

2009

**Employee
Benefits Program**

Dental

Table of Contents

Dental

Important Information	3
This Is Only A Summary	3
It Describes Current Plan Terms	3
Not An Employment Contract	3
Right To Interpret	3
Administrative Committee	3
Oral Or Other Unofficial Modifications Are Not Permitted	3
Overview	4
Introduction.....	4
Eligibility	4
Cost	4
Coverage.....	4
Retirees	4
About This Summary.....	4
Eligibility	5
Employees.....	5
Spouse (Or Domestic Partner) And Dependents	6
Disabled Dependents	7
Full Time Student Dependents.....	8
Affirmation.....	9
Eligibility Audit	9
Other Consequences	10

When Coverage Begins	11	Note Regarding Timelines	24
Employee Coverage.....	11	Legal Action	25
Spouse (Or Domestic Partner) And Dependent Coverage.....	11	The Administrative Committee Has The Authority To Determine Whether You Are Eligible To Participate Under The Plan ..	25
Cost	13	Benefit Claims And Appeal Procedure – Aetna Dental Plan	25
If You Are An Employee.....	13	Fraud/Misrepresentation	25
If You Are A Retiree	13	Other Important Information	26
Choosing Your Dental Coverage	14	Coordination Of Benefits	26
Changing Dental Coverage	14	Third-Party Liability (Subrogation).....	26
Summary Of Benefits	15	When Coverage Ends	27
The Aetna Dental Plan	16	Employee Coverage.....	27
Choosing A Provider	16	Spouse (Or Domestic Partner) And Dependent Coverage.....	27
Deductible	16	Right To Terminate	28
Maximum Benefits	16	Continuing Coverage Under COBRA	28
Usual And Prevailing Charges.....	16	Role Of Insurer	29
What The Aetna Dental Plan Covers ..	17	Your Rights Under ERISA	30
Dental Benefits	17	General Information	32
Preventive Services.....	17	Plan Name.....	32
Basic Services	17	Type Of Plan	32
Major Services	18	Plan Sponsor And Administrator	32
Orthodontic Services.....	19	Named Fiduciary	32
Predetermination Of Benefits	19	Medium For Providing Benefits	32
Dental Plan Chart	20	Source Of Contributions.....	32
What The Aetna Dental Plan Does Not Cover	21	Plan Year	32
Claim And Appeal Procedures	23	Plan Number	32
Eligibility Claims And Appeal Procedure	23	Employer Identification Number.....	33
Initial Review Procedure	23	Agent For Service Of Legal Process.....	33
Appeal Procedure	24		

Important Information

This Is Only A Summary

This booklet is a summary of the Dental Plan (“plan”), which is a component benefit program under the Travelers Trusteed Employee Benefit Plan. The plan operates under a detailed legal document. A summary cannot deal with every set of circumstances. If this summary is incomplete in some respect, or can be read to be inconsistent with the legal document or the insurance contract, the legal document or insurance contract will control. A copy of the legal document and the insurance contract are available for review from the Travelers Employee Services Unit..

It Describes Current Plan Terms

This booklet describes the terms of the plan in effect as of January 1, 2009.

Not An Employment Contract

The plan is not a contract of employment or a guarantee of continued employment for any definite period of time.

Right To Interpret

Travelers, its Administrative Committee, and others have broad discretionary authority to make factual determinations and to interpret the plan. This is described in the section entitled “Claim and Appeal Procedures.”

Administrative Committee

The “Administrative Committee” is a person or committee appointed to this position in accordance with the terms of the plan. Currently, the Administrative Committee consists of a single person – the Executive Vice President – Human Resources of Travelers.

Oral Or Other Unofficial Modifications Are Not Permitted

The legal document governing the plan cannot be modified by oral statements made by anyone, or by unofficial communications (such as e-mail or mailings) or any other contracts (such as employment contracts or stock or asset purchase agreements). The plan can only be amended by official amendments. Amendments can only be adopted by authorized persons, such as the Board of Directors, the Chief Executive Officer, or others to whom the Board or the Chief Executive Officer has delegated amendment authority.

Overview

Introduction

To encourage good dental care, Travelers offers all eligible employees protection under the plan. This coverage is available for you only, or for you and your eligible family members. You may also waive coverage.

