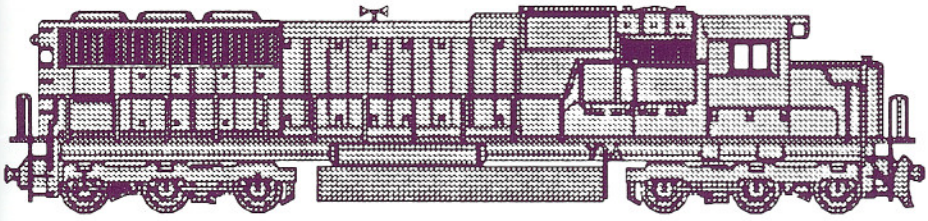
# RAILROAD EMPLOYEES NATIONAL DENTAL PLAN

## for U.S. Employees



JANUARY 1, 2005

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# I
# Important Notice to Employees

This booklet describes the Railroad Employees National Dental Plan ("Plan").

The Plan was established effective March 1, 1976, and has been amended on various occasions since then. This booklet describes the Plan as now in effect. Certain changes in the Plan became effective on January 1, 1999. These changes as well as the provisions that they replaced which remain applicable are described in this booklet. As described in more detail below, the changes apply, however, only to Plan participants covered by collective bargaining agreements that provide for those changes. Accordingly, this booklet also describes the applicable provisions that are still in effect with respect to Plan participants not covered by collective bargaining agreements that provide for the changes. Your supervisor or union representative should be able to tell you whether or not the changes apply to you.

Aetna, Inc. ("Aetna") provides certain administrative services under the Plan. The Plan benefits described in this booklet are not insured by Aetna or by anyone else. They are payable directly by the Plan.

**For information about Plan benefits or how to file a claim, call Aetna toll-free at 1-877-277-3368 which is 1-877-2RR-DENT.**

**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 summary of the highlights of the Plan. A fuller explanation of the Plan provisions, including limitations, exclusions and other details, appears in the body of this booklet.

In 1996, national collective bargaining agreements were reached which provided for an immediate change to the eligibility rules for some employees represented by some labor organizations (see the definitions of **Requisite Amount of Compensated Service** and **Requisite Amount of Vacation Pay** on pages 43-44) and for enhanced "new level" benefits effective January 1, 1999, for those same employees. Subsequent to the national agreements, some local collective bargaining agreements also provided for the changed eligibility rules and the "new level" benefits. Both the old and new benefit levels are described in this booklet. If you have any questions as to which benefit level applies to you and your family, please contact Aetna at the number listed on page 4, your labor representative, or your supervisor.

Benefits commence after a **Covered Family Member** has incurred $50 in Covered Dental Expenses in a calendar year. However, when the **Covered Family Members** in a family have collectively incurred $100 of Covered Dental Expenses, counting not more than $50 with respect to any individual, the deductible has been met with respect to all **Covered Family Members** in that family. Thereafter, the Plan pays 100%, 80% (75% if the Plan changes effective on January 1, 1999, don't apply to you) or 50% of Covered Dental Expenses, depending on the type of services received, but no more than $1,500 in benefits are payable for any one person in any calendar year ($1,000 if the Plan changes effective on January 1, 1999, don't apply to you). To be a Covered Dental Expense, a charge may not, among other things, be more than the **Reasonable and Customary Charge**.

Covered and Non-Covered Dental Expenses are described on pages 21-24. They are subject to the conditions and limitations that are there stated and to the GENERAL EXCLUSIONS described on pages 33-34.

The Plan pays 100% of Covered Dental Expenses for Type A dental services. Generally speaking, these are emergency visits, **Preventive Services** and x-rays. See pages 24-25.

The Plan pays 80% of Covered Dental Expenses for Type B dental services (75% if the Plan changes effective on January 1, 1999, don't apply to you). Generally speaking, these are basic dental care (including extractions and ordinary fillings). See pages 25-26.

The Plan pays 50% of Covered Dental Expenses for Type C dental services. Generally speaking, these are prosthetic services such as bridgework, inlays, crowns, gold fillings, and dentures. See pages 26-27.

There is also a separate Plan benefit for orthodontic treatment for **Eligible Dependents** who are unmarried children under 19. These benefit payments are spaced out so that they are made as the treatment progresses. See pages 30-32. No deductible applies to this benefit, and the Plan pays for covered treatment on a 50% basis up to a lifetime maximum per individual of $1,000 ($750 if the Plan changes effective on January 1, 1999, don't apply to you).

*Aetna Preferred Dental Network*

You have access to Aetna's preferred dental network, which is a Preferred Provider Organization of 55,000 participating dentists across the country. This will enable you and your **Eligible Dependents** to receive discounts when using a participating dentist.

Although there are no benefit differentials (i.e., higher benefit levels) for using an Aetna participating dentist, there are some advantages:

- Negotiated discounts - usually means lower out of pocket expenses - Aetna has contracted with these providers to perform services at a discounted fee. Your Explanation of Benefits will show the negotiated fee, amount paid by Aetna and amount you are responsible for based on the Plan's coinsurance. If you use a participating dentist, he or she cannot bill you for the difference between actual charges and the negotiated fee.

- No claim forms to complete - Participating dentists will submit claims for you. Some dentists may bill you at time of service.
- Discounts extended to services not covered by the Plan usually mean lower costs to you.

Call Aetna member services toll-free at 1-877-277-3368 if you have questions or would like more information on the network of participating dentists or check online at www.aetna.com.

