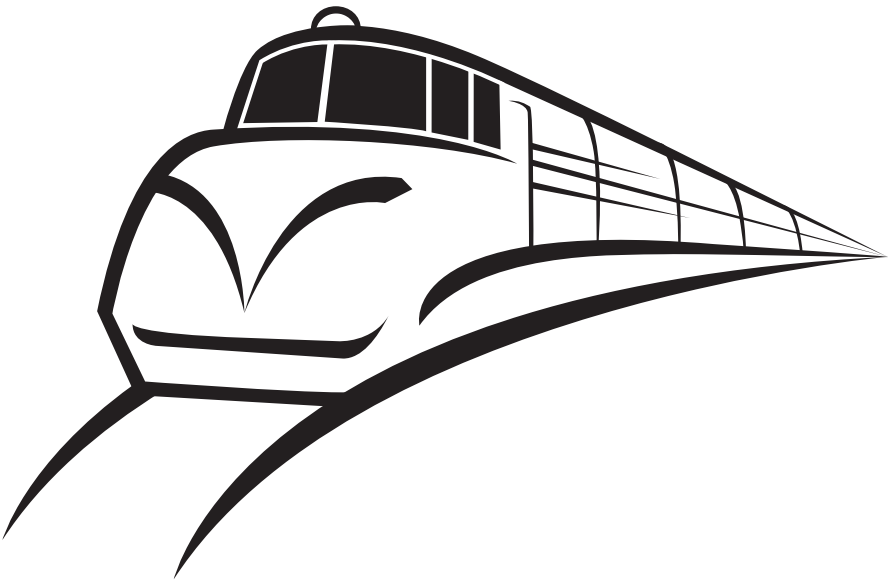
Railroad Employees

National Vision Plan

2013



EyeMed

VISION CARE®

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I
Important Notice to Employees

This booklet describes the Railroad Employees National Vision Plan ("Plan") as amended effective January 1, 2013.

The benefits provided by the Plan are fully insured by Fidelity Security Life Insurance Company powered by the EyeMed Vision Care Network, 4000 Luxottica Place, Mason, OH 45040.

EyeMed/First American Administrators, Inc. ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care, is the claims payer for EyeMed Vision Care. You will see references to FAA in the claims paying sections of this booklet.

Among other things, this booklet provides information about Plan benefits and how to file a claim. If you have any questions, or want further information about these benefits or claim-filing procedures, please call EyeMed Vision Care toll-free (855) 212-6003.

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

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

II
Plan Highlights

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

The Plan provides benefits only for the particular vision services and eyewear outlined below. The benefits are subject to various exclusions, conditions, limitations, and maximum amounts. These are described on pages 22-31 of this booklet.

Vision care services and eyewear covered by the Plan may be obtained from any **Participating Provider** in the EyeMed Vision Care Network. Services may also be obtained from an **Out-of-Network Provider**. However, when covered services and eyewear are obtained from a **Participating Provider**, the benefits provided by the Plan are greater than when the services and eyewear are obtained from an **Out-of-Network Provider**.

A list of **Participating Providers** is furnished to you automatically, without charge, by EyeMed Vision Care. When making an appointment for vision care services, double check with the provider location to make sure that the provider participates in the EyeMed Network shown on the front of your EyeMed ID card.

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

The chart below lists the Plan's benefits. This is only a short outline. See pages 22-29 for a more complete description.

Covered Services and Eyewear	EyeMed Network Benefit	Out-of-Network Reimbursement
One eye exam every 12 months, counting from the most recent **Service Date**	Covered in Full	Up to $35
One pair of **Prescription Lenses** and one pair of eyeglass frames for **Prescription Lenses**, every 24 months, counting from the most recent **Service Date**		
Single Vision Lenses	Covered in Full	Up to $25
Bifocal Lenses	Covered in Full	Up to $40
Trifocal Lenses	Covered in Full	Up to $55
Lenticular Lenses	Covered in Full	Up to $80
Frames	Covered in Full up to $115 retail allowance; if the retail price exceeds $115, you pay 80% of the difference between the retail price and $115.	Up to $35
Prescription contact **Lenses** once every 24 months or one year's worth of 1-day, 7-day or 14-day disposable contact lenses, every 24 months, counting from the most recent **Service Date** (in lieu of **Prescription Lenses** and frames)	Up to a $105 allowance	Up to $105