Eligibility

You are eligible to enroll in the plan on your first day of work as a regular status, salaried employee. You also can elect to cover eligible family members. To be eligible, you must be scheduled to work at least 20 hours a week and not be a temporary employee.

Cost

You and Travelers share the cost of coverage. The amount you pay depends on whether you choose employee only or family coverage.

Coverage

Travelers provides the Aetna Dental Plan, in all employee locations. You can choose to enroll or waive coverage.

Retirees

Effective January 1, 2005, retiree dental was eliminated for individuals retiring on or after January 1, 2005. Certain retirees under age 65 who retired prior to January 1, 2005 are eligible to continue participating in the Dental Plan if they elected to participate within 60 days of their retirement date. In addition, certain Legacy TPC retirees are eligible for retiree dental. Otherwise, retirees are not eligible for retiree dental coverage. If you were a legacy retiree participant and you return to active employment with Travelers, you will not be eligible for retiree dental when you later terminate your active employment and return to retiree status.

About This Summary

Aetna administers the Aetna Dental Plan, which is described in this summary. Aetna provides a detailed booklet describing the Aetna Dental Plan. The Aetna Dental Plan is summarized on the Dental Plan Chart in this summary. If you have a question about eligibility, cost, or when coverage begins or ends, you should refer to this summary.

If the information in the Dental Plan Chart conflicts with the summary prepared by Aetna, the summary prepared by Aetna will govern.

Employees

You are eligible to participate in the plan if you are:

- A regular status, salaried employee of Travelers or a participating affiliate; and
- You are scheduled to work at least 20 hours per week, or 50% of a full-time equivalent schedule if your office's workweek is less than 40 hours per week.

The "participating affiliates" currently are:

- Travelers Indemnity Company
- The Premier Insurance Company of Massachusetts (also known as Travelers of Massachusetts)
- First Floridian Auto and Home Insurance Company (also known as Travelers of Florida)
- TCI Global Services, Inc.

The following groups of people are not eligible to participate in the plan:

- TRAVTemps
- Any employee classified as an "intern"
 - Any employee who is:
 - Paid from a payroll system other than the U.S. payroll system of Travelers
 - A local national employee – that is, citizen of another country who is not working in the United States unless Travelers specifically extends eligibility to the employee (including any such individual who has dual citizenship and thus is also a citizen of the United States, unless he or she is an expatriate on assignment from the United States); or
 - A citizen of a country other than the United States who is working on temporary assignment in the United States, as determined under the employment policies of Travelers unless Travelers specifically extends eligibility to the employee
- Individuals employed with, performing services through, or paid by a third-party (such as an employee leasing or staffing agency)
- Individuals performing services pursuant to a contract or agreement (whether verbal or written) which provides that he or she is an independent contractor or a consultant
- Retirees who retired on or after January 1, 2005

If you are a legacy St. Paul retiree under age 65, and you retired prior to January 1, 2005, you are eligible for the Aetna Dental Plan.

Spouse (Or Domestic Partner) And Dependents

Your family members are also eligible for coverage under the plan if you meet the eligibility criteria above, and you elect coverage for your family members under the plan. Eligible family members include:

- Your spouse
 - Your spouse means a person of the opposite sex to whom you are legally married (including a common-law spouse in a state that recognizes common-law marriage, so long as you provide acceptable proof and certification of common-law married status to Travelers) and from whom you are not legally separated
- Your domestic partner.* For this purpose, a person is your “domestic partner” if:
 - You and this person have a long-term, intimate, committed relationship with each other, which is demonstrated to be one of mutual caring, affection, and responsibility for each other’s common welfare;
 - You and this person hold yourselves out as in a relationship similar to marriage;
 - You and this person intend to continue your relationship with each other indefinitely;
 - You and this person meet the following marital status requirements:
 - If you and this person are of the opposite sex, both you and this person are unmarried to each other or anyone else; or
 - If you and this person are of the same sex, both you and this person are unmarried to anyone else;
 - You and this person are each other’s sole domestic partner;
 - Both you and this person are at least 18 years of age;
 - Both you and this person are capable to enter into a contract;
 - You and this person are not related by blood closer than permitted by marriage law in your state of residence;
 - You and this person share a principal residence and have lived together for at least six (6) consecutive months (and this six-month period immediately precedes the date you complete the domestic partnership affidavit);
 - You and this person are jointly responsible to each other for basic living expenses; and
 - The following timing requirements are met (as applicable):
 - At least six (6) months has elapsed since (i) the later of your divorce or this person’s divorce from a previous spouse or (ii) the later of the death of your previous spouse or this person’s previous spouse; and
 - At least six (6) months has elapsed since the date you notified the company that your previous domestic partnership ended (or the date your previous domestic partner was removed from your active coverage under this plan, if later).
- Your, your spouse’s, or your domestic partner’s unmarried “child” who depends on you for maintenance and support. A “child” for this purpose includes your natural child, adopted child, stepchild, child for whom you are the legal guardian (sponsored dependent) and a child named in a Qualified Medical Child Support Order who is under 19, or under age 25 if registered and attending classes as a full-time student at an accredited or licensed educational institution, or a disabled dependent.