# 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 an employer that participates in the Plan, and
- are represented by a Railway Labor Organization that participates in the Plan, 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 page 7 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 between 19 and 25 years of age, who legally reside with you, are wholly dependent upon you for maintenance and support, and are registered students in regular, full-time attendance at an accredited school (orthodontia limited to unmarried children under age 19),

(d) your unmarried children 19 years of age or over who legally reside with you, are wholly dependent upon you for

maintenance and support, and have a permanent physical or mental condition which is such that they are unable to engage in any regular employment providing that such disabling condition began prior to the date the child attained 19 years of age.

Your children include your natural children, stepchildren and 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.

You are required to advise Aetna of any change in your dependents' status, and to provide Aetna with all documents and information requested in order to determine the eligibility of any individual as a dependent of yours. (This may include, but is not limited to, divorce decrees, marriage certificates, birth certificates, and student information.) This information should be sent directly to the Lexington, Kentucky address set forth on page 46.

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 35-38). 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. An employee who is eligible for both the old and new levels of benefits in any given month based upon performing the **Requisite Amount of Compensated Service** during the preceding month for more than one participating employer will be provided coverage at the new level.

## Dependents Covered Under Another Railroad Health and Welfare Plan

If dental 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 become an **Eligible Employee***. 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, your coverage will cease according to the provisions set forth under WHEN COVERAGE STOPS, below. 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 you 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 a 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 9-13, 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 for reasons other than retirement.

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 furloughed 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 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 again render compensated service.

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**.

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

### Suspended or 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.

If you received **Vacation Pay** before the date on which you are suspended or 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 again render compensated service.

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 again render compensated service.

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 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 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 Aetna. Failure to provide this proof of disability, when requested, will cause your coverage to end. Aetna 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 the month of your death.

## Employees Under Compensation Maintenance Agreements, etc.

All coverage will continue for as long as your employer is obligated to provide continued coverage of the kind provided under the Plan because of an agreement, statute, or order of a regulatory authority, but only if your employer makes a payment for you as if you had rendered the **Requisite Amount of Compensated Service** 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, 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 this 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 AN ELIGIBLE EMPLOYEE CEASES 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 during which 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. Under certain circumstances and provided the Plan is continued, certain benefits may be payable after coverage terminates. Information in this regard is contained in the section on pages 29-30 entitled BENEFITS AFTER TERMINATION OF COVERAGE.
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 employment rights.

# 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 60$^{th}$ 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

This Plan pays the benefits described in this section for certain charges for various dental services and supplies provided to **Covered Family Members** for certain injuries or diseases. The Plan does not provide benefits for all dental care. There are limitations, exclusions, deductibles and stated maximum benefit amounts that are described on subsequent pages in this booklet. The benefits provided by the Plan apply separately to each **Covered Family Member**.

## SPECIAL ARRANGEMENTS WITH PROVIDERS

The Plan enjoys arrangements with various dental care providers pursuant to which those providers' charges for Covered Dental Expenses are discounted. These discounts are made available to **Covered Family Members** as a result of direct and indirect arrangements with the providers through Aetna. The Plan from time to time may enter into arrangements with entities other than Aetna that would allow for discounted charges for Covered Dental Expenses obtained through other providers.

If these dental providers are used, the amount of Covered Dental Expenses for which you are responsible will generally be less than if other providers had been used. The percentage of Covered Dental Expenses payable remains the same, but, because of the discount arrangement, the dollar amount that you must pay will be less.

## DEDUCTIBLE

The deductible is the amount of Covered Dental Expenses which must be incurred each calendar year before benefits are payable. There are two types of deductible, individual and family.

The amount of the individual deductible is $50. It applies separately to each **Covered Family Member** each calendar year.

The family deductible is $100. It can be met by two **Covered Family Members** with $50 each in Covered Dental Expenses or by all **Covered Family Members** when their individual Covered Dental Expenses add up to $100. But no one **Covered Family Member** can contribute more than $50 to meet the $100 family deductible.

## CALENDAR YEAR MAXIMUM BENEFIT

Not more than $1,500 ($1,000, if the Plan changes effective January 1, 1999, don't apply to you) will be payable for all Covered Dental Expenses incurred by an individual in a calendar year, regardless of any interruption in coverage under the Plan.

For purposes of determining whether this maximum benefit has been exceeded, and, also whether a deductible described above has been met, an expense is incurred:

- For full or partial dentures, fixed bridgework, crowns, gold restorations or endodontics, including root canal therapy, when the supplies involved are **Ordered** or the treatment involved commences.

- For all other Covered Dental Expenses, when treatment is received.

## COVERED DENTAL EXPENSES

The Plan pays benefits for Covered Dental Expenses incurred by a **Covered Family Member** in a calendar year in excess of the deductible and subject to the calendar year maximum benefit, both as described above.

An expense is a Covered Dental Expense only if it is a Type A, Type B or Type C dental expense (see pages 24-27), or an expense for orthodontic treatment for **Eligible Dependents** who are children under age 19 (see pages 30-32), and

- it is incurred for services or supplies that are **Necessary** (see definition on pages 41-42) for treatment of a dental condition, and

- it is incurred for services and supplies received or **Ordered** (see definition on page 42), while the patient is covered under the Plan, and

- it is charged for by a **Dentist**, and
- you are required to pay the charge.

In addition, charges are Covered Dental Expenses only to the extent that:

- they are no more than the **Reasonable and Customary Charges** (see definition on page 43) for the services or supplies that are provided, which, in the case of a Dentist participating in Aetna's preferred dental network, is the fee the Dentist has negotiated with Aetna, and in the case of a Dentist with a direct or indirect arrangement with any entity other than Aetna, is the amount determined pursuant to that arrangement, and
- the services involved are performed by a **Dentist** (except as otherwise stated), and
- the services and supplies to which the charges apply are customarily employed nationwide for treatment of the disease or injury suffered by the patient and are recognized by the dental profession to be appropriate methods of treatment in accordance with broadly accepted standards of dental practice, taking into account the patient's total current oral condition. *This is referred to as an **Alternate Benefit Provision**, and the following examples illustrate some ways that this provision will limit the benefits payable.*

**Restorative:**

- As to charges made for inlays and onlays, if a tooth can be restored with a material such as amalgam, the benefit paid for the procedure actually performed will be limited to the **Reasonable and Customary Charges** for the procedures using amalgam.
- Covered Dental Expenses will include only charges for those procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary solely to increase vertical dimension or restore the occlusion are considered optional and are not covered.