Covered Services and Eyewear	EyeMed Network Benefit	Out-of-Network Reimbursement
One pair of **Medically Necessary Contact Lenses** every 24 months counting from the most recent service date (in lieu of **Prescription** contact **Lenses** or **Prescription Lenses** and Frames)	Covered in full (i) following cataract surgery; (ii) when necessary to correct extreme visual acuity problems that cannot be corrected with spectacle lenses (iii) to treat certain conditions of Anisometropia, (iv) to treat Keratoconus, or (v) to treat High Ametropia	Reimbursement up to $210 (i) following cataract surgery; (ii) when necessary to correct extreme visual acuity problems that cannot be corrected with spectacle lenses (iii) to treat certain conditions of Anisometropia, (iv) to treat Keratoconus, or (v) to treat High Ametropia

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III
Eligibility and Coverage

WHO IS ELIGIBLE

Employees

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

- are employed by a participating employer, and
- are represented by a labor organization that has negotiated the Plan benefits with your employer, 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. See WHEN COVERAGE STARTS section of this booklet.

Dependents

Your **Eligible Dependents** are:

(a) your wife or husband,

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

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

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

For the purpose of determining who is an **Eligible Dependent** under (b), (c), and (d) above, your children include:

- your natural children;
- your stepchildren;
- your adopted children (including children placed with you for adoption); plus
- your "grandchildren", provided they have their legal residence with you and are dependent for care and support mainly upon you and wholly, in the aggregate, upon themselves, you, your spouse, scholarships and the like, and governmental disability benefits and the like. "Grandchildren" does not include your step-grandchildren.

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 section of this booklet. If you are eligible both as an employee and as the child of an employee, your total benefits will be limited to your benefits as an employee. An employee who works for more than one participating employer cannot receive duplicate benefits.

Dependents Covered Under Another Railroad Plan

If vision benefits are payable under **Another Railroad Plan** for a person who is a dependent not only of an employee covered by that plan but also of an **Eligible Employee**

covered by this Plan, and that dependent is covered under this Plan as an **Eligible Dependent**, benefits will be payable under this Plan for that dependent only

- if the **Eligible Employee** covered under this Plan has a birthday earlier in the calendar year than the employee covered by the other plan, and
- in all other cases, only to the extent that payments under both plans do not exceed the benefits that would have been paid under this Plan alone.

WHEN COVERAGE STARTS

Employees

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

If you are an **Eligible Employee** and your employment relationship terminates, you will no longer be an **Eligible Employee**, and your coverage will cease according to the provisions set forth under WHEN COVERAGE STOPS section of this booklet. However, if you return to service with the same employer in a covered position, you will be an **Eligible Employee** immediately upon your return and you will again have coverage on the **first day of the calendar month**

following the month in which you again render the **Requisite Amount of Compensated Service**.

If you are an **Eligible Employee** and begin service with another employer participating in the Plan, you will be considered a new employee and you will be an **Eligible Employee** again only when you have completed one year of service with your new employer. However, if after your employment relationship with your former employer had terminated you begin service with the new employer at the direction of your former employer or by reason of seniority with your former employer, you will be an **Eligible Employee** as soon as you begin service with your new employer, and coverage will begin on the first day of the calendar month following the month in which you render the **Requisite Amount of Compensated Service** for your new employer.

Dependents

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

WHEN COVERAGE STOPS

All coverage stops when:

- your employer or the labor organization that represents you and has negotiated the Plan benefits with your employer 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 of this booklet, 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 or dismissal.

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

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

CONTINUATION OF COVERAGE AFTER YOU LAST RENDERED COMPENSATED SERVICE

Furloughed Employees

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

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

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

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

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

Suspended and Dismissed Employees

If you are suspended or dismissed after you became an **Eligible Employee** AND you have rendered compensated service for three months, you and your **Eligible Dependents** will be covered under the Plan during your suspension or after your dismissal until the end of the fourth month following the month in which you last rendered compensated service or, if you were suspended, the month in which you last received **Vacation Pay**, if later.

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

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

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

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

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

Pregnant Employees

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

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

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

Disabled Employees

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

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

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

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

You may be required to submit proof of your disability to UnitedHealthcare (UHC). Failure to provide this proof of disability, when requested, will cause your coverage to end. UHC will determine the date that coverage terminated based on the most current disability information available. This information will be sent to EyeMed Vision Care and your eligibility will be reflected in EyeMed Vision Care's system accordingly.