* In order to add your domestic partner to coverage, you and your domestic partner must complete the required domestic partner affidavit and agreement.

Eligibility

The individuals listed above will not be eligible unless you timely affirm their eligibility and/or complete any eligibility audit as required under the rules of the plan. See the Affirmation and Eligibility Audit sections of this summary.

If you are divorced or separated, the following special rules apply:

- Your child must receive over half of his or her support from his or her parents (including you and the child's other parent).
- Your child must be in your custody or the other parent's custody for more than half of the year.
- You and the child's other parent must be divorced or legally separated under a court order, living separately under a written separation agreement, or living apart at all times for the last six months of the calendar year.

If these conditions are met, then you may cover your child under the plan even if the child's other parent receives the dependent exemption.

You will be asked to provide documentation supporting legal custody or legal guardianship when adding a sponsored dependent. If you fail to timely provide such documentation your sponsored dependent will not be added to your coverage. You will not be able to add your sponsored dependent until the next Annual Enrollment period, unless you have a Qualified Status Change before then and adding your sponsored dependent is consistent with that Qualified Status Change. See the Qualified Status Change summary for more information.

If you and your spouse or domestic partner are both regular status employees of Travelers, you may be covered as an employee or as a family member, but not as both. In addition, only one of you may cover your eligible children as dependents.

To enroll your domestic partner in the Dental Plan, call the ESU at 800.441.4378 for a domestic partner application and enrollment packet.

Disabled Dependents

If your dependent child is incapable of self-sustaining employment because of a mental or physical disability and is unmarried, his or her coverage and dependent status can continue beyond the age limit of 19 (or age 25 if a full-time student). The mental or physical disability must be incurred before age 19, or before age 25 if covered as a full-time student and the child must have been continually covered if eligible. Coverage continues for as long as your child remains disabled unless coverage is terminated as described on the page entitled "When coverage ends," found later in this booklet.

Upon reaching the age limit, you must provide proof that your disabled child meets both the following requirements:

- He or she is incapable of self-sustaining employment because of a mental or physical disability; and
- He or she is unmarried.

Proof must be provided to UHC or Blue Cross Blue Shield. Periodically thereafter, you will be asked to submit a new statement of eligibility. The time period for such submission may vary depending on the nature of the disability. If you fail to timely submit a new statement of eligibility upon request, your dependent's coverage will be terminated as of the date described in the plan's request for the new statement of eligibility. If you later provide evidence supporting disabled status, coverage will be provided prospectively from the date the new evidence is received and approved by the plan. If

Eligibility

there is a gap in coverage, you may elect COBRA continuation coverage for your dependent for the gap period. If you fail to submit evidence supporting disabled status, your dependent will not be eligible for any COBRA continuation coverage under the plan, unless your child is no longer disabled and you have notified ESU within 60 days of the loss of your dependent's eligibility. See the COBRA summary for more information.

New hires enrolling a disabled dependent over the age of 18 must provide documentation that the dependent has been continually covered under the employee's previous group medical coverage as a disabled dependent.

Full Time Student Dependents

Your child who is age 19 or older will no longer be eligible to be covered under the plan at the end of the month in which he or she graduates from high school or college unless he or she is already registered as a full-time student at an accredited or licensed educational institution.

To maintain full-time student dependent status, your child must keep a full-time class load as defined by the educational institution. Coverage will continue during the summer period after high school graduation or other college academic term between classes if the dependent student is registered as a full-time student for the following academic term. If your registered full-time student dependent does not return to school on a full-time basis immediately following the missed academic term, coverage will be terminated at the end of the last month of the missed academic term.

