most recent **Service Date**	Covered in Full	Up to $35

Covered Services and Supplies	VSP Doctor Benefit	Non-VSP Provider Benefit
One pair of **Visually Necessary** eyeglass lenses and one pair of eyeglass frames for **Corrective Lenses**, every 24 months, counting from the most recent **Service Date**		
Single Vision Lenses	Covered in Full	Up to $25
Bifocal Lenses	Covered in Full	Up to $40
Trifocal Lenses	Covered in Full	Up to $55
Lenticular Lenses	Covered in Full	Up to $80
Frames	Up to $75 retail allowance	Up to $35
Elective contact lenses One pair of **Visually Necessary** contact lenses, or one year's worth of 1-day, 7-day or 14-day **Visually Necessary** disposable contact lenses, every 24 months, counting from the most recent **Service Date**.	Up to $105 allowance	Up to $105

Covered Services and Supplies	VSP Doctor Benefit	Non-VSP Provider Benefit
Medically required contact lenses One pair of **Visually Necessary** contact lenses, or one year's worth of 1-day, 7-day or 14-day **Visually Necessary** disposable contact lenses, every 24 months, counting from the most recent **Service Date**. Medically required contact lenses will be covered only under one of the following circumstances: (i) following cataract surgery; (ii) to correct extreme visual acuity problems that VSP determines cannot be corrected with spectacle lenses; (iii) to treat **Certain Conditions of Anisometropia**; or (iv) to treat **Keratoconus**.	Covered in Full with **Prior Authorization** from VSP	Up to $210 with approval by VSP

III
Eligibility and Coverage

WHO IS ELIGIBLE

Employees

You are an **Eligible Employee** and therefore eligible for coverage under the Plan if you:

- are employed by a participating employer, and
- are represented by a participating railway labor organization, and
- have completed one or more years of service.

An employee will be regarded as having completed one year of service when he/she has completed 365 continuous days during which he/she has maintained an employment relationship with the same participating employer.

An explanation of WHEN COVERAGE STARTS appears on pages 7 - 8 of this booklet.

Dependents

Your **Eligible Dependents** are:

(a) your wife or husband,

(b) your unmarried children under 19 years of age,

(c) your unmarried children 19 years of age but under 25 years of age, who legally reside with you, are dependent for care and support mainly upon you and wholly, in the aggregate, upon themselves, you, your spouse and scholarships and the like, and are registered students in regular, full-time attendance at an accredited secondary

school, college or university or institution for the training of nurses, and

(d) your unmarried children 19 years of age or over who legally reside with you, are dependent for care and support mainly upon you and wholly, in the aggregate, upon themselves, you, your spouse and scholarships and the like, and have a permanent physical or mental condition which is such that they are unable to engage in any regular employment, provided that such disabling condition began prior to the date the child attained 19 years of age.

Your children include your own or adopted children (including children placed with you for adoption), plus any other child related to you by blood or marriage who depends on you for support and lives with you in a regular parent-child relationship, provided they qualify under (b), (c) or (d) above.

If you are eligible both as an employee and as the wife or husband of an employee, your total benefits will be limited as provided under COORDINATION OF BENEFITS (see pages 29 - 32). If you are eligible both as an employee and as the child of an employee, your total benefits will be limited to your benefits as an employee. An employee who works for more than one participating employer cannot receive duplicate benefits.

Dependents Covered Under Another Railroad Health and Welfare Plan

If vision benefits are payable under **Another Railroad Health and Welfare Plan** for a person who is a dependent not only of an employee covered by that plan but also of an **Eligible Employee** covered by this Plan, and that dependent is covered under this Plan as an **Eligible Dependent**, benefits will be payable under this Plan for that dependent only:

- if the **Eligible Employee** covered under this Plan has a birthday earlier in the calendar year than the employee covered by the other plan, and

- in all other cases, only to the extent that payments under both plans do not exceed the benefits that would have been paid under this Plan alone.

WHEN COVERAGE STARTS

Employees

- If you are an **Eligible Employee**, and if you rendered the **Requisite Amount of Compensated Service** during the immediately preceding month, you become covered on the ***first day of the calendar month beginning after you have completed one year of service***. *To become an* ***Eligible Employee****, you have to complete one year of service, which means that you must complete 365 continuous days during which you have maintained an employment relationship with the same participating employer*.
- Once an **Eligible Employee** has become covered under the Plan, he/she will continue to be covered during each month following a month in which he/she renders the **Requisite Amount of Compensated Service** or receives the **Requisite Amount of Vacation Pay**.

If you are an **Eligible Employee** and your employment relationship terminates, you will no longer be an **Eligible Employee**, and your coverage will cease according to the provisions set forth under WHEN COVERAGE STOPS, on pages 8 - 9. However, if you return to service with the same employer in a covered position, you will be an **Eligible Employee** immediately upon your return and you will again have coverage on the **first day of the calendar month following the month** in which you again render the **Requisite Amount of Compensated Service**.

If you are an **Eligible Employee** and begin service with another employer participating in the Plan, you will be considered a new employee and you will be an **Eligible Employee** again only when you have completed one year of service with your new employer. However, if after your

employment relationship with your former employer had terminated you begin service with the new employer at the direction of your former employer or by reason of seniority with your former employer, you will be an **Eligible Employee** as soon as you begin service with your new employer, and coverage will begin on the first day of the calendar month following the month in which you render the **Requisite Amount of Compensated Service** for your new employer.

Dependents

Your **Eligible Dependents** become covered on the same day you become covered.