Retired Employees

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

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

Deceased Employees

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

Employees under Compensation Maintenance Agreements, etc.

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

Returning Veterans

If you had been an **Eligible Employee** and if you returned to compensated service for the same employer after completion of service in the armed forces of the United States or Canada, you will become an **Eligible Employee** and your coverage will begin on the day you first render compensated service upon your return.

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

Solely for purposes of determining coverage for you and your **Eligible Dependents** during the month immediately following any month in which you take a period of family or medical leave authorized and provided for under the Family and Medical Leave Act ("FMLA") enacted by Congress in 1993, such period of authorized leave will be treated as if it were a period during which you rendered compensated service. FMLA leave will not be treated as compensated service (i) for purposes of measuring any continued coverage described in this CONTINUATION OF COVERAGE AFTER YOU LAST RENDERED COMPENSATED SERVICE section of 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 YOU CEASE TO RENDER COMPENSATED SERVICE
(OTHER THAN CONTINUATION UNDER COBRA
OR THE FAMILY AND MEDICAL LEAVE ACT)

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

Notes:

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

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

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

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

OPTIONAL CONTINUATION COVERAGE UNDER COBRA

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

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

UnitedHealthcare ("UHC") 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 Railroad Enrollment Services toll free at 1-800-753-2692.

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 UHC 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 UHC 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 UHC within 60 days after the qualifying event occurs.** The notice must be in writing and must be sent to:

Railroad Enrollment Services
Railroad Administration (COBRA)
P. O. Box 30791
Salt Lake City, UT 84130-0791

How is COBRA Coverage Provided?

Once UHC 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. Eligible 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 UHC of the determination within sixty (60) days from the date it was made, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep UHC 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 UHC.

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 Railroad Enrollment Services toll free (1-800-753-2692).

Contact Information

Information about COBRA continuation coverage can be obtained on request by calling Railroad Enrollment Services toll free (1-800-753-2692) or by writing:

Railroad Enrollment Services
Railroad Administration (COBRA)
P. O. Box 30791
Salt Lake City, UT 84130-0791

IV
Benefits

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

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

The Plan pays different levels of benefits depending upon whether you obtain covered services and eyewear from a **Participating Provider** or from an **Out-of-Network Provider**. To receive the highest benefit level, you must receive the covered services and eyewear from a **Participating Provider**.

A list of the **Participating Providers** is furnished to you automatically, without charge, by EyeMed Vision Care. Visit EyeMed Vision Care's website at

www.eyemedvisioncare.com/railroad

to find a listing of **Participating Providers** or call toll-free (855) 212-6003. When making an appointment for vision care, double check with the provider location to make sure that he or she participates in the EyeMed Network shown on the front of your EyeMed ID card.

This Plan is designed to cover *visual needs* rather than *cosmetic preferences.* When you select any of the following options, the benefit provided by the Plan will be the applicable benefit for eyeglass lenses and eyeglass frames described below under COVERED SERVICES AND EYEWEAR, and you will be responsible for paying the additional costs for the options you select. These costs will be based upon EyeMed

Vision Care's preferred member pricing, or, if you select something that is not listed below, according to the provider's usual and customary fees.

1. Standard Polycarbonate
2. Photochromic lenses
3. Tinted lenses (Solid and Gradient)
4. Progressive lenses
5. UV (ultraviolet) protected lenses
6. Standard Anti-reflective coating
7. Standard Plastic Scratch coating
8. Polarized

COVERED SERVICES AND EYEWEAR

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

Eye Exam Benefit

- One eye exam every 12 months, counting from the most recent **Service Date**. This exam consists of a complete vision analysis, including an appropriate exam of visual functions and the prescription of corrective eyewear where indicated.
    - If you go to a **Participating Provider**, this exam is covered in full.
    - If you go to an **Out-of-Network Provider** for an exam, the benefit provided by the Plan (through reimbursement to you) is the amount you actually pay for the exam up to, but no more than, $35.
    - Exam Option - Retinal Imaging (In-network only)

      The Plan provides an in-network benefit for retinal imaging. Retinal imaging is a photograph of the eye that can help detect potential diseases of the eye earlier, like glaucoma, diabetic retinopathy, and age-

related macular degeneration to allow for early intervention. Your in-network cost for this exam is up to $39. There is no out-of-network benefit for retinal imaging.