**Prosthodontics:**

- Partial dentures - If a cast chrome or acrylic partial denture would restore your dental arch satisfactorily and you and the **Dentist** select a more elaborate or precision appliance, the benefit paid for the procedure performed will be limited to the **Reasonable and Customary Charges** for a cast chrome or acrylic denture.

- Complete dentures - If, in the provision of complete denture services, you and the **Dentist** decide on personalized restorations or specialized techniques as opposed to a standard procedure, the Covered Dental Expenses for the procedure actually performed will be limited to the **Reasonable and Customary Charges** for the standard procedure.

- Replacement of existing dentures - Charges for replacement of an existing denture can be included as Covered Dental Expenses only if the existing denture is not serviceable and cannot be made serviceable. Otherwise, the Covered Dental Expenses for the replacement will be limited to the **Reasonable and Customary Charges** for those services that would render such appliances serviceable.

  If the charges for the installation of an existing prosthodontic appliance were paid for under this Plan, replacement of the appliance will be covered only if at least 5 full years have elapsed.

## NON-COVERED DENTAL EXPENSES

**Covered Dental Expenses do not include and no benefits are payable for charges incurred for:**

- Treatment by other than a **Dentist**, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the **Dentist**.

- Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures, specialized techniques, or precision attachments.

- The replacement of a lost, missing or stolen prosthetic device.

- Services covered under **Another Railroad Health and Welfare Plan**.
- Appliances, restorations, or procedures to increase vertical dimension or alter or restore occlusion (such as periodontal appliances including bite guards and appliances to control harmful habits).
- Any services or supplies which are for orthodontic diagnostic procedures or treatment except to the extent specifically provided (see pages 30-32).
- Services or supplies received as a result of disease or defect or injury due to an act of war, declared or undeclared.
- Charges for injuries resulting from a direct blow to the mouth.
- Education or training and supplies used for personal oral hygiene or dental plaque control, or dietary or nutritional counseling.
- Temporary crowns.
- Implantology, including synthetic grafting, and sealants, if the Plan changes effective on January 1, 1999, don't apply to you.
- The diagnosis and treatment of a **Jaw Joint Disorder**.
- Orthognathic surgeries (osteotomies).
- Temporary dentures replaced by a permanent denture within 12 months from the date of initial installation of the temporary denture.

## AMOUNT OF BENEFITS

Subject to the conditions, limitations and exclusions described elsewhere in this booklet, the Plan pays 100% of Type A Covered Dental Expenses, 80% of Type B Covered Dental Expenses (75% if the Plan changes effective on January 1, 1999, don't apply to you), and 50% of Type C Covered Dental Expenses.

Type A Covered Dental Expenses are the **Reasonable and Customary Charges** for:

- Routine oral examinations and prophylaxis (scaling and cleaning of teeth), but each not more than twice in any calendar year. Any oral examination and prophylaxis expense that is applied towards the deductible is considered as one service towards the calendar-year maximum of two.

- Topical application of fluoride for **Eligible Dependents** who are children, but not more than once in any calendar year.

- Space maintainers designed to preserve the space created by the premature loss of a tooth for an **Eligible Dependent** who is a child with mixed dentition, until normal eruption of the permanent tooth takes place.

- Emergency palliative treatment (to provide temporary relief of pain or discomfort).

- Dental x-rays, including panorex or full mouth x-rays (but not more than once in any period of 36 consecutive months), supplementary bitewing x-rays (but not more than twice in any calendar year). Any full mouth or supplementary bitewing x-ray expense that is applied towards the deductible is counted as one service towards the applicable maximum stated above.

- Dental sealant treatment given on or after January 1, 1999, if the Plan changes effective on that date apply to you, but only if the person is under 14 years of age and only if the sealant is applied to permanent bicuspids and molars. Only one sealant treatment of any tooth during a calendar year for a person is covered.

Type B Covered Dental Expenses are the **Reasonable and Customary Charges** for:

- Extractions, including routine post-operative care.

- Oral surgery, including surgical extractions and procedures to improve the function of a malformed body member, and routine post-operative care.

- Amalgam, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or **Accidentally Broken Teeth**. This does not include teeth broken as a result of a direct blow injury.

- General anesthetics when medically required AND administered in connection with covered oral surgical or periodontal procedures.

- Treatment of periodontal and other diseases of the gums and tissues of the mouth. After definitive periodontal treatment (surgical or non-surgical), periodontal maintenance procedures are allowed twice within a calendar year.

- Endodontic treatment, including root canal therapy.

- Injection of antibiotic drugs by the attending **Dentist**.

- Repair or recementing of crowns, inlays, onlays, bridgework or dentures; or relining or rebasing of dentures more than 6 months after the installation of an initial or replacement denture, but no more than one relining or rebasing in any 36 consecutive months.

- On or after January 1, 1999, repair of existing dental implants only if the Plan changes effective January 1, 1999, apply to you.

Type C Covered Dental Expenses are the **Reasonable and Customary Charges** for:

- Implants provided on or after January 1, 1999, to replace one or more natural teeth extracted while a person is covered, subject to all other terms of this dental benefit and only if the Plan changes effective January 1, 1999, apply to you and subject to the Plan's **Alternate Benefit Provision**.