WHEN COVERAGE STOPS

All coverage stops when:

- your employer or labor organization stops participating in the Plan,
- the class of employees you belong to stops being included under the Plan, or
- the Plan discontinues.

In addition, except as provided in the section CONTINUATION OF COVERAGE AFTER YOU LAST RENDERED COMPENSATED SERVICE on pages 9 - 14, all coverage will stop on the earlier of the following:

- the last day of the month following the month you last rendered the **Requisite Amount of Compensated Service** or received the **Requisite Amount of Vacation Pay**.
- the date your employment relationship ends.

Coverage for an individual dependent stops sooner when one of the following happens:

- a dependent child becomes covered as an **Eligible Employee** under the Plan,
- a dependent stops being an **Eligible Dependent**, or

- dependent coverage under the Plan is discontinued.

CONTINUATION OF COVERAGE AFTER YOU LAST RENDERED COMPENSATED SERVICE

Furloughed Employees

If you are an **Eligible Employee** AND you have rendered compensated service for three months, you and your **Eligible Dependents** will be covered under the Plan during any period of furlough until the end of the fourth month following the month in which you last rendered compensated service.

If you received **Vacation Pay** before the date on which you are furloughed but in a month subsequent to the month in which you last rendered compensated service, the continued coverage described above will be measured from the month in which you receive that **Vacation Pay**.

If you return to work as an **Eligible Employee** before your coverage ends, you will continue to be covered during the month in which you return to work.

If you return to work as an **Eligible Employee** after coverage ends, you will not be covered again until the month following the month in which you next render the **Requisite Amount of Compensated Service**.

If you become disabled before your coverage ends, please refer to the section below for Disabled Employees.

Suspended and Dismissed Employees

If you are suspended or dismissed after you became an **Eligible Employee** AND you have rendered compensated service for three months, you and your **Eligible Dependents** will be covered under the Plan during your suspension or after your dismissal until the end of the fourth month following the

month in which you last rendered compensated service or, if you were suspended, the month in which you last received **Vacation Pay**, if later.

If you received **Vacation Pay** before the date on which you are dismissed but in a month subsequent to the month in which you last rendered compensated service, the continued coverage described above will be measured from the month in which you receive that **Vacation Pay**.

If you return to work as an **Eligible Employee** before your coverage ends, you will continue to be covered during the month in which you return to work.

If you return to work as an **Eligible Employee** after your coverage ends, you will not be covered again until the month following the month in which you next render the **Requisite Amount of Compensated Service**.

If you are awarded full back pay for all time lost as a result of your suspension or dismissal, your coverage will be provided as if you had not been suspended or dismissed in the first place.

If you become disabled before your coverage ends, please refer to the section below for Disabled Employees.

Pregnant Employees

If you cease to render compensated service as a result of your pregnancy, you and your **Eligible Dependents** will be covered under the Plan until the end of the fifth month following the month in which you last rendered compensated service.

If you return to work as an **Eligible Employee** before your coverage ends, you will continue to be covered during the month in which you return to work.

If you return to work as an **Eligible Employee** after coverage ends, you will not be covered again until the month following the month in which you next render the **Requisite Amount of Compensated Service**.

Disabled Employees

If you cease to render compensated service solely as a result of disability, including disability due to your pregnancy, or if you become disabled by reason of pregnancy or otherwise before your coverage as a Furloughed, Suspended or Dismissed Employee ends, and provided in any case that you remain continuously disabled, you and your **Eligible Dependents** will be covered under the Plan until the end of the calendar year next following the year in which you last rendered compensated service.

If you received **Vacation Pay** before the date on which you relinquished your employment rights for any reason but in a year subsequent to the year in which you last rendered compensated service, the continued coverage described above will be measured from the year in which you received that **Vacation Pay**.

If your disability ends before the end of the calendar year next following the year in which you last rendered compensated service or received **Vacation Pay**, your coverage will end when your disability ends, unless at that time you return to compensated service, in which event your coverage by reason of disability will continue until the end of the month in which your disability ends.

If you return to work as an **Eligible Employee** after coverage ends, you will not be covered again until the month following the month you next render the **Requisite Amount of Compensated Service**.

You may be required to submit proof of your disability to VSP. Failure to provide this proof of disability, when requested, will cause your coverage to end. VSP will determine the date that

coverage terminated based on the most current disability information available.

Your coverage ends if your employment relationship terminates for reasons other than retirement or dismissal.

Retired Employees

If you retire, you will be covered during the month following the month in which you last rendered compensated service.

If you received **Vacation Pay** before the date you relinquish your employment rights to retire, but in a month subsequent to the month in which you last rendered compensated service, the continued coverage described above will be measured from the month in which you received that **Vacation Pay**.

Deceased Employees

If you die while covered, your **Eligible Dependents** will continue to be covered under the Plan until the end of the fourth month following your death.

Employees under Compensation Maintenance Agreements, etc.

All coverage will continue for as long as your employer is obligated, because of an agreement, statute, or order of a regulatory authority, to provide continued coverage of the kind provided under the Plan but only if your employer makes a payment for you as if you had rendered the **Requisite Amount of Compensated Service** during the prior month and you have not relinquished your employment rights.

Returning Veterans

If you had been an **Eligible Employee** and if you returned to compensated service for the same employer after completion of service in the armed forces of the United States or Canada,

you will become an **Eligible Employee** and your coverage will begin on the day you first render compensated service upon your return.