Eyeglass Lens and Frame Benefit

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

  Lenses

  - If you get **Prescription Lenses** from a **Participating Provider**, they are covered in full except for non-covered lens options, which are described on pages 27.

  - If you get **Prescription Lenses** from an **Out-of-Network Provider**, the benefit provided by the Plan (through reimbursement to you upon submission by you of a claim form and receipt) is the amount you actually pay for them up to, but no more than:

    - $25 for single vision lenses,
    - $40 for bifocal lenses,
    - $55 for trifocal lenses, and
    - $80 for **Lenticular Lenses**

  Frames

  - If you get a frame for your **Prescription Lenses** from a **Participating Provider**, the Plan covers in full any

frame with a retail price of $115 or less. If you select a frame with a retail price higher than $115, you will pay 80% of the difference between the retail price and $115.

- If you go to a **Participating Provider** for a pair of lenses and frames not covered by the Plan because, for example, 24 months have not gone by since you got your last pair of glasses under the Plan, the **Participating Provider** will offer you, as a Plan participant, a 40% discount on the purchase of frame and lens and lens options. The 40% discount only applies to complete pair eyeglass purchases once the initial benefit has been exhausted. Members will receive a 20% discount on items purchases separately (i.e. lenses only or frames only),

- If you get a frame for your **Prescription Lenses** from an **Out-of-Network Provider**, the Plan will reimburse you in the amount you actually pay for the frame up to, but no more than, $35.

Contact Lens Benefit

- **Prescription** contact **Lenses** (or two separate **Prescription** contact **Lenses**), This applies to 1-day, 7-day or 14-day disposable contact lenses, every 24 months, counting from the most recent **Service Date**, *This benefit is provided in lieu of and not in addition to the eyeglass lens and frame benefit described above. During any 24 month period, you may receive either the eyeglass lens and frame benefit or this contact lens benefit, but not both.*

Contact Lenses from a Participating Provider

- A $105 allowance towards the materials for **Prescription** contact **Lenses** will be provided. Any costs exceeding this allowance are your responsibility.

- When prescribed by a **Participating Provider, Medically Necessary Contact Lenses** are covered in full if one of the following conditions is met:

    - Following cataract surgery;
    - Anisometropia of 3D in meridian powers
    - High Ametropia exceeding –10D or +10D in meridian powers
    - Keratoconus when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
    - Vision improvement other than Keratoconus for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to the best corrected standard spectacle lenses.

The frequency limits include one benefit every 24 months counting from the most recent **Service Date**, filed on one claim.

The benefit may not be expanded for other eye conditions even if you, or your provider, deem contact lenses necessary for other eye conditions or visual improvement.

Contact Lenses from an Out-of-Network Provider

- If you purchase **Prescription** contact **Lenses** from an **Out-of-Network Provider,** the plan will reimburse you in the amount you actually pay for the covered services and eyewear up to, but no more than, $105.

- If, however, your **Out-of-Network Provider** establishes to the satisfaction of EyeMed Vision Care that the **Medically Necessary Contact Lenses** and services are provided in order to correct extreme visual acuity problems that cannot be corrected with spectacle lenses, the benefit provided by the Plan (through reimbursement to you) is the amount you actually pay for the contact lenses up to, but no more than $210. These qualifying conditions include:

- Following cataract surgery;
- Anisometropia of 3D in meridian powers
- High Ametropia exceeding –10D or +10D in meridian powers
- Keratoconus when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
- Vision improvement other than Keratoconus for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to the best corrected standard spectacle lenses.

EXCLUSIONS

The Plan provides no benefits for any of the following services or materials arising from:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
- Medical and/or surgical treatment of the eye, eyes or supporting structures;
- Any eye or vision examination, or any corrective eyewear required by a policyholder as a condition of employment;
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
- Plano (non-prescription) lenses and/or contact lenses;
- Non-prescription sunglasses;
- Two pair of glasses in lieu of bifocals;
- Services rendered after the date an insured person ceases to be covered under the policy, except when

vision materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.

- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.
- Benefits may not be combined with any discount, promotional offering, or other group benefit plans.

