Life and Accidental Death
and Dismemberment Benefits
The Railroad Employees National Health and Welfare Plan

POLICY NUMBER: 1023000

Coverage: Basic Life and Accidental Death & Dismemberment
Life Benefits ...................... $20,000 (active employees)
AD&D ............................... $16,000 (active employees)
Life Benefits ...................... $2,000 (retired employees)

• Coverage is extended to all eligible employees and retirees

LIFE BENEFITS
• If you die while you are covered for Life Benefits, we will pay to the beneficiary the amount of Life Benefits that is in effect on your life on the date of your death.
• Accelerated Benefits Option (ABO)—The Accelerated Benefits Option is a part of your life insurance that allows you to receive a portion of your group life benefit before death if you’ve been diagnosed as having a terminal illness. A request for ABO payment is subject to an independent medical review and approval by MetLife. Retirees are not eligible for ABO, active members only.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS
The Accidental Death or Dismemberment Benefits for a covered loss will be paid when we receive notice and satisfactory proof of that loss.
Accidental Death or Dismemberment Benefits will be paid:
• To your beneficiary for the loss of your life.
• To you for any other covered loss sustained by you.
• Written proof of a claim must be given to us no later than 90 days after the date of the loss.

WHEN YOU RETIRE
If you are eligible for retiree benefits, the amount of your Life Benefits will be reduced to $2,000.

The Accelerated Benefits Option (ABO) is subject to state regulation and is intended to qualify for favorable federal income tax treatment, in which case the benefits will be includable from your income and not subject to federal taxation. This information was written as a supplement to the marketing of life insurance products. Tax laws relating to accelerated benefits are complex and limitations may apply. You are advised to consult with and rely on an independent tax advisor about your own particular circumstances. Receipt of accelerated benefits may affect your eligibility, or that of your spouse or your family, for public assistance programs such as medical assistance (Medicaid), Temporary Assistance to Needy Families (TANF), Supplementary Social Security Income (SSI) and drug assistance programs. You are advised to consult with social service agencies concerning the effect that receipt of accelerated benefits will have on public assistance eligibility for you, your spouse or your family.

MetLife
Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166
www.metlife.com
# Railroad Employees National Dental Plan

## Dental Benefits Summary

<table>
<thead>
<tr>
<th></th>
<th>Passive PPO With PPO/l Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$50</td>
</tr>
<tr>
<td>Family</td>
<td>$100</td>
</tr>
<tr>
<td>Preventive Services</td>
<td></td>
</tr>
<tr>
<td>Basic Services</td>
<td></td>
</tr>
<tr>
<td>Major Services</td>
<td></td>
</tr>
<tr>
<td>Annual Benefit Maximum</td>
<td>$1,500</td>
</tr>
<tr>
<td>Orthodontic Services**</td>
<td></td>
</tr>
<tr>
<td>Orthodontic Lifetime Maximum</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

*The deductible applies to Preventive, Basic & Major services. Orthodontia is not subject to the deductible.*

**Orthodontia is covered only for children under the age of 19.

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### Partial List of Services

#### Preventive

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral examinations (twice per calendar year)</td>
<td>100%</td>
</tr>
<tr>
<td>Cleanings - Adult/Child (twice per calendar year)</td>
<td>100%</td>
</tr>
<tr>
<td>Fluoride (once per calendar year)</td>
<td>100%</td>
</tr>
<tr>
<td>Sealants (permanent molars and bicuspid teeth)</td>
<td>100%</td>
</tr>
<tr>
<td>Bitewing X-rays (twice per calendar year)</td>
<td>100%</td>
</tr>
<tr>
<td>Full mouth series X-rays (once every 36 months)</td>
<td>100%</td>
</tr>
<tr>
<td>Space Maintainers</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency Palliative Treatment</td>
<td>100%</td>
</tr>
</tbody>
</table>