Employees Taking Family or Medical Leave Pursuant to the Family and Medical Leave Act of 1993

Solely for purposes of determining coverage for you and your **Eligible Dependents** during the month immediately following any month in which you take a period of family or medical leave authorized and provided for under the Family and Medical Leave Act ("FMLA") enacted by Congress in 1993, such period of authorized leave will be treated as if it were a period during which you rendered compensated service. FMLA leave will not be treated as compensated service (i) for purposes of measuring any continued coverage described in this CONTINUATION OF COVERAGE AFTER YOU LAST RENDERED COMPENSATED SERVICE section of your booklet, or (ii) for any purpose whatsoever if you are not covered under the Plan immediately prior to the beginning of the FMLA leave.

If you do not return to compensated service at the end of any period of family or medical leave, you will ordinarily be responsible for reimbursing your employer for its cost of continuing, during the period of leave, any Plan benefits that were in fact continued for you or your **Eligible Dependents** during your leave.

Contact your employer for more information about family or medical leave under the federal statute.

SUMMARY OF CONTINUATION OF COVERAGE
IF YOU CEASE TO RENDER COMPENSATED SERVICE
(OTHER THAN CONTINUATION UNDER COBRA
OR THE FAMILY AND MEDICAL LEAVE ACT)

Reason for Ceasing to Render Compensated Service	**The Date Coverage Terminates (See Note 1)**
Furlough, Suspension or Dismissal	End of fourth month following the month in which you last rendered compensated service or received **Vacation Pay**. (See Note 2)
Leave of Absence	End of month following the month in which you last rendered the **Requisite Amount of Compensated Service** or received the **Requisite Amount of Vacation Pay**.
Employment Relationship Terminates other than for Retirement or by Dismissal	Date of termination of employment relationship. (See Note 3)
Employment Relationship Terminates for Retirement	End of month following the month in which you last rendered compensated service or received **Vacation Pay**. (See Note 4)
Disability - Inability to Perform Work in your Regular Occupation	The earlier of the date your disability ends, or the end of the calendar year following the year you last rendered compensated service or received **Vacation Pay**.
Pregnancy	End of fifth month following the month in which you last rendered compensated service.

Notes:

1. For complete information concerning termination of coverage, including modifications of the provisions outlined above, see the section of this booklet entitled ELIGIBILITY AND COVERAGE beginning on page 5.

2. For a Furloughed Employee, **Vacation Pay** must be received prior to furlough. For a Suspended Employee, **Vacation Pay** must be received prior to suspension. For a Dismissed Employee, **Vacation Pay** must be received prior to severance of the employment relationship.

3. In the event an **Eligible Employee** dies while covered, coverage for **Eligible Dependents** continues to the end of the fourth month following the month in which the **Eligible Employee** died.

4. For a Retired Employee, **Vacation Pay** must be received prior to the relinquishment of rights for retirement.

OPTIONAL CONTINUATION COVERAGE UNDER COBRA

This part of your booklet contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **The material in this section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your Plan coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their Plan coverage. What follows is only a summary of your COBRA continuation coverage rights.

United HealthCare Railroad Administration administers the COBRA continuation coverage under this Plan. For additional information about your rights and obligations under the Plan and under federal law, you should contact United Healthcare toll free at 1-800-842-9905.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after UnitedHealthcare has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify UnitedHealthcare of the qualifying event.

You Must Give Notice Of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify UnitedHealthcare within 60 days after the qualifying event occurs. The notice must be in writing and must be sent to:

UnitedHealthcare
Railroad Administration (COBRA)
P. O. Box 150453
Hartford, CT 06115-0453

How is COBRA Coverage Provided?

Once UnitedHealthcare receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of the employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA continuation coverage for the employee's spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled, or has a total and permanent disability entitling him or her to an annuity under the Railroad Retirement Act, and you notify UnitedHealthcare of the determination within sixty (60) days from the date it was made, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to UnitedHealthcare. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions about your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Keep Your Plan Informed of Address Changes

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

Other Continuation of Coverage Provisions

Under certain circumstances, your coverage may be continued, often without cost to you, for all or part of the 18, 29 or 36 month continuation period (see "Continuation of Coverage After You Last Rendered Compensated Service"). Coverage can be continued under **COBRA** for the remainder of the 18, 29 or 36 month continuation period by making the required payments.

If in doubt as to whether or not there has been a qualifying event, or if you have any other question concerning COBRA coverage, call the UnitedHealthcare toll free telephone number (1-800-842-9905).

Contact Information

Information about the Plan and COBRA continuation coverage can be obtained on request by calling UnitedHealthcare toll free at 1-800-842-9905 or by writing UnitedHealthcare, Railroad Administration (COBRA), P.O. Box 150453, Hartford, CT 06115-0453.

IV
Benefits

The Plan pays the benefits described in this section with respect to certain, specific, vision services and supplies provided to **Covered Family Members**. The benefits provided by the Plan apply separately to each **Covered Family Member**.

The Plan does not provide benefits for all vision care, and there are limitations, exclusions, and stated maximum benefit amounts. These are described on this and subsequent pages in this booklet.

The Plan pays different levels of benefits depending upon whether you obtain covered services and supplies from a **VSP Doctor** or from a **Non-VSP Provider**. To receive the highest benefit level, you must receive the covered services and supplies from a **VSP Doctor**.

This Plan is designed to cover *visual needs* rather than *cosmetic materials.* When you select any of the following options, the benefit provided by the Plan will be the applicable benefit for eyeglass lenses and eyeglass frames described below under the heading “Covered Services and Supplies”, and you will be responsible for paying the additional costs for the options you select. These costs will be based upon VSP patient option prices or, if you select something that is not listed below, according to the provider’s usual and customary fees.