HOW TO OBTAIN PLAN BENEFITS

To obtain benefits for covered services and eyewear that you get from a **Participating Provider**, you should first contact the **Participating Provider**, identify yourself as an EyeMed Vision Care member under the Railroad Employees National Vision Plan, and provide the employee's name and date of birth. The **Participating Provider** will contact EyeMed Vision Care to verify your coverage. If you are a **Covered Family Member**, EyeMed Vision Care will authorize the **Participating Provider** to provide the covered services and eyewear.

If you need to locate a **Participating Provider**, call EyeMed Vision Care at (855) 212-6003 or log on to EyeMed Vision Care's web site at www.eyemedvisioncare.com/railroad**.** If EyeMed Vision Care declines to authorize the **Participating Provider** to provide services and eyewear for which EyeMed Vision Care determines that you are not covered under the Plan, you will be asked by the **Participating Provider** to pay the entire bill at the time the services are rendered. You can then file a claim for Plan benefits with EyeMed Vision Care as described in Part VIII of this booklet. You should include with your claim any information relevant to your Plan coverage. If you decide not to obtain the services and eyewear for which EyeMed Vision Care determines that you are not covered under the Plan, you may appeal that decision in accordance with the appeals procedures described at pages 42-44.

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

RELEASE OF VISION INFORMATION

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

Furthermore, to the extent permissible under applicable law, before you may receive benefits under the Plan, each **Covered Family Member** may be required to agree with each of his/her providers that the provider may release vision information to EyeMed Vision Care that EyeMed Vision Care 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 or vision information, see “Notice of Privacy Practices” at the end of this booklet.

V
General Exclusions

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

- **Another Railroad Plan** - services and eyewear for which an **Eligible Dependent** is entitled as an **Eligible Employee** to benefits in connection with **Another Railroad Plan**.

- Armed Forces - services or eyewear 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 **Participating Provider** or **Out-of-Network Provider.**

- Canadian Residents - services or eyewear received by a resident of Canada to the extent that Canadian law or provincial law precludes Canadian residents from obtaining insurance by non-governmental insurance carriers providing for payment of benefits for such services and eyewear.

- 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 eyewear for which your **Eligible Dependent** is entitled to indemnity under any workers' compensation or similar law.

- Employer Facilities - services rendered through a medical or vision department, clinic, or similar facility provided or maintained by the individual's employer.

- Family Members - treatment given by a member of your family (your spouse and the children, brothers, sisters and parents of either you or your spouse).

- Forms - expenses incurred for the completion of any forms relating to claims for Plan benefits.

- No Legal Obligation - services and eyewear which you are not legally required to pay or for which you would not have been charged but for the existence of coverage under the Plan. However, if the United States government or one of its agencies is authorized by law to charge the Plan for the services provided, then this exclusion will not apply.

- Non-Vision Treatment - services or eyewear which are not vision services or eyewear.

VI
Coordination of Benefits

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

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

Coordination of Benefits does not apply to:

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

HOW DOES COORDINATION WORK?

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

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

If this Plan is secondary, the benefits it pays will be reduced because of benefits payable by other plans primary to this Plan. The amount of benefits this Plan would have paid without this provision will be determined first. Then the amount of benefits payable by other plans primary to this Plan for the same charges will be subtracted from this amount. This Plan will pay the difference, if any. For example, if this Plan is secondary, and if the primary plan pays $25 for charges covered under this Plan for an eye exam with an **Out-of-Network Provider**, then this Plan will pay $10 for that exam.

WHICH PLAN IS PRIMARY?

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

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

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

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

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

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

If a determination of which plan is primary cannot be made by any of the above rules, then the plan which has covered the person for the longest time will be primary to all other plans.

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

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

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

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

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

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

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

IF BOTH WIFE AND HUSBAND WORK FOR A PARTICIPATING EMPLOYER AND ARE COVERED UNDER THIS PLAN

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

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

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

First determine the covered services and supplies.

Then subtract the amount paid by the primary plan.

The secondary plan pays the difference, provided the difference is no more than the amount that would have been paid without this provision.

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

VII
Definitions

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

ANOTHER RAILROAD 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

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

ELIGIBLE DEPENDENT

(a) your wife or husband,

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

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

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

any regular employment; provided that such disabling condition began prior to the date the child attained 19 years of age.