- Initial installation of fixed bridgework, including inlays and crowns used as abutments, and partial or full removable dentures, subject to the Plan's **Alternate Benefit Provision** described on pages 22-23.

- Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by a new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:

    (a) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or

    (b) The existing denture or bridgework cannot be made serviceable and, if it was paid for under this Plan, is more than 5 years old; or

    (c) The existing denture is an immediate temporary denture which cannot be made permanent, and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

  Temporary dentures which are not replaced with a permanent denture within 12 months are subject to the 5-year replacement provision described on page 23 of this booklet.

  Normally, dentures will be replaced by dentures, but if a professionally adequate result can be achieved only with bridgework, charges for such bridgework will be included as Type C Covered Dental Expenses.

- Inlays, onlays, veneers, or crown restorations to restore diseased or **Accidentally Broken Teeth**, but only when the tooth, as a result of extensive decay or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain or composite filling.

## ADVANCE CLAIM REVIEW

*Be sure to read this section carefully.*

Before beginning a course of treatment for which the charges are expected to be in excess of $300, or if one of the following procedures is to be performed, you may obtain an advance determination from Aetna as to the benefits the Plan will pay.

Restorative Treatment:
All cast or baked porcelain restorations, crowns, caps, veneers, inlays, or onlays

Prosthodontics:
Partial Dentures
Complete Dentures
Fixed Bridgework
Implants

Oral Surgery:
All oral surgery, including surgical extractions, impactions, ridge augmentation, and alveolar bone grafts

Periodontal Surgery:
All Periodontal Surgery

A course of treatment is a planned program of one or more services or supplies, whether rendered by one or more **Dentists**, for the treatment of a dental condition diagnosed by the attending **Dentist** as a result of an oral examination. The course of treatment commences on the date a **Dentist** first renders a service to correct or treat such diagnosed dental condition.

To obtain this advance determination, you or your **Dentist** must send Aetna a description of the proposed course of treatment and of the charges proposed to be made. Also, you should have your **Dentist** send x-rays (and periodontal charting, if applicable) with your claim form.

Aetna will review the proposed course of treatment, and may consult with your **Dentist** with respect to an alternate course of treatment, if appropriate, and will advise you and your **Dentist** of the estimated benefits payable for Covered Dental Expenses expected to be incurred.

You should not seek Advance Claim Review from Aetna before undergoing oral examinations including prophylaxis, dental x-rays and treatment of any traumatic injury or condition which occurs unexpectedly, requires immediate diagnosis and treatment, and is characterized by symptoms such as severe pain and bleeding. In these circumstances, the services should be performed first, followed by a claim for Plan benefits.

As part of Advance Claim Review and as part of proof of loss for any claim:

- Aetna has the right to require an oral examination of the treated individual. This will be done at no cost to you.
- You are responsible for furnishing to Aetna all diagnostic and evaluative material which it may require to perform Advance Claim Review or process your claim. Examples of this material are dental x-rays, models, charts and written reports.

If you do not seek Advance Claim Review, the benefits for a course of treatment will be determined after the fact and may be based on a smaller amount than the **Dentist's** charges. This is because the **Alternate Benefit Provision** described on pages 22-23 will apply and benefits will be paid only with respect to charges for the course of treatment which Aetna, upon review, determines to be customarily employed nationwide to treat your disease or injury and to be recognized by the dental profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account your total current oral condition. Also, if any required verifying material is not furnished, the benefits may be for a smaller amount than would otherwise be payable, to the extent Aetna cannot verify Covered Dental Expenses.

Actual benefits will be based on the Advanced Claim Review estimate but may change if subsequent claims are paid before the claim submitted for advanced review, or if there is coordination of benefits with other group plans. The Advance Claim Review is not a guarantee of benefits. Benefits are subject to all terms and conditions of the Plan and contingent upon the patient being covered by the Plan at the time services are rendered.

## BENEFITS AFTER TERMINATION OF COVERAGE

Some charges that would have been Covered Dental Expenses if incurred while an individual was covered by the Plan will still be Covered Dental Expenses after termination of the individual's coverage, but only if (a) the supplies involved were **Ordered** or the treatment involved commenced while the individual was covered, and (b) the item is finally installed or delivered or the treatment is completed no later than 30 days after termination of the individual's coverage.

This applies only to:

- Dentures, full or partial,
- Fixed bridgework, crowns and gold restorations.
- Endodontics, including root canal therapy.

## SPECIAL PROVISIONS FOR ORTHODONTIC TREATMENTS

(Only For **Eligible Dependents** Who Are Children Under 19)

Orthodontic treatment is appliance, surgical, or functional-myofunctional treatment of dental irregularities resulting from the anomalous growth and development of dentition and its related anatomic structures to establish normal occlusion.

Charges of a **Dentist** for services and supplies rendered to a child who is an **Eligible Dependent** in connection with orthodontic treatment which begins while the child is under age 19 will be included as Type C Dental Expenses, subject however, to the following:

1. No deductible will be applied.
2. The maximum benefit payable for all orthodontic treatment rendered to an individual during his or her life, regardless of any interruption in coverage, will not exceed $1,000 ($750 if the Plan changes effective January 1, 1999, don't apply to you). Any benefit payable for orthodontic treatment will not count against the individual's calendar year maximum benefit.
3. Except as stated in paragraphs 1. and 2. above, all other provisions of the Plan applicable to other types of dental treatment will apply to orthodontic treatment.
4. No benefit will be payable for repair or replacement of any orthodontic appliance.
5. Charges incurred for the diagnosis and treatment of a **Jaw Joint Disorder** will not be considered Covered Dental Expenses.