1. Oversize lenses (56 mm and over).
2. Photochromic lenses.
3. Tinted lenses except Pink #1 and Pink #2.
4. Progressive J and K (CR-39 plastic and glass only) lenses.

5. Progressive flat top lenses.
6. UV (ultraviolet) protected lenses.
7. Anti-reflective coating.
8. Scratch coating.

COVERED SERVICES AND SUPPLIES

The following services and supplies are the only services and supplies for which the Plan pays any benefits. They are sometimes referred to in this booklet as "covered services and supplies."

Eye Exam Benefit

- One eye exam every 12 months, counting from the most recent **Service Date**. This exam consists of a complete vision analysis, including an appropriate exam of visual functions and the prescription of corrective eyewear where indicated.
    - If you go to a **VSP Doctor**, this exam is covered in full.
    - If you go to a **Non-VSP Provider** for an exam, the benefit provided by the Plan is the amount you actually pay for the exam up to, but no more than, $35.

Eyeglass Lens and Frame Benefit

- One **Visually Necessary** pair of eyeglass lenses (or two **Visually Necessary** separate eyeglass lenses) every 24 months, counting from the most recent **Service Date** and one pair of eyeglass frames for **Corrective Lenses** every 24 months, counting from the most recent **Service Date**, along with any associated professional services. This benefit includes the prescribing and ordering of lenses; the selection, and proper fitting and adjustment, of frames; verification of the accuracy of finished lenses; and subsequent adjustments to frames to maintain comfort and efficiency.

Lenses

- If you get **Corrective Lenses** from a **VSP Doctor**, they are covered in full except for non-covered lens options, which are described at page 25.
- If you get **Corrective Lenses** from a **Non-VSP Provider**, the benefit provided by the Plan is the amount you actually pay for them up to, but no more than,
    - $25 for single vision lenses,
    - $40 for bifocal lenses,
    - $55 for trifocal lenses, and
    - $80 for **Lenticular Lenses**

Frames

- If you get a frame for your **Corrective Lenses** from a **VSP Doctor**, the Plan will provide a $75 allowance towards the retail price of the frame.
- If you get a frame for your **Corrective Lenses** from a **Non-VSP Provider**, the Plan will reimburse you in the amount you actually pay for the frame up to, but no more than, $35.

Contact Lens Benefit

- One **Visually Necessary** pair of contact lenses (or two **Visually Necessary** separate contact lenses), or one year's worth of 1-day, 7-day or 14-day disposable contact lenses, every 24 months, counting from the most recent **Service Date**, along with any evaluation, fitting and other associated professional services and supplies. *This benefit is provided in lieu of and not in addition to the eyeglass lens and frame benefit described above. During any 24 month period, you may receive either the eyeglass lens and frame benefit or this contact lens benefit, but not both.*

Contact Lenses from a VSP Doctor

- **Elective contact lenses**. A $105 allowance will be provided towards the contact lens evaluation, fitting costs and materials. Any costs exceeding this allowance are your responsibility.
- **Medically required contact lenses**. When prescribed by a VSP Doctor and Prior Authorization from VSP is obtained, medically required contact lenses are covered in full if one of the following conditions are met:

  (i) following cataract surgery;

  (ii) to correct extreme visual acuity problems that VSP determines cannot be corrected with spectacle lenses;

  (iii) to treat **Certain Conditions of Anisometropia**; or

  (iv) to treat **Keratoconus**.

  *The **VSP Doctor** must receive **Prior Authorization** from VSP for medically required contact lenses.*

Contact Lenses from a Non-VSP Provider

- **Elective contact lenses**. The benefit provided by the Plan is the amount you actually pay for the covered services and supplies up to, but no more than, $105.
- **Medically required contact lenses**. If your **Non-VSP Provider** establishes to the satisfaction of VSP that the services and supplies are provided (i) following cataract surgery; (ii) to correct extreme visual acuity problems that **VSP** determines cannot be corrected with spectacle lenses; (iii) to treat **Certain Conditions of Anisometropia**; or (iv) to treat **Keratoconus**, the benefit provided by the Plan is the amount you actually pay for the covered services and supplies up to, but no more than, $210. Written documentation

from a **Non-VSP Provider** must be submitted to VSP for review along with receipts for the supplies and services involved.

EXCLUSIONS

The Plan provides no benefits for any of the following services and supplies:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.38 diopter power); or two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Any eye exam, or any corrective eye wear, required by an employer as a condition of employment.
- Corrective vision treatment of an experimental nature.

HOW TO OBTAIN PLAN BENEFITS

To obtain benefits for covered services and supplies that you get from a **VSP Doctor**, you should first contact the **VSP Doctor**, identify yourself as a Plan participant under the VSP program, and provide the employee's social security number. The **VSP Doctor** will contact VSP to verify your coverage. If you are a **Covered Family Member**, VSP will authorize the **VSP Doctor** to provide the covered services and supplies. If you need to locate a **VSP Doctor**, call VSP at (888-877-4782) or visit VSP's world wide web site at www.vsp.com.

When you receive covered services and supplies from a **Non-VSP Provider**, you will be asked by the Provider to pay his or her entire bill at the time the services are rendered. To obtain Plan benefits with respect to such covered services and supplies, you will need to file a claim for reimbursement with VSP. Part VII of this booklet tells you, among other things, how to do that.