#### Basic

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Root canal therapy -</td>
<td>80%</td>
</tr>
<tr>
<td>Anterior teeth / Bicuspids / Molar teeth</td>
<td></td>
</tr>
<tr>
<td>Scaling and root planing (a)</td>
<td>80%</td>
</tr>
<tr>
<td>Gingivectomy</td>
<td>80%</td>
</tr>
<tr>
<td>Composite fillings</td>
<td>80%</td>
</tr>
<tr>
<td>Amalgam (silver) fillings</td>
<td>80%</td>
</tr>
<tr>
<td>Uncomplicated extractions</td>
<td>80%</td>
</tr>
<tr>
<td>Surgical removal of erupted tooth</td>
<td>80%</td>
</tr>
<tr>
<td>Surgical removal of impacted tooth (soft tissue)</td>
<td>80%</td>
</tr>
<tr>
<td>Osseous surgery (a)</td>
<td>80%</td>
</tr>
<tr>
<td>Surgical removal of impacted tooth (partial or full bony)</td>
<td>80%</td>
</tr>
<tr>
<td>General anesthesia/intravenous sedation</td>
<td>80%</td>
</tr>
<tr>
<td>Denture repairs (a)</td>
<td>80%</td>
</tr>
</tbody>
</table>

#### Major

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crowns</td>
<td>50%</td>
</tr>
<tr>
<td>Inlays</td>
<td>50%</td>
</tr>
<tr>
<td>Onlays</td>
<td>50%</td>
</tr>
<tr>
<td>Crown Build-Ups</td>
<td>50%</td>
</tr>
<tr>
<td>Implants</td>
<td>50%</td>
</tr>
<tr>
<td>Bridgework (5 year replacement frequency applies)</td>
<td>50%</td>
</tr>
<tr>
<td>Full &amp; partial dentures (5 year replacement frequency applies)</td>
<td>50%</td>
</tr>
</tbody>
</table>

(a) Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate.
Other Important Information
This Aetna Dental® Preferred Provider Organization (PPO) benefits summary is provided by Aetna Life Insurance Company for some of the more frequently performed dental procedures. Under the Dental Preferred Provider Organization (PPO) plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO plan, savings are possible because the participating dentists have agreed to provide care for covered services at negotiated rates. Non-participating benefits are subject to usual and prevailing charge limits, as determined by Aetna.

Emergency Dental Care
If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week.

When emergency services are provided by a participating PPO dentist, your co-payment/coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, you will be responsible for the difference between the plan payment and the dentist's usual charge. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

Partial List of Exclusions and Limitations* - Coverage is not provided for the following:

1. Services or supplies that are covered in whole or in part:
   (a) under any other part of this Dental Care Plan; or
   (b) under any other plan of group benefits provided by or through your employer.

2. Services and supplies to diagnose or treat a disease or injury that is not:
   (a) a non-occupational disease; or
   (b) a non-occupational injury.

3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.

4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.

5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.

6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.

7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion.

8. For purposes of determining whether treatment commenced or services or supplies were ordered while an individual was covered under the plan:
   (a) as to a denture, when impressions have been taken from which the denture will be prepared.
   (b) as to a crown, bridge, or cast or processed restoration, 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.
   (c) as to endodontics (root canal therapy), when the pulp chamber was opened.
   (d) As to implants, when they are received.

9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.


11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.

12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.

13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.

14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.

15. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.

16. Those for a crown, cast or processed restoration unless:
   (a) it is treatment for decay or fracture, and teeth cannot be restored with a filling material; or
   (b) the tooth is an abutment to a covered partial denture or fixed bridge.
17. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.


19. Services needed solely in connection with non-covered services.

20. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services. Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

*This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.

Your Dental Care Plan Coverage Is Subject to the Following Rules:

Replacement Rule
The replacement of; addition to; or modification of: existing dentures; removable denture; fixed bridgework; or other prosthetic services is covered only if:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed.

The existing denture, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and if installed under this plan, must be at least 5 years old before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Alternate Treatment Rule: If more than one service can be used to treat a covered person’s dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

(a) the service must be listed on the Dental Care Schedule;
(b) the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
(c) the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:

(a) the copayment for the approved less costly service; plus
(b) the difference in cost between the approved less costly service and the more costly covered service.

Finding Participating Providers
Consult Aetna Dental's online provider directory, DocFind®, for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna Dental or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your ID card, or use our Internet-based provider directory (DocFind) available at www.aetna.com.

Specific products may not be available on both a self-funded and insured basis. The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern.

In the event of a problem with coverage, members should contact Member Services at the toll-free number on their ID cards for information on how to utilize the grievance procedure when appropriate.

All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Dental plans are provided or administered by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc.

In Texas, the Dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN), and is administered by Aetna Life Insurance Company.