6. If orthodontic treatment is terminated for any reason before completion, only the charges for orthodontic services and supplies actually received before termination may be included as Covered Dental Expenses. The child must be under age 19 and an **Eligible Dependent** for the entire course of treatment to receive the maximum benefit.

For orthodontic treatment beginning prior to May 1, 2003, payments were made at ninety (90) day intervals and will continue to be made in that manner if otherwise eligible until the course of treatment is completed. Effective for orthodontic treatments beginning on or after May 1, 2003, payments will be calculated and made as follows:

The total submitted amount or negotiated rate will be divided by the number of months of treatment. The monthly payment will be reimbursed at 50% up to the orthodontia lifetime maximum of $1,000 ($750 if the Plan changes effective January 1, 1999, don't apply to you).

**EXAMPLES:**

Total Case Fee of $3,500.00 with a treatment length of 36 months and the patient is banded on May 9, 2003.

$3,500.00 divided by 36 months = $97.22
$97.22 payable at 50% = $48.61

$48.61 will be paid at 30 day intervals on the 9th of each month until the entire benefit (up to the orthodontia lifetime maximum of $1,000, or $750 if the Plan changes effective January 1, 1999, don't apply to you) has been paid or the coverage terminates.

If there is a break in coverage during the orthodontia treatment plan, the payments will be calculated as follows:

Total Case Fee of $3,500.00 with a treatment length of 36 months and the patient is banded on May 9, 2003. The employee goes out on Furlough on June 1, 2003 and would be covered through September 2003. The employee returns to work in December of 2003. The payments will be issued as follows:

$3,500.00 divided by 36 months = $97.22
$97.22 payable at 50% = $48.61

The amount of $48.61 would be payable from May 9, 2003 through September 2003. No payments would be made for the months of October, November and December of 2003. The next payment would be payable in January of 2004.

$48.61 x 5 months (May through September) = $243.05
$0.00 x 3 months (October through December) = $0.00
$48.61 x 16 months (January 2004 through April 2005) = $756.95.

No further payments would be made since the $1,000 ($750, if the Plan changes effective January 1, 1999, don't apply to you) lifetime maximum would have been reached.

## RELEASE OF DENTAL INFORMATION

Aetna or any other company that administers benefits under the Plan may release dental 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 dental information to Aetna or to any other companies that administer benefits under the Plan that Aetna or another company 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 pages 52-59 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 **Dentist** or hygienist.
- 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 from non-governmental insurance carriers for payment of benefits for such services or 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 dental department, clinic, or similar facility provided or maintained by the individual's employer.
- Experimental or Investigational Treatment - services or supplies that are determined by Aetna to be experimental or

investigational. A drug, a device, a procedure or treatment will be determined to be experimental or investigational if:

- there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- if required by the FDA, approval has not been granted for marketing; or
- a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
- the written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.
- 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-Dental Treatment - services or supplies which are not dental 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 or "no-fault" automobile reparation insurance required under any law of a government and provided on other than a group basis, but only to the extent of the level of benefits required by the "no-fault" law.

### 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,
- benefit plans paid for through payroll deductions unless the plan is an employer-sponsored plan, or
- any benefit that would not be payable under this 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 (if the Plan changes effective on January 1, 1999 apply to you).

### Which Plan is Primary

To pay claims, Aetna 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, 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.
    - The plan of the step-parent without custody will pay benefits fourth.

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

If a husband or a 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 Dental Expenses.
- 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 will have to give information about any other plans when you file a claim. Aetna 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.

### Accidentally Broken Teeth

Teeth that are broken as the result of a biting or chewing incident. This does not include teeth injured or broken as a result of a direct blow to the mouth, even if accidental.

### Alternate Benefit Provision

A provision which permits treatment of a dental condition with a professionally acceptable procedure other than the one provided or proposed.

### 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.

### Covered Family Members

You and your **Eligible Dependents** who are covered under the Plan.

### Dentist

A legally licensed dentist practicing within the scope of his/her license. The term **Dentist** also includes a legally licensed physician authorized by his/her license to perform the particular dental services he has rendered.

### Eligible Dependent

(a) your wife or husband,

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

(c) your unmarried children between 19 and 25 years of age, who legally reside with you, are wholly dependent upon you for maintenance and support, and are registered students in regular, full-time attendance at an accredited secondary school, college or university or institution for the training of nurses (orthodontia limited to unmarried children under age 19),

(d) your unmarried children 19 years of age or over who legally reside with you, are wholly dependent upon you for maintenance and support, and have a permanent physical or mental condition which is such that they are unable to engage in any regular employment providing 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 your 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.

## 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.

## Jaw Joint Disorder

Temporomandibular Joint Disorder (TMJ) or any similar disorder of the jaw joint, or Myofacial Pain Dysfunction or any similar disorder in the relationship between the jaw joint and muscles and nerves.

## Medicare

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

## Necessary

A service or supply that has been determined by Aetna to be necessary and appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be **Necessary**, the service or supply must:

- be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and to the person's overall health condition;
- be a diagnostic procedure indicated by the health status of the person that is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and to the person's overall health condition; and
- be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply that meets the above tests.

In determining if a service or supply is **Necessary** under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed professional literature;
- reports and guidelines published by nationally recognized dental care organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;

- the opinion of dental professionals; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be **Necessary**:

- those that do not require the technical skills of a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any dental provider or dental facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **Dentist's** office or other less costly setting.

## Ordered

For purposes of determining whether treatment or services commenced or supplies were ordered while an individual was covered under the Plan:

- As to a denture, when impressions have been taken from which the denture will be prepared.
- As to fixed bridgework, crowns and gold restorations, when the teeth which will serve as retainers or support, or which are being restored, have been fully prepared to receive the item, and impressions have been taken from which it will be prepared.
- As to endodontics (root canal therapy), when the tooth has been opened.
- As to implants, when they are received.