RELEASE OF VISION INFORMATION

VSP may release vision information about a **Covered Family Member** to any other person or organization that is authorized by the Plan to receive it and that requests such information to enable it to accurately determine what benefits are payable under the Plan.

Furthermore, to the extent permissible under applicable law, before you may receive benefits under the Plan, each **Covered Family Member** may be required to agree with each of his/her providers that the provider may release vision information to VSP that VSP considers necessary to enable it to accurately determine what benefits are payable under the Plan.

For further information on when the Plan may disclose health information, see “Notice of Privacy Practices” at the end of this booklet.

V
General Exclusions

The Plan does not cover any expense for services, supplies or treatment relating to, arising out of, or given in connection with, the following:

- Another Railroad Plan - services and supplies for which an **Eligible Dependent** is entitled as an **Eligible Employee** to benefits in connection with **Another Railroad Health and Welfare Plan**.
- Armed Forces - services or supplies furnished, paid for, or for which benefits are provided or required, by reason of the past or present service of any person in the armed forces of a government.
- Broken Appointments - expenses incurred for failure to keep a scheduled visit with a **VSP Doctor or Non-VSP Provider.**
- Canadian Residents - services or supplies received by a resident of Canada to the extent that Canadian law or provincial law precludes Canadian residents from obtaining insurance by non-governmental insurance carriers providing for payment of benefits for such services and supplies.
- Dependent Children - a dependent child's expenses if the child is receiving benefits for the same expenses under the Plan as an **Eligible Employee**.
- Dependent's Work Related Injury or Sickness - services or supplies for which your **Eligible Dependent** is entitled to indemnity under any workers' compensation or similar law.
- Employer Facilities - services rendered through a medical or vision department, clinic, or similar facility provided or maintained by the individual's employer.

- Family Members - treatment given by a member of your family, (your spouse and the children, brothers, sisters and parents of either you or your spouse).
- Forms - expenses incurred for the completion of any forms relating to claims for Plan benefits.
- No Legal Obligation - services and supplies which you are not legally required to pay or for which you would not have been charged but for the existence of coverage under the Plan. However, if the United States government or one of its agencies is authorized by law to charge the Plan for the services provided, then this exclusion will not apply.
- Non-Vision Treatment - services or supplies which are not vision services or supplies.

VI
Coordination of Benefits

These provisions will coordinate the benefits payable under this Plan with benefits payable under other plans.

You or any **Eligible Dependent** may be covered under another Plan. It may be sponsored by another employer who makes contributions or payroll deductions for it. The other plan could also be a government or tax-supported program.

Coordination of Benefits does not apply to:

- **Another Railroad Health and Welfare Plan,** except as set forth under the heading "Dependents Covered Under Another Railroad Health and Welfare Plan" on pages 6 - 7 of this booklet.
- an individual insurance policy which a person may purchase with his/her own funds, or
- benefit plans paid for through payroll deductions unless the plan is an employer-sponsored plan.
- any benefit that would not be payable under the Plan in the absence of any coordination of benefits.

How Does Coordination Work?

One of the plans involved will pay benefits first. That plan is primary. The other plans will pay benefits next. These plans are secondary.

If this Plan is primary, it will pay benefits first, as if it were the only plan involved. Benefits under this Plan will not be reduced because benefits are payable under other plans.

If this Plan is secondary, the benefits it pays will be reduced because of benefits payable by other plans primary to this

Plan. The amount of benefits this Plan would have paid without this provision will be determined first. Then the amount of benefits payable by other plans primary to this Plan for the same charges will be subtracted from this amount. This Plan will pay the difference, if any. For example, if this Plan is secondary, and if the primary plan pays 50% of the charges covered under this Plan for Type B Covered Expenses, then this Plan will pay 30% of those charges.

Which Plan is Primary?

To pay claims, VSP must find out which plan is primary and which plans are secondary.

There are rules to find out which plan is primary and which plans are secondary when benefits are payable under more than one plan. The rules that usually apply are as follows:

- A plan which has no coordination of benefits provision will be primary to a plan which does have such a provision.

- A plan which covers the person as an employee, whether active, laid-off, retired or inactive for any other reason, will be primary to a plan which covers the same person as a dependent.

- If a person is covered as a dependent under two or more plans, then the plan which covers that person as a dependent of the person whose birthday is earlier in the calendar year will be primary to a plan which covers that person as a dependent of a person whose birthday is later in the calendar year.

- If the **Eligible Employee** under this Plan is also covered as a laid-off or retired employee under another plan, then this Plan will be primary to that other plan provided the other plan has this same rule.

- If a determination of which plan is primary cannot be made by any of the above rules, then the plan which

has covered the person for the longest time will be primary to all other plans.

- If the birthday rule above would apply except that the other plan does not have the same rule based on birthday, then the rule in the other plan will determine which plan is primary.

- If the birthday rule above would apply except that the person is covered as a dependent under two or more plans of divorced or separated parents, then the rule that applies depends upon whether there is a court order giving one parent financial responsibility for the dental expenses of the dependent child.

- If there is a court decree, then the plan of the parent with financial responsibility will be primary to any other plan.

- If a court decrees that parents share joint custody, without stating which of the parents has financial responsibility for the child's health care expenses, the parent birthday rule will apply. The birthday rule refers only to the month and day in the calendar year, not the year in which the person was born.

- If there is no court decree, the plan of the parent with custody will be primary to the plan of the parent without custody. Further, if the parent with custody has remarried, the order of payment will be as follows:

    - The plan of the natural parent with custody will pay benefits first.
    - The plan of the step-parent with whom the child lives will pay benefits second.
    - The plan of the natural parent without custody will pay benefits third.