For the purpose of determining who is an **Eligible Dependent** under (b), (c), and (d) above, your children include:

- your natural children;
- your stepchildren;
- your adopted children (including children placed with you for adoption); plus
- your "grandchildren," provided they have their legal residence with you and are dependent for care and support mainly upon you and wholly, in the aggregate, upon themselves, you, your spouse, scholarships and the like, and governmental disability benefits and the like. "Grandchildren" does not include your step-grandchildren.

ELIGIBLE EMPLOYEE

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

- employed by a participating employer,
- represented by a labor organization that has negotiated the Plan benefits with the employee's employer, 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.

LENTICULAR LENSES

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

MEDICALLY NECESSARY CONTACT LENSES prescribed:

- Following cataract surgery
- For Keratoconus where the member is not correctable to 20/30 in either or both eyes using standard spectacle lenses.
- For High Ametropia exceeding –12D or +9D in spherical equivalent
- For Anisometropia of 3 D or more
- For Members whose vision can be corrected two (2) lines of improvement on the visual acuity chart when compared to best corrected spectacle lenses.

MEDICARE

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

OUT-OF-NETWORK PROVIDER

Any licensed optometrist, ophthalmologist, or dispensing optician licensed to practice vision care and/or provide vision care materials who has not contracted with the EyeMed Vision Care Network to provide vision care services and/or vision care materials to **Covered Family Members**.

PARTICIPATING PROVIDER

An optometrist, ophthalmologist, or dispensing optician licensed to practice vision care and/or provide vision care materials who has contracted with EyeMed Vision Care to provide vision care services and/or vision care materials on behalf of **Covered Family Members**. When **Participating Provider** appears in this booklet, it means a provider location which participates in the EyeMed Vision Care Network.

PRESCRIPTION LENSES

Lens must accommodate a refractive prescription to improve the member's vision. EyeMed does not have a minimum prescription requirement; however, at least one lens of a pair must have a prescription for the lenses to qualify for benefits. Lens products may be classified as either standard or premium.

REQUISITE AMOUNT OF COMPENSATED SERVICE

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

REQUISITE AMOUNT OF VACATION PAY

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

SERVICE DATE

The date specified to EyeMed by your **Participating Provider** or **Out-of-Network Provider** as the date on which the covered service was rendered.

VACATION PAY

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

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

VIII
Claim Information

HOW TO FILE A CLAIM

When you get covered services and eyewear from a **Participating Provider**, you do not need to file a claim with EyeMed Vision Care. The **Participating Provider** will file the claim for you.

To file a claim for covered services and eyewear you get from an **Out-of-Network Provider**, you must submit the following documents and information:

- A completed Out-of-Network Claim Form. Obtain a claim form by logging onto www.eyemedvisioncare.com/railroad or by calling (855) 212-6003.
- The **Out-of-Network Provider's** bill that includes a detailed list of the services and eyewear you received and the charges for them.

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

Mail claims to:

EyeMed Vision Care/FAA
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

EyeMed/FAA will make a decision on your claim and send a written or electronic Explanation of Benefits (EOB) to you about that decision within 30 days after receiving your claim. This period may be extended by up to 15 days if EyeMed Vision Care/FAA needs additional information from you about the claim and notifies you about the extension before the expiration of the 30-day period. If EyeMed/FAA needs additional information from you, you must provide this

information to EyeMed/FAA 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 EyeMed/FAA rule, guideline protocol, or similar criterion that EyeMed/FAA relied on in making the decision, or a statement that such information will be provided at no charge upon request. If a decision adverse to you is based on a judgment about medical necessity or a similar exclusion or limitation, the Explanation of Benefits will include either an explanation of the scientific or clinical judgment for the determination or a statement that such an explanation will be provided to you at no charge upon request.

HOW TO APPEAL A CLAIM DENIAL

First Level Appeal

If your claim is denied, in whole or in part, you may appeal. The Explanation of Benefits that you will receive from EyeMed/FAA will set forth the reasons for the claim denial and the name, and address of the appropriate EyeMed/FAA office that will conduct the review of the claim denial if you request that such a review be made. The appeal in writing must be filed within one hundred eighty days (180) after you receive your Explanation of Benefits. EyeMed/FAA will make a decision on your appeal within 60 days after receipt.