## Preventive Services

Oral examinations, including scaling and cleaning of teeth, x-rays, and fluoride applications performed during regular visits to the **Dentist** in order to maintain a state of good dental health.

## Reasonable and Customary Charges

For services rendered by a **Dentist** with whom Aetna has a direct or indirect discount arrangement, an amount that does not, as determined by Aetna, exceed the discounted amount. Included among those providers are **Dentists** participating in Aetna's preferred dental network described on page 3 of this summary plan description. For services rendered by a **Dentist** with whom another entity has a direct or indirect discount arrangement, an amount that does not, as determined by the entity in question, exceed the discounted amount.

For all other services, the actual fees charged by a **Dentist** for a service rendered or supplies furnished but only to the extent that the fees are reasonable, taking into consideration the following:

(a) The usual fee which the individual **Dentist** most frequently charges the majority of his/her patients for a service rendered or a supply furnished; and

(b) The prevailing range of fees charged in the same area by **Dentists** of similar training and experience for the service rendered or supplies furnished; and

(c) Unusual circumstances or complications requiring additional time, skill and experience in connection with the particular dental service or procedure.

For purposes of this definition, the term "area" as it would apply to any particular service or supply means a metropolitan area, a county, or such greater area as is necessary to obtain a representative cross section of **Dentists** rendering such services or furnishing such supplies.

## 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.

## 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.

# VIII
# Claim Information

## How to File a Claim

Your claim must be submitted to Aetna in writing and you must give proof of the nature and extent of the loss. Forms complete with instructions are available from Aetna.

You must complete items 1 through 18 on the Benefit Request form. Please be sure that you complete all items, particularly the patient's name, the employee's name and social security number, and the names of your employer and the union by which you are represented.

If you wish benefits to be paid directly to your **Dentist**, sign the authorization item 18b.

Give the partially completed Benefit Request form to the **Dentist** for him or her to complete items 19 through 34. If the Benefit Request form is being submitted for an Advance Claim Review, this is to be indicated on the upper left-hand corner.

If, however, the Benefit Request form is being submitted as a statement of actual services rendered, that is to be indicated in the upper left-hand corner and the **Dentist** should enter the date the service was performed in Section 34 at the bottom of the form.

If the charges that are made are for examinations, cleanings or x-rays, you must submit an itemized bill. Make sure that any bills you submit indicate the employee's name, social security number and address, the patient's name and relationship to the employee, the date, and the nature of the dental services rendered.

To help speed the payment of your claim, be certain that all of the items are completed on the Benefit Request form and that the claim is filed promptly. Incomplete forms may have to be returned, resulting in delay in processing your claim. The deadline for filing a claim for any benefits is 90 days after the date the services were rendered.

If, through no fault of your own, you are unable to meet the deadline for filing claims, your claims will still be accepted if you file as soon as reasonably possible, but not later than two years after the deadline unless you are legally incapacitated. Otherwise, late claims will not be covered.

Mail claims to:

Aetna
P.O. Box 14094
Lexington, KY 40512-4094
1-877-277-3368

Aetna 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 Aetna needs additional information from you about the claim and notifies you about the extension before the expiration of the 30-day period. If Aetna needs additional information from you, you must provide this information to Aetna 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 Aetna rule, guideline, protocol, or similar criterion that Aetna 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 whether a service of supply is **Necessary** 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 Aetna. The Explanation of Benefits that you will receive from Aetna will set forth the reasons for the claim denial and the name, address and telephone number of the appropriate Aetna 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. Aetna 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 Aetna. All formal appeals must be in writing and sent to Aetna at P.O. Box 14625, Lexington, KY 40512-4625. 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 dental records. Information, documents, and records are relevant to your claim if they were relied upon by Aetna in deciding your claim, were

submitted to or considered by Aetna, or were generated by Aetna in deciding your claim. Relevant information also would include any Aetna statement of policy or guidance concerning the services or supplies described in your claim for which benefits were not paid. You are also entitled to receive upon request and at no charge any information generated or obtained by Aetna to verify that Aetna complied with its own internal rules to ensure consistent claims handling, as well as information about the identities of any **Dentists** or other dental practitioners whose advice Aetna obtained in connection with your claim, even if Aetna did not rely on that advice.

Aetna will make a decision upon your formal appeal within thirty (30) days after it receives the appeal if you are appealing an Advance Claim Review decision by Aetna or if you are appealing a decision by Aetna which determined that you are not covered under the Plan and you decided not to obtain services and supplies from a **Dentist** who participates in Aetna's preferred dental network because of that decision. For all other claims, Aetna 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 decision under review is based on a dental judgment, the individuals reviewing your formal appeal will consult with a dental care professional who has appropriate training and experience. That dental 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 Aetna 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

Aetna 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. Aetna 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, unless you have assigned the payment of such benefits to the **Dentist** by executing the authorization on the claim form.

Also, if you are a minor or otherwise legally unable to give a valid release, Aetna has the right to pay up to $1,500 ($1,000 if the Plan changes effective January 1, 1999, don't apply to you) of 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 Aetna in connection with the coverage of employees 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 Aetna, 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, the Plan 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 may have with respect to such overpayment.

## Dental Expense Records

Keep careful, complete records of the dental expenses of each individual. They will be required when a claim is made.

Very important are:

1. Names of **Dentists** and others who furnish dental services.
2. Dates expenses are incurred.
3. Copies of all bills and receipts.

## Examinations

Aetna will have the right and opportunity to have a physician or **Dentist** of its choice examine any person for whom benefits have been requested. This examination may be made at any reasonable time while a claim for benefits is pending or under review. All examinations shall be done at Aetna'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, or before the appeals process described in this booklet (pages 47-49) is exhausted.