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Some benefits are subject to limitations or exclusions. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.
What's in it for me?

Options. It's simple really. We love our members—that's why we are dedicated to helping you see clearly and we've built a network that gives you lots of choices and flexibility. You can choose from independent doctors and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy to use and to save you money. Welcome to EyeMed.

Benefits Snapshot

<table>
<thead>
<tr>
<th>Service</th>
<th>With Us</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam with dilation as necessary (If every 12 months)</td>
<td>$0 Copay</td>
<td>Up to $35</td>
</tr>
<tr>
<td>Frames (If every 24 months)</td>
<td>$0 Copay, $115 Allowance; 20% off balance over $115</td>
<td>Up to $35</td>
</tr>
<tr>
<td>Single Vision Lenses (If every 24 months) Or Contacts (If every 24 months)</td>
<td>$0 Copay, $105 Allowance; plus balance over $105</td>
<td>Up to $105</td>
</tr>
</tbody>
</table>

And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs $163 with single vision lenses that have UV and scratch protection. Now let's see the difference . . .

83% SAVINGS with us

<table>
<thead>
<tr>
<th>Service</th>
<th>With Us</th>
<th>Without Insurance*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>$0 Copay</td>
<td>Exam $106</td>
</tr>
<tr>
<td>Frame $163</td>
<td>$48</td>
<td>Frame $163</td>
</tr>
<tr>
<td>- $115 Allowance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- $9.60 (20% discount off balance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- $38.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lens $0 Copay $15 UV treatment add-on</td>
<td></td>
<td>Lens $78</td>
</tr>
<tr>
<td>+ $15 Scratch coating add-on</td>
<td></td>
<td>$23 UV treatment add-on</td>
</tr>
<tr>
<td>Total $68.40</td>
<td></td>
<td>+ $25 Scratch coating add-on</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$126</td>
</tr>
</tbody>
</table>

Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) 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 subdvision thereof; 5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care; 9) Services rendered after the date on 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; 10) Last 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. Standard/Premium Progressive lens not covered—fund as a Bifocal lens.

Benefit allowance provides no remaining balance for future use within the same benefit year. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. *Based on industry averages.
### Railroad Employees National Vision Plan

#### Vision Care Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Member Cost</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam With Dilation as Necessary</td>
<td>$0 Copay, $40 Allowance</td>
<td>Up to $35</td>
</tr>
<tr>
<td>Contact Lens Fit and Follow-Up</td>
<td>Up to $30, 10% off retail price</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Contact Lens Fit &amp; Follow-Up</td>
<td>Up to $60</td>
<td>N/A</td>
</tr>
<tr>
<td>Premium Contact Lens Fit &amp; Follow-Up</td>
<td>Up to $70</td>
<td>N/A</td>
</tr>
<tr>
<td>Retinal Imaging</td>
<td>$480</td>
<td>N/A</td>
</tr>
<tr>
<td>Frames</td>
<td>$500</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Plastic Lenses</td>
<td>$500</td>
<td>N/A</td>
</tr>
<tr>
<td>Single Vision</td>
<td>$500</td>
<td>N/A</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$500</td>
<td>N/A</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$500</td>
<td>N/A</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$500</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Progressive Lens</td>
<td>$500</td>
<td>N/A</td>
</tr>
<tr>
<td>Premium Progressive Lensa</td>
<td>$500</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 1</td>
<td>$480</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$480</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 3</td>
<td>$480</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 4</td>
<td>$480</td>
<td>N/A</td>
</tr>
<tr>
<td>Remaining balance beyond plan coverage</td>
<td>$500</td>
<td>N/A</td>
</tr>
<tr>
<td>These discounts are for in-network providers only</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Lens Options (paid by the member in addition to the price of the lenses)

<table>
<thead>
<tr>
<th>Option</th>
<th>Cost</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>UV Treatment</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Tint (Solid and Gradient)</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Plastic Scratch Coating</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Polycarbonate—Adults</td>
<td>$30</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Polycarbonate—Kids under 19</td>
<td>$0</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Anti-Reflective Coating</td>
<td>$39</td>
<td>N/A</td>
</tr>
<tr>
<td>Premium Anti-Reflective Coating</td>
<td>$51 - $62</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 1</td>
<td>$51</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$52</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 3</td>
<td>$52</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 4</td>
<td>$52</td>
<td>N/A</td>
</tr>
<tr>
<td>Photochromic/Transitions</td>
<td>$75</td>
<td>N/A</td>
</tr>
<tr>
<td>Polarized</td>
<td>$20% off retail price</td>
<td>N/A</td>
</tr>
<tr>
<td>Other Add-Ons and Services</td>
<td>$20% off retail price</td>
<td>N/A</td>
</tr>
</tbody>
</table>