- Whether or not there is a court decree, this Plan will not cover a step-child of an **Eligible Employee** with whom the child does not live.

If Both Wife and Husband Work for a Participating Employer and Are Covered Under This Plan

If a husband or wife is covered under this Plan both as an **Eligible Employee** and as an **Eligible Dependent**, then this Plan will be treated as two separate plans, and the rules previously stated will be used to determine which plan is primary and which plan is secondary.

If a person is covered under this Plan as an **Eligible Dependent** of two **Eligible Employees**, the **Eligible Dependent** benefits will be paid on behalf of each **Eligible Employee** as if there were two separate plans, and the rules previously stated will be used to determine which plan is primary and which plan is secondary.

For the secondary plan, benefits will be determined under what is commonly known as a “make whole” Coordination of Benefits approach, namely:

- First determine the covered services and supplies.
- Then subtract the amount paid by the primary plan.
- The secondary plan pays the difference, provided the difference is no more than the amount that would have been paid without this provision.

You may have to give information about any other plans when you file a claim. VSP has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer the rules set forth above.

VII
Definitions

These definitions apply when the following terms are used in this booklet.

Another Railroad Health and Welfare Plan

An employee welfare benefit plan established pursuant to agreement between a railroad or railroads and a labor organization or labor organizations other than this Plan or a hospital association plan.

Certain Conditions of Anisometropia

A condition of unequal refractive state for the two eyes, where one eye requires a lens correction that is at least two diopters different, in both the sphere and the cylinder, from the other eye.

Corrective Lenses

Lenses with at least ±.38 diopter power.

Covered Family Members

Those **Eligible Employees** and their **Eligible Dependents** who are covered under the Plan.

Eligible Dependent

(a) your wife or husband,

(b) your unmarried children under 19 years of age,

(c) your unmarried children 19 years of age but under 25 years of age, who legally reside with you, are dependent for care and support mainly upon you and wholly, in the aggregate, upon themselves, you, your spouse and scholarships and the like, and are registered students in

regular, full-time attendance at an accredited secondary school, college or university or institution for the training of nurses,

(d) your unmarried children 19 years of age or over who legally reside with you, are dependent for care and support mainly upon you and wholly, in the aggregate, upon themselves, you, your spouse and scholarships and the like, and have a permanent physical or mental condition which is such that they are unable to engage in any regular employment; provided that such disabling condition began prior to the date the child attained 19 years of age.

Your children include your own or adopted children, plus any other child who depends on you for support and lives with you in a regular parent-child relationship, provided they qualify under (b), (c) or (d) above.

Eligible Employee

An **Eligible Employee** is an employee who is:

- employed by a participating employer,
- represented by a participating Railway Labor Organization, and
- has completed one or more years of service.

An employee will be regarded as having completed one year of service when he/she has completed 365 continuous days during which he/she has maintained an employment relationship with the same participating employer.

Keratoconus

A development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.

Lenticular Lenses

Lenses where the power is in the center of the lens and the edge of the lens is plain glass.

Medicare

The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act.

Non-VSP Provider

Any licensed optometrist, ophthalmologist or dispensing optician who has not contracted with VSP to provide vision care services and/or vision care materials to **Covered Family Members**.

Prior Authorization

An affirmative determination by VSP in response to a written request from a VSP Doctor for professional review of services and/or supplies deemed by that doctor as medically necessary (applies only to contact lenses). VSP will review and rule on each Prior Authorization on a case by case basis.

Requisite Amount of Compensated Service

Compensated service rendered on an aggregate of at least seven (7) calendar days during a calendar month, if you are covered under the Plan pursuant to a collective bargaining agreement that provides for such a “seven-day” rule; otherwise, compensated service rendered on a least one (1) day during the month. Where the seven-day rule governs, it will be applied in accordance with the terms of the collective bargaining agreement providing for it, including any side letter to such agreement dealing with application of the rule.

Requisite Amount of Vacation Pay

Vacation Pay received for an aggregate of at least seven (7) calendar days during a calendar month, if you are covered under the Plan pursuant to a collective bargaining agreement that provides for such a “seven-day” rule; otherwise, Vacation

Pay received for at least one (1) day during the month. Where the seven-day rule governs, it will be applied in accordance with the terms of the collective bargaining agreement providing for it, including any side letter to such agreement dealing with application of the rule.

Service Date

The date specified to VSP by your **VSP Doctor** or **Non-VSP Provider** as the date on which the covered service was rendered.

Vacation Pay

- **Vacation Pay** received after an **Eligible Employee** is furloughed will not continue coverages or benefits after the coverage ends.

- **Vacation Pay** received after an employment relationship has terminated will not continue coverage or benefits after coverage ends. This includes **Vacation Pay** received after an **Eligible Employee** has resigned, is dismissed or has given up employment rights for retirement.

Visually Necessary

Dispensing of lenses (contact or spectacle) by a VSP Doctor or Non-VSP Provider meeting a minimum prescription of ± .38 diopter power.

VSP Doctor

An optometrist or ophthalmologist licensed to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of **Covered Family Members**.

VIII
Claim Information

How to File a Claim

When you get covered services and eyewear from a **VSP Doctor**, you do not need to file a claim with VSP. The **VSP Doctor** will file the claim for you.