"Academic term" is generally defined as follows, subject to the specifics of the institution:

- Fall term: September 1 – December 31;
- Winter term: January 1 – May 31;
- Summer term: June 1 – August 31.

Your child who qualified as a full-time student is no longer eligible to be covered under the plan at the end of the month in which the first of the following occurs:

- Turning age 25;
- Graduating;
- Ceasing to be enrolled and in attendance on a full-time basis;
- Ceasing to be registered as a full-time student;
- Completing a defined course of study; or
- Dropping below full-time student status as defined above (unless the reason that the student dropped below full-time status was due to mental or physical disability, in which case coverage could continue if your child qualifies as a disabled dependent).

If your child loses eligibility because he or she no longer qualifies as a full-time student, you must notify the ESU within 60 days of the loss of student status in order for your child to qualify for COBRA continuation coverage. Failure to notify the ESU within 60 days of the loss of student status will result in a loss of continuation coverage rights.

Eligibility

You will be asked periodically to affirm your child's full-time student status. If you fail to timely affirm your child's full-time student status, your child will lose his/her coverage under the plan effective as of the date described in the plan's notice to you during the affirmation process. Your child will not be eligible for COBRA continuation coverage unless you have also notified the ESU within 60 days of your child's loss of student status.

If you later respond to the affirmation request and want to affirm your child's student status, you will need to timely complete the eligibility audit process. See the Eligibility Audit section of this summary for details on that process.

From time to time, the plan may (outside of the affirmation and/or audit process) request evidence of full-time student status. If you fail to provide evidence of full-time student status within 60 days of a request by the plan, your dependent coverage will be terminated effective as of the date described in the plan's request. Your child will not be eligible for COBRA continuation coverage unless you have also notified the ESU within 60 days of your child's loss of student status. If you later provide evidence supporting full-time student status, coverage will be provided prospectively from the date evidence is received, and approved. If there is a gap in coverage, you may elect COBRA continuation coverage for that period.

Affirmation

In addition to periodic requests for affirmation of full-time student status, whenever you seek to cover (or to continue to cover) an eligible family member under the plan, you will be asked to affirm that each family member meets the eligibility requirements as described in this summary.

If you fail to timely affirm your family member's eligibility during Annual Enrollment, the consequence depends on whether the affected family member was previously covered. If your family member was not previously covered, that individual will not receive coverage, and Travelers will adjust your coverage level appropriately. For example, if you elect Employee/children coverage, but you do not affirm that your children are eligible dependents, Travelers will adjust your election to Employee only coverage. If your family member was previously covered, your family member will lose his/her coverage under the plan. The loss of coverage will generally be effective as of the date specified in the plan's notice to you during the affirmation process.

If you later respond to the affirmation request and want to affirm your family member's eligibility, you will need to timely complete the eligibility audit process described below before your family members may be covered.

If you fail to timely affirm your family member's eligibility when you seek to cover your family member during the year as a result of a Qualified Status Change, then your family member will not receive coverage and you will not be able to add your family member to the plan until the next open enrollment period, unless you have another Qualified Status Change and adding your family member is consistent with that Qualified Status Change. See the Qualified Status Change summary for more information.

Eligibility Audit

Employees who fail to timely affirm their family member's eligibility upon request by the plan (other than requests related to mid-year additions of family members, which are subject to the Qualified Status Change timing rules) will be referred to the eligibility audit.

In addition to these referrals from the eligibility affirmation process, Travelers conducts random audits of employees and their covered family members on a quarterly basis. If you are selected for, or referred to, the eligibility audit, you will be asked to certify each family member's eligibility under the plan and to provide certain othersupporting information as requested.

Eligibility

If you do not respond to the eligibility audit, or if you are not able to prove your family member's eligibility, your family member(s) will lose their coverage under the plan. The loss of coverage will generally be effective as of the later of:

- the date specified in the plan's notices regarding the eligibility.

If you later provide evidence that demonstrates your family member's eligibility, coverage will be provided prospectively from the date the eligibility audit is completed. If there is a gap in coverage with respect to family members previously covered under the plan, you may elect COBRA continuation coverage for that period. If you fail to complete the eligibility audit, your family member will not be eligible for any continuation coverage under the plan.