Aetna will never attempt to reduce or deny a benefit payable to any person on the grounds that a disease or condition existed before his or her coverage became effective, if the dental service was rendered more than 2 years after the date coverage commenced. This provision will not apply to conditions specifically named as excluded from coverage on the date the dental service was rendered.

## 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
# Additional Information

## NOTICE OF PRIVACY PRACTICES

***THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY*.**

The Plan is required by law to protect the privacy of your protected health information. As used in this section of your booklet, "Plan" refers not only to the Plan itself, but also to any agents or contractors acting on its behalf, including those entities that the Plan has retained to administer the benefits it provides. Federal law prohibits the Plan from disclosing your health information to an agent or contractor unless that agent or contractor has agreed in writing to maintain the privacy of your health information.

The Plan is required to provide this notice. It explains how the Plan uses protected health information about you and when the Plan discloses that information to others. Federal law requires the Plan to use and disclose your protected health information only as described in this notice. The Plan is also required by law to honor your rights with respect to your protected health information that are described in this notice.

The term "protected health information" as used in this notice includes any personal information that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. The provisions of this notice apply to protected health information that is created by the Plan or received by the Plan from others.

If the Plan changes its privacy practices, it will provide notice of the change to you within 60 days by direct mail.

## How the Plan Uses and Discloses Your Protected Health Information

### Required Uses and Disclosures

The Plan must use and disclose your protected health information to provide information:

- To you or a representative with the legal right to act for you;
- To the Secretary of the Department of Health and Human Services, if necessary, to ensure that your privacy is protected; and
- When required by law; for example, a court could order the Plan to disclose protected health information in its possession for the purpose of litigation.

### Permitted Uses and Disclosures

The Plan has the right to use and disclose protected health information to pay for your health care and manage the provision of benefits to you. The Plan will use or disclose your protected health information only as permitted by law, including the federal Privacy Rule for protected health information. For example, the Plan may, consistent with the Privacy Rule, use or disclose your protected health information for the following purposes:

- Payment. Payment activities include, among other things, collecting contributions due to the Plan and paying for dental services provided to you. For example, the Plan may receive information from a dentist concerning treatment provided to you. The Plan may review that information to evaluate whether the treatment is eligible for coverage under the Plan. The Plan may also use your protected health information for purposes of making Advance Claim Review determinations for certain types of benefits (see Pages 27-29).
- Treatment. The Plan may use or disclose protected health information for the purpose of assisting health care professionals in their efforts to provide you with medical treatment. For example, the Plan may disclose your protected health information to facilitate referrals between dentists or to coordinate your treatment among health care providers.

- Health Care Operations. The Plan may use or disclose protected health information as necessary to operate the Plan and to manage coverage under the Plan. For example, the Plan may use your protected health information to analyze trends in the coverage it provides or to set contribution levels. Other ways in which your protected health information may be used for health care operations include quality assessment and improvement activities, audits of performance under the Plan, cost management and planning-related analyses, review of the qualifications of health care professionals, administration of Plan activities in general, and arrangement for medical review or legal services. The Plan may disclose your protected health information to others for the purpose of conducting health care operations. For example, the Plan may contact your dentist to suggest a disease management or wellness program that could help improve your health.

- Communications with You. The Plan may contact you to provide information about health related products or services such as alternative treatments available to you under the Plan. The Plan may use your protected health information to identify programs and treatments that would be most beneficial to you. The Plan may also contact you to provide appointment reminders for your medical treatment.

- Disclosures to the Plan Administrator. The Plan is governed by a Plan Administrator. The Plan Administrator is described at pages 60-61 of this booklet. The Plan may share statistical information about usage under the Plan and enrollment and disenrollment information with the Plan Administrator. In addition, the Plan may share other protected health information with the Plan Administrator solely for purposes of plan administration. Neither the Plan nor the Plan Administrator will share your protected health information with your employer without your express written authorization or as may be permitted under applicable law.

## Other Uses and Disclosures Permitted by Law

The Plan may, consistent with the federal Privacy Rule for protected health information, use or disclose your protected health information for the following purposes under limited circumstances:

- Disclosure for Public Health Purposes. The Plan may be required to disclose your protected health information for public health activities, such as reporting disease outbreaks or adverse reactions caused by a prescription drug.

- Disclosure to Persons Involved with Your Care. The Plan may disclose your protected health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.

- Disclosure to Report Abuse, Neglect or Domestic Violence. The Plan may be required to disclose your protected health information to government authorities, including a social service or protective service agency, to help them identify and aid victims of abuse, neglect, or domestic violence.

- Disclosure for Health Oversight Activities. The Plan may be required to disclose your protected health information to government officials responsible for overseeing health insurers, health care providers, government benefit programs, or civil rights laws relating to health care.

- Disclosure in Judicial or Administrative Proceedings. The Plan may be required to disclose your protected health information in response to a court order, search warrant or subpoena or other lawful process.

- Disclosure to Law Enforcement Officials. The Plan may be required to disclose your protected health information to law enforcement officials for limited purposes, such as missing person investigations.

- Disclosure to Avoid a Serious Threat to Health or Safety. The Plan may be required to disclose your protected health information to public health agencies.

- Disclosure for Workers Compensation. The Plan may be required to disclose protected health information arising out of job-related injuries pursuant to applicable laws.

- Disclosure for Specialized Government Functions. The Plan may be required to disclose limited information for military and veteran activities, national security and intelligence activities, and the protective services for the President and other public officials.

- Use or Disclosure for Research Purposes. The Plan may use or disclose protected health information for research purposes subject to limitations imposed by law.

- Disclosure to Coroners or Medical Examiners. The Plan may disclose protected health information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. The Plan may also disclose information to funeral directors as necessary to carry out their duties.