#### Contact Lenses

<table>
<thead>
<tr>
<th>Type</th>
<th>In-Network Member Cost</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conventional</td>
<td>$0 Copay, $105 Allowance, 15% off balance over $105</td>
<td>Up to $105</td>
</tr>
<tr>
<td>Disposable</td>
<td>$0 Copay, $105 Allowance, plus balance over $105</td>
<td>Up to $105</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>$0 Copay, Paid in Full</td>
<td>Up to $210</td>
</tr>
<tr>
<td>Laser Vision Correction</td>
<td>15% off the retail price or 5% off the promotional price</td>
<td>N/A</td>
</tr>
<tr>
<td>Additional Pairs Discount</td>
<td>Members also receive a 40% discount off complete pair eyeglass purchase and 15% off conventional contact lenses once the funded benefit has been used.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

#### Frequency

| Examination                  | Once every 12 months |
| Lenses or Contact Lenses     | Once every 24 months |
| Frame                       | Once every 24 months |

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*Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed’s Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.*
Things to remember about SSB

- Not all unions are covered by Aetna's supplemental sickness benefit plan. Please contact your local representative if you are unsure of your union's eligibility for this benefit.
- Claims must be filed with and approved by the RRB to be eligible for Supplemental Sickness Benefits.
- RRB does not have to approve disability benefits prior to you filing your SSB claim with Aetna. File your SSB claim right away.
- Claims must also be separately filed with Aetna to determine eligibility for SSB, and amount/length of benefits.
- Maximum length of benefit payments is 12 months.
- **Supplemental Sickness Benefit claims must be filed with Aetna within 60 days of Date of Disability.**
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Aetna
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Trustmark
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Health Flexible Spending Account
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COBRA (PageContent.aspx?MenuId=30)
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Your Track to Health Last updated December 5, 2014

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Supplemental Sickness Benefit Plan
Frequently Asked Questions

A. General Questions

Q-1. How often does Aetna issue checks for the Supplemental Sickness Benefit (SSB) Plans?
   A. Checks are issued on a daily basis once approval made and taxation is applied.

Q-2. Is my SSB claim divided into claim periods in the same manner as my claim for Railroad Retirement Sickness (RUIA) benefits?
   A. No. Aetna does not assign claim periods in the same sense as the RRB. However, your SSB benefit payments are linked to eligibility criteria reported in the RUIA claim periods. Aetna will not pay you for any day of disability for which you have been disqualified under RUIA.

Q-3. How long after I file for SSB will I get my first check from Aetna?
   A. Realistically, expect your first SSB check to be issued between four and six weeks after claim is received by Aetna. It depends on when you file with both the RRB and Aetna, when your benefit under RUIA posts to the RRB’s database, and whether Aetna has received wage verification from your employer and any required medical information.

   If Aetna has wage and supporting medical information at the time that the RRB record of payment is posted, Aetna can approve SSB for the same period of time as that covered by RRB within 24-48 hours. After a processing period of 3-4 days to calculate and deduct for taxes, the SSB is issued via regular mail.

   The sooner you file with the RRB, the sooner your benefit will post in the RRB’s electronic database from which Aetna verifies your eligibility. You have a maximum of 60 days to initiate your claim with Aetna and it is advisable to file for your SSB as early as possible. **Note: RRB does not have to approve your benefit prior to filing with Aetna.

Q-4. How many days will I get paid for in each check I receive from Aetna?
   A. You are potentially eligible for benefits from the fifth day of your disability forward. Accordingly, your first claim check will not include payment the first four days of your disability. Subsequent checks will be for all days of certified disability that is verified by RRB records.

Q-5. How much will I receive from the SSB for each day I am disabled?
A. Basic Benefit Amounts are shown on Page 1 of your Plan SPD. Generally, the amount you will receive depends on your hourly negotiated wage and whether or not you have exhausted RUIA benefits.