Other Consequences

Providing incorrect information during the affirmation or eligibility audit process or failing to respond to the affirmation or audit could result in termination of your family member's eligibility, disciplinary action, your liability for benefits incorrectly paid, and civil or criminal prosecution. If your family member's coverage is cancelled, premiums for the retroactive period of cancelled coverage (if any) will not be refunded.

When Coverage Begins

Employee Coverage

Your coverage begins on:

- The day you become eligible for coverage, if you apply on or before that day or within 31 days after the day you become eligible;
- The first day of a calendar year, if you enroll during the annual enrollment period; or
- The day you have a Qualified Status Change, if your enrollment is consistent with your Qualified Status Change and your election is received within 31 days of the Qualified Status Change (see the Qualified Status Changes summary for more information, including information about pre-tax and post-tax premiums).

If you are a new hire and do not elect coverage within 31 days of employment, you will automatically be considered to have waived coverage. If you have not elected coverage and you are terminated within five (5) business days of your hire date, you will not be enrolled in the plan for that period.

If your employment was terminated because you could not prove eligibility to work in the United States or you did not affirm Travelers' Principles of Employment within the time required by the company, a special rule applies if you are subsequently rehired. If you prove eligibility to work in the United States or you affirm the Principles of Employment and you are rehired, coverage will be reinstated or may be added. Your coverage will be effective on the date eligibility is proven or you make your affirmation, or, if later, the date you are rehired. If you are rehired within 30 days of your termination date and you elected coverage before your termination date, the reinstated coverage will be based on your prior election. If you did not elect coverage before your termination date or you are rehired more than 30 days after your original date of hire, then you will be treated as a new employee for purposes of the plan upon rehire.

If you are not working on the day your coverage is scheduled to begin, (and your absence is for a reason other than your own medical condition), coverage will take effect when you return to work.

Spouse (Or Domestic Partner) And Dependent Coverage

If you enroll for family coverage, your eligible family members will be covered when you are. Any person who becomes an eligible family member after you enroll in the plan is eligible for coverage if your election for coverage is received within 31 days of the day they become eligible.

When adding a dependent you must notify the ESU and complete the online enrollment within 31 days of the event, and complete the Benefit Affidavit. The effective date of that person's coverage will be the day of the Qualified Status Change. If your enrollment change request is not received within 31 days, you must wait until the next annual enrollment period or Qualified Status Change event to add your new dependent. "Received" means physically or electronically received by the ESU with a postmark, date stamp, or other reliable evidence dated within the 31-day timeframe. If the ESU does not receive your enrollment change request within the required timeframe, you will need to prove that you sent it to the ESU within the required timeframe in order for the change to be honored (e.g. by producing a dated fax receipt or certified mail receipt). Refer to the Qualified Status Changes summary for more information.

When Coverage Begins

Qualified Medical Child Support Orders

Under federal law, group health plans must provide benefits in accordance with the requirements of a qualified medical child support order (QMCSO). A child on whose behalf such an order is issued is an “alternate recipient” and will be treated as a participant under the plan. The court order may not require the plan to provide any type of benefit not otherwise provided.

All QMCSOs must be approved and accepted by the plan before benefits will be provided to the alternate recipient. If you are subject to a QMCSO, you must notify Travelers when you are hired or within 31 days of the issuance of the court order, if later. Travelers will provide you with the required enrollment materials.

You may obtain a copy of the plan’s QMCSO procedures from Corporate Employee Benefits by contacting the ESU.

If You Are An Employee

You and Travelers share the cost of your dental coverage. When you enroll in the plan, the company informs you of your share of the premium. Generally, you pay your share of the premium with pre-tax dollars deducted from your salary.

If you cover your domestic partner or your domestic partner's children, the cost of the coverage for your domestic partner and your domestic partner's children will be deducted from your paycheck on a post-tax basis, unless you have certified that your domestic partner and children, if applicable, qualify as your dependents for tax purposes on your Certification of Domestic Partner Tax Status form.

Premiums are fixed by pay period and not pro-rated for coverage of less than a pay period. However, if you start coverage during the second half of a pay period, you will start paying premiums in the second pay period of coverage.

The company pays the balance of the cost.

If You Are A Retiree

The premium you pay for dental coverage can change and is generally communicated each fall.