- Disclosure for Organ Procurement Purposes. The Plan may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.

Whenever the Plan discloses your protected health information for a purpose permitted by the federal Privacy Rule, it is required to disclose only the minimum amount of information necessary to serve that purpose.

If none of the above reasons applies, **then the Plan must get your written authorization to use or disclose your protected health information.** Once you authorize disclosure of your protected health information, the Plan cannot guarantee that the person to whom the information is provided will not disclose the information. You may revoke your written authorization, unless the Plan has already acted based on your authorization. To revoke an authorization, contact the privacy officer identified below.

In some states, state law may impose restrictions on the use or disclosure of protected health information more stringent than those described in this notice. For example, some states may require plans to obtain a person's express authorization before using or disclosing his or her protected health information for the

purposes described above. The Plan will comply with such state laws to the extent they apply to the Plan.

## Your Rights with Respect to Your Protected Health Information

The following are your rights with respect to your protected health information.

- Restrictions on Uses and Disclosures of Your Protected Health Information. You have the right to ask the Plan to agree to restrictions on the uses or disclosures it makes of your protected health information for purposes of treatment, payment, or health care operations. You also have the right to ask the Plan to impose restrictions on disclosures of your protected health information to family members or to others who are involved in your health care or payment for your health care. While the Plan will try to honor your request and will permit requests consistent with its policies, the Plan is not required to agree to any restriction. If the Plan determines that it cannot accommodate your request to restrict uses or disclosures of your protected health information for the purposes of treatment, payment, or health care operations, the Plan will provide you with reasonable notice of its decision.

- Restrictions on Methods of Communications from the Plan. You have the right to ask the Plan to restrict its communications with you to a more confidential mode of communication or to contact you at a different address. The Plan will accommodate reasonable requests to communicate in a confidential format.

- Inspection of Protected Health Information. You have the right to inspect and obtain a copy of your protected health information maintained by the Plan. You also may receive a summary of this protected health information. A request to inspect or copy your protected health information must be made in writing to the address provided below. In certain limited circumstances, the Plan may deny your request to inspect and copy your protected health information. The Plan may impose a reasonable fee reflecting the actual costs of copying, mailing or preparing a summary of your protected health information.

- Amendment of Protected Health Information. You have the right to ask the Plan to amend protected health information it

maintains about you if you believe that the information is inaccurate or incomplete. You must make such a request in writing to the address provided below. If the Plan denies your request, you may have a statement of your disagreement added to your protected health information.

- Accounting of Disclosures of Protected Health Information. You have the right to ask the Plan to provide you with an accounting of disclosures of your protected health information made by the Plan during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) made for treatment, payment, and health care operations purposes; (iii) made to you or pursuant to your authorization; (iv) made to correctional institutions or law enforcement officials; or (v) other disclosures for which federal law does not require the Plan to provide an accounting.

## How to Exercise Your Rights

- Contacting the Plan. For further information about the privacy of your protected health information, to obtain a copy of this notice, or to ask the Plan to agree to restrict the ways in which it uses or discloses your protected health information, contact the Plan's privacy compliance officer as follows:

  Joseph Epstein
  1901 L Street, N.W. Suite 500
  Washington, D.C. 20036
  Tel: (202) 862-7200

- Filing a Complaint. If you believe your privacy rights have been violated, you may file a written complaint with the Plan at the following address:

  c/o Joseph Epstein
  1901 L Street, N.W. Suite 500
  Washington, D.C. 20036

  ***You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint***. The Plan will not take any action against you for filing a complaint.

- Exercising Your Rights With Respect to Your Protected Health Information. You are entitled to inspect, copy or amend your protected health information maintained by or on behalf of the

Plan, to request an accounting of disclosures of your protected health information, or to ask that communications from the Plan be made in a confidential manner or place. Please make such requests to Aetna as indicated below:

Aetna
P.O. Box 14094
Lexington, KY 40512-4094
Tel: 1-877-277-3368

# 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 Dental Plan.

- **Plan Identification Numbers:**

  Employer Identification Number (EIN): 52-1102730
  Plan Number (PN): 505

- **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. Service of process upon the Plan may also be made by serving its trustee.

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

- **Administration of the Plan:** Trusteed and Self-Funded.

  The Plan is administered directly by the Plan Administrator. Plan benefits are funded directly by the Plan. They are not insured.

The Plan's administration is governed by the terms of the Plan Document. This Summary Plan Description provides a description of the benefits that are available under the Plan. In connection with those benefits, the Plan Document gives Aetna the discretion to construe and interpret the terms of the Plan. If you do not agree with a determination made by Aetna, you may request a review of your claim (see HOW TO APPEAL A CLAIM DENIAL on pages 47-48).

- **Trustee:**

  SunTrust Bank
  919 East Main Street
  Seventh Floor
  Richmond, VA 23219

- **Source of contributions to the Plan:** Employer contributions.

  Each employer's contribution is determined on the basis of estimates of the dollar amount of claims and expenses that will be paid by the Plan during the year and of the number of employees with respect to whom participating employers will contribute to the Plan during the year.

  Benefits under the Plan are payable from funds that are held in trust under the Plan and invested by the Plan's trustee until needed to pay benefits.

- **Date of the end of the Plan Year:**

  Each Plan Year ends on December 31.

- **Claims Procedure:**

  See Section VIII of this booklet, pages 45-51, for information about claim procedures.

- **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 the Trustee and Aetna of written notice of such termination, except as such right may be limited by obligations undertaken in collective bargaining agreements.

An employer has the right to terminate its participation in the Plan at any time by delivery to the Plan Administrator 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 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 Aetna.

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 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 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 Dental Plan Coverage.**

  Continue dental 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 15-19 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 Aetna 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 Aetna 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.

## NOTES