Q-6. I filed for the SSB a few years ago, and as I recall my benefit checks were larger than I am currently receiving.
A. The previous Plan administrator (Provident) paid monthly, whereas Aetna pays every two weeks. Benefit amounts have not changed since the effective date of the benefit amount specified in your current Collective Bargaining Agreement. Also, Aetna withholds applicable federal and state employment taxes from the gross benefit.

Q-7. Is direct deposit available?
A. Yes, the direct deposit program is available.
B. **WorkAbility System Questions**

Q-1. **How do I register?**
A. Select the "New User Registration" link on the Login page at www.wkabsystem to begin. You will be prompted to enter the Company Identifier code after the Company Identifier has been entered, the registration form is displayed. Complete the registration form to create your User ID and Password.

Q-2. **What is my Company Identifier?**
A. RR

Q-3. **Why do I need to supply an email address to register?**
A. Your User ID and Password will be sent to your email address upon completion of the registration process.

Q-4. **I am a new user, how do I get a User ID and Password?**
A. New users need to complete the User Registration form to obtain a User ID and Password. You can access the registration form by selecting the "New User Registration" link on the Login page.

Q-5. **What do I do if I forget my password?**
A. You can reset your password by selecting the "Forgot Your Password?" link on the Login page.

Q-6. **What if I've forgotten my User ID?**
A. If you do not know your User ID you will need to contact Aetna. Contact information can be obtained by selecting the "Contact Us" link on the Login page. Our Help Desk will be happy to assist you.

Q-7. **I get "Login failed; please enter your User ID and Password." when logging in.**
A. Your User ID and Password are case-sensitive. Make sure you are using the proper case. If you still receive this error, you can reset your password by selecting the "Forgot Your Password?" link on the Login page.

Q-8. **I get "This account has been locked." when logging in.**
A. You will need to contact Aetna. Contact information can be obtained by selecting the "Contact Us" link on the Login page. Our Help Desk will be happy to assist you.
C. Claim Filing Support

Q-1. How do I file a claim online?
A. Select the "New User Registration" link on the Login page to begin. You will be prompted to enter the Company Identifier code (RR). After the Company Identifier has been entered, the registration form is displayed. Complete the registration form to create your User ID and Password. You will then see the Home Page. Select "Create New Claim" to begin.

Q-2. How do I file a claim over the phone?
A. Call 1-800-205-7651 and select option 1. Your call will be routed directly to a customer service representative. Our customer service representatives are available Monday through Friday, 8:00am – 8:00pm EST.

Q-3. How long do I have from the start of my absence to file a claim for Supplemental Sickness Benefits?
A. Notice of any injury or sickness must be given to Aetna within 60 days of the start of disability for Supplemental Sickness Benefits. You can do so by calling the toll-free number, filing a claim online, mailing or faxing your notice of disability form.

B. Appeals

Q-1. Will Aetna deny my claim?
A. Notice of any injury or sickness must be given to Aetna within 60 days of the start of disability for Supplemental Sickness Benefits. You can do so by calling the toll-free number, filing a claim online, mailing or faxing your notice of disability form.

Q-2. What can I do if Aetna denies my claim?
A. Aetna has an appeals process if you feel your claim has been incorrectly denied. If your claim is denied, you will receive a letter from your Claim Specialist that will explain the reasons for the denial and describe the appeals process. You can also contact your Claim Specialist for additional information. Additional information on your appeal rights is shown under the "Appeals from Claim Denials" section of the Supplemental Sickness Plan booklet.

Q-3. How much time do I have to file an appeal if my claim is denied?
A. 60 days from the date of denial

Q-4. After I appeal, how long does Aetna have to review and make a determination?
A. 60 days from the date of receipt of the appeal

Q-5. Where do I file an appeal of a denial of benefits?
A. Aetna has an appeals process if you feel your claim has been incorrectly denied. If your claim is denied, you will receive a letter from your Claim Specialist that will explain the reasons for the denial and describe the appeals process. You can also contact your Claim Specialist for additional information. Additional information on your appeal rights is shown under the "Appeals from Claim Denials" section of the Supplemental Sickness Plan booklet.
A. Appeals must be submitted in writing (no e-mails or phone calls) as follows:

**By Mail:**
Appeals Department
Aetna
Attn: Railroad Appeals
P. O. Box 14578
Lexington, KY 40512-4578

**By FAX:** (855) 733-1262

Q-6. **What information should my appeal include?**
A. Your appeal should include information or documents not previously submitted, inasmuch as the denial you received was based on the information already in your file. For example, if your claim was denied because you failed to file within 60 days, your appeal should state in detail the extenuating circumstances that prohibited you from timely filing, with supporting documentation where possible.