Projected premium costs are fixed monthly premiums and are not pro-rated for periods of coverage of less than one month.

You pay your share of the annual premium with post-tax dollars through monthly deductions from your pension check or via personal check. The company currently pays the balance of the cost (however, see "Right To Terminate Coverage" later in this summary).

Choosing Your Dental Coverage

The Aetna Dental Plan is available in all locations. If you enroll in the plan, you may choose from the following coverage levels:

- Employee only (coverage for you only)
- Employee/spouse or domestic partner (coverage for you and your spouse or domestic partner)
- Employee/children (coverage for you and one or more children)
- Family (coverage for you, your spouse, or your domestic partner and one or more children)

If you are a new employee, you may choose dental coverage when you are first hired. If you waive or are considered to “waive” (i.e., because you do not enroll in dental coverage within 31 days of hire) coverage in any year of employment, you may elect coverage during the next annual benefits enrollment period. Your coverage will take effect on the following January 1.

Changing Dental Coverage

Once you choose a dental option, your coverage will be effective the entire calendar year. You cannot make midyear changes to your coverage unless you experience a Qualified Status Change Event, and the coverage change is consistent with the status change. The change in coverage takes effect on the date of the Qualified Status Change Event. See the “Qualified Status Changes” summary for more information on Qualified Status Changes.

Your request to change your coverage must be received within 31 days after the Qualified Change in Status, or you must wait until the next annual benefits enrollment period. You may be asked to provide proof of the Qualified Status Change.

Summary Of Benefits

The information on the following pages summarizes the major benefits for the Aetna Dental Plan. This summary does not describe all of the benefits, maximums, limitations and exclusions that may apply. If the terms of the summary and certificate prepared by Aetna are different from or inconsistent with the provisions of this summary, the terms of the summary and certificate prepared by Aetna will control. Refer to the summary and certificate prepared by Aetna for more details about specific benefits, maximums, limitations and exclusions. You may obtain a copy of Aetna's summary and certificate online through myHR or by requesting a copy from the ESU.

The Aetna Dental Plan

The Aetna Dental Plan is administered by Aetna. This section outlines the benefits available under this plan.

Choosing A Provider

If you enroll in the Aetna Dental Plan for your dental coverage, you may choose any licensed dentist for your dental care needs.

Some dentists have agreed to discount their fees for Aetna Dental Plan participants. Visit the Aetna website at “www.aetna.com/docfind” and select dentist type and “Dental PPO” or call Aetna at 800.741.4781 to find out whether your dentist participates in the network. You still may choose a dentist who does not participate in the network.

Deductible

Before you start to receive benefits for basic and major services, you must pay a deductible of \$75 per person per calendar year. If you have family coverage, once your family’s deductible expenses reach \$150 in a calendar year, no further deductibles will be required for the rest of the calendar year. There is no deductible for preventive or orthodontic services.

Maximum Benefits

The Aetna Dental Plan will pay up to a maximum of \$2,000 for each covered participant each year for all covered dental services except orthodontia and treatment of temporal mandibular joint (TMJ) syndrome.

For orthodontic expenses, \$2,000 is the maximum lifetime benefit for each covered participant. The orthodontia maximum lifetime benefit does not count toward the annual \$2,000 limit for other dental services. However, the lifetime benefit will apply even if coverage is interrupted, or if you or a dependent has been covered both as an employee and as a dependent.

The maximum lifetime benefit for TMJ is \$750 per covered person. The lifetime maximum for TMJ does not count towards the annual \$2,000 maximum for other covered services.

Usual And Prevailing Charges

The Aetna Dental Plan considers up to a usual and prevailing charge when it pays benefits. “Usual” refers to a provider’s fee when there is no insurance. “Prevailing” refers to the range of charges for similar services and supplies in the same geographic area.

If a charge exceeds the usual and prevailing fee, you will be responsible for paying the excess portion, as well as any deductible or coinsurance that would normally apply.

Note: If the dentist participates in the Aetna Dental PPO, he or she has agreed to accept the negotiated amount as payment. This eliminates usual and prevailing fee reductions.