Your written letter of appeal should include the following:

- The applicable claim number or a copy of the EyeMed/FAA denial information or Explanation of Benefits, if applicable.

- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member's eye care provider that will assist EyeMed/FAA in completing its review of the member's appeal, such as documents, records, questions or comments.

You may authorize someone else to file and pursue a complaint or appeal on your behalf. If you do so, you must notify EyeMed/FAA in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number, and a statement indicating the extent to which he or she is authorized to pursue the complaint and/or appeal on your behalf. A consent form that you may use for this purpose will be provided to you upon request

The appeal should be mailed or faxed to the following address:

EyeMed Vision Care, LLC
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-3259

You may also request and receive at no charge copies of documents, records and other information relevant to your claim appeal.

Second Level Appeal (Formal Appeal)

If you remain dissatisfied with the first appeal decision, you may request a second appeal from EyeMed/FAA within one hundred eighty days (180) after you receive notice of the first appeal decision and submit any new additional supporting documentation. EyeMed/FAA will conduct a new independent review and notify you in writing of its decision within 30 days of receipt of the second appeal.

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

You will be notified of the decision on your 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 EyeMed 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.

When you have completed all appeals mandated by ERISA, additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. You should contact the U. S. Department of Labor or the state insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)), *see*, 29 U.S.C. 1132(a)(1)(B), you have the right to bring a civil (court) action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and you disagree with the outcome.

INTERPRETING PLAN PROVISIONS

EyeMed 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. If there is any conflict between this document and other policies and documents, contracts or booklets, then such other documents will control unless otherwise required by law or specified in this document. EyeMed shall be deemed to have properly exercised this discretionary authority unless it has acted arbitrarily or capriciously.

PAYMENT OF BENEFITS

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

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

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

RECOVERY OF OVERPAYMENTS

If a benefit payment is made by EyeMed Vision Care, 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, EyeMed Vision Care has the right to require the return of the overpayment on request, or to reduce, by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family. Such right does not affect any other right of recovery the Plan or EyeMed Vision Care may have with respect to such overpayment.

EXAMS

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

LEGAL ACTION

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

MISSTATEMENTS

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

IX

Information Required by the Employee Retirement Income Security Act of 1974

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

- Name of Plan:

  Railroad Employees National Vision Plan

- Plan Identification Numbers:

  Employer Identification Number (EIN): 52-2084181

  Plan Number (PN): 509

- Plan Administrator:

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

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

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

- Type of Plan: Group health plan limited to specified vision services and eyewear

- Type of administration of the Plan: Insured

    - Fidelity Security Life Insurance Company insures the payment of Plan benefits on behalf of EyeMed Vision Care which provides the provider network and other administrative functions.

    - The Plan's administration is governed by the terms of an insurance policy issued by Fidelity Security Life Insurance Company and by other Plan documents. The Summary Plan Description provides a description of your Plan benefits. In connection with benefits, the insurance policy and other plan documents give EyeMed Vision Care the discretion to construe and interpret the terms of the Plan. If you do not agree with a determination made by EyeMed Vision Care, you may request a review of your claim (see HOW TO APPEAL A CLAIM DENIAL).

- Source of contributions to the Plan:

    Employer contributions at least sufficient to enable the Plan to pay the premiums for the insurance of Plan benefits.

- Date of the end of the Plan Year:

    Each Plan Year ends on December 31.

- Plan Termination:

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

  The Plan Administrator has the right to terminate the Plan at any time by delivery to participating employers and labor organizations written notice of such termination, except as such right may be limited by obligations undertaken in collective bargaining agreements.

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

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

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

  Receive Information About Your Plan and Benefits

  - Examine, without charge, at the Plan Administrator's office (the office of the National Carriers' Conference Committee), at the headquarters office of the labor organization that represents you, at each employer establishment in which 50 or more employees covered by the Plan customarily work, and at the meeting hall

or office of each union local in which there are 50 or more members covered by the Plan, all documents governing the Plan, including insurance contracts and collective bargaining agreements, a list of the employers and of the railway labor organizations that have agreed to participate in the Plan, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, a list of the employers and of the railway labor organizations that have agreed to participate in the Plan, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Receive, without charge, from the Plan Administrator, upon written request to its address, information as to whether a particular employer participates in the Plan, as to whether a particular labor organization is a participating organization (and if so, its or their addresses), and as to whether such employer is a participating employer with respect to one or more groups of its employees who are represented by such organization. However, the Plan Administrator cannot inform you whether you as an individual employee are covered as a participant, because that information is subject to agreements between the respective employers and organizations, to which the Plan

Administrator is not a party and as to which it is not informed.