If your claim was denied due to a failure to provide medical records, provide the records or explain why they are unavailable.

If your claim was denied due to a disqualification by the Railroad Retirement Board that was later reversed or overturned, provide documentation to that effect.

If your claim was denied because the documentation submitted did not support a functional impairment, additional documentation would be needed to support an impairment.

In all situations, the denial letter will provide you with specific examples of documentation that can be submitted in support of your Supplemental Sickness Benefits (SSB)

Q-7. **After I file an appeal, and have additional general questions, how can I contact Aetna?**
A. Please call 1-800-205-7651, and select option # 4.

Q-8. **If I have not yet filed an appeal, but have general questions about the process, who can I talk to?**
A. If an appeal has not yet been filed, please contact your case manager at 1-800-205-7651.
E. **General Support**

Q-1. **How can I obtain my Supplemental Sickness Benefit Plan booklet?**
A. All employees should have received a Supplemental Sickness Benefit Plan booklet issued by the National Carriers' Conference Committee. If you did not receive one or you would like another copy, please call us at 1-800-205-7651 to speak with a customer service representative. It will be necessary for you to provide your name, address, and the union.

Q-2. **What is Aetna's phone number for SSB benefits?**
A. (800) 205-7651

Q-3. **What is Aetna's address?**
A. Aetna Disability  
P.O. Box 14560  
Lexington, KY 40512-4560

Q-4. **What is Aetna's fax number?**
A. (866) 667-1987

Q-5. **What is Aetna's email address?**
A. RailroadMail@Aetna.com

Q-6. **Who will I reach at Aetna's e-mail address? How long will it take for them to respond to a question for assistance?**
A. The mailbox associated with the above address is monitored on a daily basis by an Aetna Claim Liaison. The response time will vary depending on the complexity of the request. The target response time is one business day.

Q-7. **How do I know if I am eligible for Supplemental Sickness benefits?**
A. Please review your Supplemental Sickness Benefit Plan booklet. Eligibility is based on the provisions outlined in Section II – Eligibility and Termination of Coverage. However, generally, an employee must be employed by a participating railroad, and represented by a participating union. Employees must also have 30 days of continuous employment with the same participating railroad and meet the qualifications for RUIA benefits as established under the Railroad Retirement Act.

Q-8. **How often will I receive my disability checks?**
A. Refer to General Questions in Section A.
Q-9. Are my Supplemental Sickness Benefits subject to taxes?
A. Yes. Federal Law requires that benefit payments under your Plan be reported to the Internal Revenue Service if your employer makes contributions to the Plan. You will be sent a W-2 Form showing the amount of benefits, if any, you are paid each year.

Federal Law also requires that Railroad Retirement Tier I Taxes be withheld from Plan payments made during the first six (6) months following the month of disability, if your employer makes contributions to the Plan. Tier I taxes are deducted for both job and non-job related sicknesses.

Q-10. Do I need to send in a form with my Notice of Disability to provide proof of loss?
A. No. After you've reported your claim to Aetna, you will receive a package of information in the mail which includes an Authorization for Release of Medical Information and a W-4 form. Please sign all forms and mail or fax to Aetna. Your Claim Specialist assigned to your claim will use those forms to contact your treating provider to obtain the proof of loss directly from their office.

The W-4 form is provided to you to complete as we do not receive information regarding your withholding status from your employer. Failure to complete the W-4 form, including the number of exemptions you are claiming for tax filing purposes, will result in an automatic Federal withholding at single rate with zero exemptions.

Please make sure you complete your full name, address, social security number and number of exemptions you will be taking while out on disability. Please note, a separate W-4 form will be provided at the beginning of each calendar year.

Q-11. How can I contact the National Carriers' Conference Committee?
A. 1901 L Street, N.W., Suite 500
   Washington, DC. 20036
   Phone: 202-862-7200

Q-12. How do I apply for RUIA sickness benefits?
A. Please contact your local Railroad Retirement Board office or your Labor Relations representative. You can find contact information for your local office at http://www.rrb.gov. You can also find additional information on page IV in your Supplemental Sickness Benefit Plan booklet.