To file a claim for covered services and eyewear you get from a **Non-VSP Provider**, you must send VSP the following documents and information:

- the **Non-VSP Provider's** bill that includes a detailed list of the services and eyewear you received and the charges for them.
- the patient's name, address, phone number, and date of birth.
- the **Eligible Employee's** social security number, employer, and the name of the labor organization that represents him or her, which organization must be one that has negotiated the VSP Standard Network Benefits with the **Eligible Employee's** employer.
- the **Eligible Employee's** relationship to the patient (i.e., "self," "spouse," "child," etc.).

Claims must be submitted within one year of completion of services, and you should keep a copy of anything you send to VSP.

Please mail claims to:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

VSP will make a decision on your claim and send a written or electronic Explanation of Benefits to you about that decision

within 30 days after receiving your claim. This period may be extended by up to 15 days if VSP needs additional information from you about the claim and notifies you about the extension before the expiration of the 30-day period. If VSP needs additional information from you, you must provide this information to VSP within 45 days after you receive notice that the additional information is necessary.

The Explanation of Benefits will be written in a manner designed to be understood by Plan participants. If the decision is adverse to you, the Explanation of Benefits will contain the reasons for the decision, references to specific Plan provisions that explain the decision, an explanation of any additional material or information that may be necessary for your claim and why that information is necessary, and a description of the claims review procedures (see below) and time limits. The Explanation of Benefits will also include information about any VSP rule, guideline protocol, or similar criterion that VSP relied on in making the decision, or a statement that such information will be provided at no charge upon request. If a decision adverse to you is based on a judgment about medical necessity or a similar exclusion or limitation, the Explanation of Benefits will include either an explanation of the scientific or clinical judgment for the determination or a statement that such an explanation will be provided to you at no charge upon request.

How to Appeal a Claim Denial

Informal Claim Review

If you do not agree with a claim denial, you may request that an informal review of your claim be made by VSP. The Explanation of Benefits that you will receive from VSP will set forth the reasons for the claim denial and the name, address and telephone number of the appropriate VSP office that will conduct the informal review of the claim denial if you request that such a review be made. Requests for informal review must be filed within sixty (60) days after you receive your Explanation of Benefits. VSP will make a decision on your informal claim review promptly.

You are not required to pursue informal claim review before you request a formal claim review. In other words, you may elect not to pursue informal claim review without adversely affecting your rights to receive benefits under the Plan or your rights to file a formal appeal (see below).

Formal Appeals from Claim Denials

If you are not satisfied with the informal review of your claim denial, or if you decide not to pursue informal review, you may make a formal appeal to VSP. All formal appeals must be in writing and sent to VSP at ATTN: C&G Unit, P.O. Box 997100, Sacramento, CA 95899-7100. A formal appeal must be submitted within one hundred eighty (180) days after you receive notice that your request for informal claim review was denied. If you do not seek informal review within sixty (60) days after you receive your Explanation of Benefits, your request for a formal appeal must be submitted before one hundred eighty (180) days after you received your Explanation of Benefits.

As part of your formal appeal, you may submit issues and comments in writing. You may also request and receive at no charge copies of documents, records and other information relevant to your claim, although in some cases approval may be needed for the release of confidential information such as medical records. Information, documents, and records are relevant to your claim if they were relied upon by VSP in deciding your claim, were submitted to or considered by VSP, or were generated by VSP in deciding your claim. Relevant information also would include any VSP statement of policy or guidance concerning the services or eyewear that were not covered by VSP for your claim. You are also entitled to receive upon request and at no charge any information generated or obtained by VSP to verify that VSP complied with its own internal rules to ensure consistent claims handling, as well as information about the identities of any physicians or other medical practitioners whose advice VSP obtained in connection with your claim, even if VSP did not rely on that advice.

VSP will make a decision upon your formal appeal within thirty (30) days after it receives the appeal if you are appealing a decision by VSP to deny **Prior Authorization** for contact lenses prescribed by a **VSP Doctor** or if you are appealing a decision by VSP which determined that you are not covered under the Plan and you decided not to obtain services and eyewear from a **VSP Doctor** because of that decision. For all other claims, VSP will make a decision on formal appeal within sixty (60) days after it receives your appeal.

Decisions on Formal Appeals

Decisions on your requests for formal appeal will be made without any deference to the initial decision on your claim. The individuals who conduct formal appeal will not include the same person who initially decided your claim, nor a subordinate of that person. If the vision decision under review is based on a medical judgment, the individuals reviewing your formal appeal will consult with a vision care professional who has appropriate training and experience. That vision care professional will not be a person who was consulted in connection with the initial decision on your claim nor a subordinate of a person consulted on the initial decision.

You will be notified of the decision on your formal appeal in writing or electronically. This notice will specify the reasons for the decision and will be written in a manner calculated to be understood by Plan participants, and will contain a reference to specific Plan provisions relevant to the decision, as well as a statement that you may receive, upon request and at no charge to you, reasonable access to and copies of documents and information relevant to your claim. The notice will also include a description of your right to bring an action under ERISA section 502(a), along with any VSP rule, guideline, or protocol relied on in deciding your appeal, or an offer to provide such rule, guideline or protocol at no charge upon request. The notice will also identify any experts whose advice was obtained on behalf of the Plan in connection with your claim, even if the advice was not relied on in making a

decision. A decision on your formal appeal will be final, except that you may appeal that decision to a court (see below).

Interpreting Plan Provisions

VSP has discretionary authority to determine whether and to what extent **Eligible Employees** and **Eligible Dependents** are entitled to benefits under the Plan and to construe all relevant terms, limitations and conditions set forth in this booklet or in any other document or instrument pursuant to which the Plan is established or maintained. VSP shall be deemed to have properly exercised this discretionary authority unless it has acted arbitrarily or capriciously.