Continue Group Health Plan Coverage

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

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, provided such suit is filed within three (3) years from the deadline for filing the claim for the relevant benefit. 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 Plan 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. Any such suit must be filed within three (3) years from the deadline for filing the claim for benefits.

- 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 EyeMed Vision Care 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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NOTICE OF PRIVACY PRACTICES

EyeMed Vision Care, LLC ("EyeMed")

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

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you or it can be viewed on our Web site.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care and service that you receive. Your health information is contained in a record that is the physical property of EyeMed.

How We May Use or Disclose Your Health Information

For Treatment. We may use or disclose your health information to an optometrist, ophthalmologist, optician or other healthcare providers providing treatment to you for:

- the provision, coordination, or management of health care and related services by health care providers;
- consultation between health care providers relating to a patient/customer;
- the referral of a patient for health care from one health care provider to another.

For Payment. We may use and disclose your health information to facilitate payments of benefits for treatment and services provided to you. This may include:

- billing and collection activities and related data processing;
- actions by a health plan or insurer to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, or subrogation of health benefit claims;
- medical necessity and appropriateness of care reviews, utilization review activities; and
- disclosure to consumer reporting agencies of information relating to collection of payments.

For Health Care Operations. We may use and disclose health information about you for operational purposes. Health care operations include:

- rating the insurance risk related to the benefit and determining premiums for the plan;
- conducting quality assessments and improvement activities;
- conducting or arranging for medical review, legal services, audit services, fraud and abuse detection and compliance programs;
- business planning and development.

To You, Your Family and Friends. We must disclose your health information to you, as described in the Your Health Information Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so or, if you are not able to agree, if it is necessary in our professional judgment.

Persons Involved in Care. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location or your general condition. Prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. If you are not present or in the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Required by Law. We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence;
- to assist law enforcement officials in their law enforcement duties; or
- to assist public health officials avert a serious threat to the health or safety of you or any other person.

Decedents. Health Information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Government Functions. Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Workers Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.
Marketing Health Products or Services. We will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding products or services that we offer related to your health care needs. We will never sell your health information without your prior authorization.

Your Authorization. In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Your Employer or Organization Sponsoring Your Health Plan: We may disclose your Protected Health Information and the Protected Health Information of others enrolled in your group insurance plan to the employer or other organization that sponsors your group insurance plan to permit the plan administrator to perform plan administration functions. We may also disclose summary information about the enrollees in your group insurance plan to the plan administrator to use to obtain premium bids for the health insurance coverage offered through your group insurance plan or to decide whether to modify, amend or terminate your group insurance plan. The summary information we may disclose will summarize claims history, claims expenses, or types of claims experienced by the enrollees in your group insurance plan. The summary information will be stripped of demographic information about the enrollees in the group insurance plan, but the plan administrator may still be able to identify you or other participants in your group health plan from the summary information.

We may also disclose enrollment and disenrollment information to either the plan administrator or plan sponsor of your group insurance plan.

Underwriting: We may receive your Protected Health Information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use of further disclose this Protected Health Information for any other purpose, except as required by law, unless the contract of health insurance or health benefits is placed with us, or where we disclose such information to MIB Group, Inc., a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. In those cases, our use and disclosure of your Protected Health Information will only be as described in this notice.

YOUR HEALTH INFORMATION RIGHTS

Access: You have the right to review or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You may be asked to make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice setting forth the specific information to which you desire access. If you request an alternative format, provided that it is practicable for us to produce the information in such format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, where you have provided an authorization and certain other activities, for the last 6 years, but only for disclosures made on or after April 14, 2003 or the date coverage became effective for you, whichever is later. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. You may obtain a form to request an amendment to your health information by using the contact information listed at the end of this Notice.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

if you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

If you have any questions or complaints, please contact:

Privacy Office,
EyeMed Vision Care, LLC
4000 Luxottica Place
Mason, Ohio 45040
Phone: 513-765-4321
Email: privacyoffice@eyemedvisioncare.com
Web site: www.eyemedvisioncare.com