Q-13. How long can I receive Supplemental Sickness Benefits?
A. Your plan can pay up to 12 months of benefits during any period of Total Disability.
Q-14. How long do I have to send in my medical information?
A. To ensure timely processing of your claim, medical documentation should be submitted as soon as possible. However, you have up to 90 days after the start of the Period of Disability for which benefits are claimed under the Plan. If documentation is not received within the 90 day time limit, your claim may be suspended or denied.

Q-15. How long will Aetna take to make a decision on my claim?
A. Aetna will respond to your claim for benefits under the Plan within 30 days after it receives your claim.

Q-16. What will happen if Aetna’s Claim Specialist doesn’t receive my medical information from my treating physician?
A. Aetna contacts you if we are unable to obtain the medical information that supports your absence. You will be requested to lend assistance in obtaining records that may include lab results, X-rays, various reports and office visit notes. If Aetna has not received the necessary medical information within 30 days after the start of the Period of Disability for which benefits are claimed, benefits cannot be authorized. Aetna will send you a letter to notify you of what you need to do next in the claim process.

Q-17. What can I do to help in the claim process?
A. Immediately sign and complete all forms and return to our office. You may fax the information to (866) 667-1987.

Contact your healthcare providers who are treating you for your disability and request that they forward any and all office notes, test results, and any other information that would support your claim for disability to your claims examiner.

While Aetna will attempt to obtain information from your healthcare provider(s), it is ultimately your responsibility to make sure the information is provided.

Q-18. Can I get Supplemental Sickness Benefits if I am receiving a military pension?
A. As long as you qualify for benefit under RUIA and meet the other eligibility criteria under the Plan, you would be eligible to receive benefits even if no sickness benefit is actually issued to you by the Railroad Retirement Board. Reductions in the basic benefit will be applied for the receipt of an annuity payment under the Railroad Retirement Act; benefit payments under Title II of the Federal Social Security Act; unemployment, maternity, or sickness benefits under any unemployment, maternity or sickness compensation law other than RUIA; and any other social insurance payments under any law. Military pensions fall under the category Social Insurance Payments under any law.

Q-19. Can I receive Supplemental Sickness Benefits if I do not file a sickness claim under RUIA, or if I file for unemployment benefits under RUIA?
A. No. Benefits are only payable when RUIA sickness benefits are applied for and/or received.

Q-20. Is my union representative permitted to act on my behalf in resolving any issues concerning my claim for SSB?
A. Yes, provided you have completed the Member Designation of Authorized Representative section of the MEDICAL INFORMATION RELEASE AUTHORIZATION form. Without such authorization, Aetna is prohibited by privacy regulations from discussing your claim with any outside party. Of course, Aetna would like the first opportunity to resolve any service issues you might have.

Q-21. How can I check the status of my claim or payments?
A. You can review the status of your claim by contacting Aetna at (800) 205-7651 or by accessing your personal account information on www.wkabsystem.com. Please see the above information under section B for access and login instructions.

Q-22. What role does a Claim Specialist play in the processing of my claim?
A. The claim specialist's role is to obtain the information needed to make disability and benefit level determinations. They request the medical information from medical providers, they acquire the wage information from the employers, they obtain approval information from RRB and they contact the member, acting as the point of contact with regard to the claim.

Q-23. Do I have to repay my SSB benefits if the RRB retroactively grants me an annuity?
A. Yes, for the period of duplicate benefits. Contact your Aetna Claim Specialist for full details, including the amount that must be repaid and Aetna's policy with respect to taxes already withheld from amounts repaid.

Q-24. What happens if there is an overpayment on my claim?
A. In the event of a calculation error, a late notification that you have returned to work, an award of annuity or other event that impacts the benefit, your claim is sent to client accounting for a calculation of the overpaid amount. Once the overpayment is calculated, the examiner is directed to request the overpayment recovery from the employee. A letter is issued to the employee indicating how the overpayment occurred and the amount that is due for recovery.

Q-25. What if my injury or sickness is the result of a third party?
A. In the event that a third party (other than a participating RR) is involved with your injury or illness, the claim will also be referred to a subrogation vendor (Ingenix) who will follow up with you, or your attorney, regarding any settlement issues.