Payment of Benefits

Benefits will be paid as soon as the necessary written proof to support the claim is received. Benefits will be paid directly to you. However, if you are a minor or otherwise legally unable to give a valid release, VSP has the right to pay any benefit directly to any of your relatives whom it may determine to be fairly entitled to the payment.

All payments made by or to VSP in connection with the coverage of employees located in Canada shall be made in U.S. dollars using the exchange rate in effect at the time the check for the payment is issued.

All payments made by or to VSP in connection with the coverage of employees located elsewhere (other than in Canada) shall be made in lawful money of the United States, which, at the time of payment, is legal tender for public and private debts.

Recovery of Overpayments

If a benefit payment is made by VSP, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the Plan, VSP has the right to require the return of the overpayment on request, or to reduce, by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family. Such right does not affect

any other right of recovery the Plan or VSP may have with respect to such overpayment.

Exams

VSP will have the right and opportunity to have an ophthalmologist or optometrist of its choice examine any person for whom benefits have been requested. This exam may be made at any reasonable time while a claim for benefits is pending or under review. All exams shall be done at VSP's expense.

Legal Action

No legal action can be brought to recover any Plan benefit after three (3) years from the deadline for filing the claim for such benefit.

Misstatements

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

IX
Information Required by the Employee Retirement Income Security Act of 1974

The following information together with this booklet form the Summary Plan Description under the Employee Retirement Income Security Act of 1974, sometimes called “ERISA.”

- Name of Plan:

  Railroad Employees National Vision Plan

- Plan Identification Numbers:

  Employer Identification Number (EIN): 52-2084181

  Plan Number (PN): 509

- Plan Administrator:

  National Carriers’ Conference Committee
  Suite 500
  1901 L Street, N.W.
  Washington, D.C. 20036
  (Telephone (202) 862-7200)

  The Plan Administrator has authority to control and manage the operation and administration of the Plan and is the agent for service of legal process.

The Plan was established and is maintained pursuant to collective bargaining agreements between participating employers and various railway labor organizations. The employers are represented in connection with the establishment and maintenance of the Plan by the National Carriers' Conference Committee.

- Type of Plan: Group health plan limited to specified vision services and eyewear
- Type of administration of the Plan: Insured
    - Vision Service Plan, Inc. (VSP) insures the payment of Plan benefits.
    - The Plan's administration is governed by the terms of an insurance policy issued by VSP and by other Plan documents. The Summary Plan Description provides a description of your Plan benefits. In connection with benefits, the insurance policy and other plan documents give VSP the discretion to construe and interpret the terms of the Plan. If you do not agree with a determination made by VSP, you may request a review of your claim (see HOW TO APPEAL A CLAIM DENIAL on page 39).
- Source of contributions to the Plan:

    Employer contributions at least sufficient to enable the Plan to pay the premiums for the insurance of Plan benefits.
- Date of the end of the Plan Year:

    Each Plan Year ends on December 31.
- Plan Termination:

    The right is reserved in the Plan for the Plan Administrator to amend or modify the Plan in whole or in part at any time.

    The Plan Administrator has the right to terminate the Plan at any time by delivery to participating employers and labor organizations of written notice of such

termination, except as such right may be limited by obligations undertaken in collective bargaining agreements.

In the event of termination of the Plan, the assets of the Plan will be used towards payment of obligations of the Plan and any remaining surplus will be distributed in the manner determined by the Plan Administrator to best effectuate the purposes of the Plan in accordance with the applicable regulations under ERISA.

The Plan will terminate as to an employer effective as of the first day of the second calendar month beginning after the month during which the employer failed to pay in full all amounts required by the Plan to be paid within the time specified in a notice of termination transmitted to the employer from the Plan Administrator or VSP.

- As a Plan participant, 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**
    - Examine, without charge, at the Plan Administrator's office (the office of the National Carriers' Conference Committee), at the headquarters office of the labor organization that represents you, at each employer establishment in which 50 or more employees covered by the Plan customarily work, and at the meeting hall or office of each union local in which there are 50 or more members covered by the Plan, all documents governing the Plan, including insurance contracts and collective bargaining agreements, a list of the employers and of the railway labor organizations that have agreed to participate in the Plan, 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 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, collective bargaining agreements, a list of the employers and of the railway labor organizations that have agreed to participate in the Plan, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Receive, without charge, from the Plan Administrator, upon written request to its address, information as to whether a particular employer participates in the Plan, as to whether a particular labor organization is a participating organization (and if so, its or their addresses), and as to whether such employer is a participating employer with respect to one or more groups of its employees who are represented by such organization. However, the Plan Administrator cannot inform you whether you as an individual employee are covered as a participant, because that information is subject to agreements between the respective employers and organizations, to which the Plan Administrator is not a party and as to which it is not informed.

- **Continue Group Health Plan Coverage.**
  - Continue vision care 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 pages 15 - 20 of this summary plan description on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan or VSP 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 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 $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court, but not until you exhaust the appeals process described in this booklet.
- 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, but not until you exhaust the appeals process described in this booklet.
- 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 (but not until you exhaust the appeals process described in this booklet). 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 the terms of the Plan or about the proper payment of benefits, you may obtain more information from VSP or contact the Plan Administrator. If you have any questions about whether you are covered, you may obtain that information from 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 the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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.

* * *

APPENDIX

Notice of Privacy Practices