What The Aetna Dental Plan Covers

The Aetna Dental Plan pays a percentage of the usual and prevailing charges for most dental services, and dependent child orthodontia according to the schedule in the chart below:

Dental Benefits

Preventive services	100%
Basic services	80%
Major services	50%
Orthodontic services	50% (Dependent Children under age 20)

Preventive Services

The Aetna Dental Plan encourages you to take good care of your teeth. By having routine checkups, you may avoid serious problems. With this in mind, the plan pays 100 percent of the usual and prevailing charges for the following preventive dental services:

- Dental exams and cleaning (twice each calendar year)
- Fluoride treatments for children under age 19 (once each calendar year)
- Bite-wing X-rays (twice each calendar year)
- Full-mouth X-rays (once every 36 months)
- Periapical X-rays (single film)
- Fissure sealants for dependents under age 19 (for the first and second permanent molars; limited to one treatment in any 36-month period)

However, the plan provides no coverage for any services that are performed beyond the frequency indicated above, even for emergency services.

Basic Services

Most covered services are considered basic services. These are services performed primarily to help restore decayed or damaged teeth. The Aetna Dental Plan pays 80 percent of the usual and prevailing charges for the following basic services:

- Fillings (amalgam, silicate cement, plastic, or composite). Composite fillings are allowed on anterior teeth, numbers 6–11 and 22–27
- Space maintainers
- Simple and surgical tooth extractions including wisdom teeth
- General anesthesia (only when medically necessary and in connection with oral surgery)
- Root canal therapy and treatment of the dental pulp (endodontics)

What The Aetna Dental Plan Covers

- Adjustments to dentures
- Replacement of broken teeth which are part of complete or partial dentures
- Recementing of bridges
- Treatment of the gums and tissues of the mouth (periodontics)
- Biopsy of oral tissue

Major Services

Major services are those that treat the alignment of the jaw, and teeth that are beyond restoration. The Aetna Dental Plan pays 50 percent of usual and prevailing charges for the following major services and supplies:

- Treatment of temporal mandibular joint syndrome (jaw alignment)
- Gold inlay fillings
- Crowns
- Abutment crowns
- Bridge pontics (artificial teeth)
- Complete and partial dentures

Crowns will be covered expenses only when X-rays show sufficient disease or decay to require crowns for restoration of the tooth. Also, the replacement of missing teeth is covered only if the tooth is lost while you participate in one of Travelers' dental plan options.

The Aetna Dental Plan will not cover the replacement of crowns, bridgework or dentures unless one the following occurs:

- It is required to replace one or more natural teeth lost or extracted while you or your family members are covered under one of Travelers' dental plan options;
- Five years have passed since the initial or most recent replacement of the current bridgework or dentures, and they cannot be made serviceable; or
- The present bridge or denture is a temporary device that will require replacement by a permanent bridge or denture (such replacement must take place within 12 months from the date the temporary device was installed).

What The Aetna Dental Plan Covers

Orthodontic Services

The Aetna Dental Plan pays 50 percent of the usual and prevailing charges for orthodontics or teeth straightening for dependent children who are under age 20 on the date orthodontic treatment begins, to a lifetime maximum benefit of \$2,000. The Aetna Dental Plan covers:

- The preliminary study, including X-rays, diagnostic costs, and treatment plans
- The first month of active treatment, including all active and retention appliances
- Active treatment per month thereafter

Benefits are paid quarterly only while receiving active treatment.

Predetermination Of Benefits

Before receiving a dental service, you can obtain a predetermination that will tell you what your benefits will be. If you ask, your dentist will submit the expected treatment plan to the claim administrator for you. The request for predetermination should be mailed to:

Aetna
P.O. Box 14094
Lexington, KY 40512-4094

Dental Plan Chart

This chart provides an overview of the Aetna Dental Plan.

Aetna Dental Plan	
Plan Features	
Availability	All locations
Choosing a dentist	Any licensed provider
Deductible (excluding orthodontia)	\$75 per individual, \$150 per family
Orthodontia deductible	None
Annual benefit maximum	\$2,000
Lifetime orthodontia maximum	\$2,000
Preventive Services: Exam and cleanings Fluoride Sealants Routine X-rays	Covered at 100%, no deductible
Basic Services: Fillings Routine extractions Periodontia Non-routine x-rays Endodontia Oral surgery	Covered at 80% after deductible
Major Services: Inlays, onlays, and crowns Dentures and bridgework	Covered at 50% after deductible
TMJ treatment	Covered at 50% after deductible to \$750 lifetime maximum.
Orthodontia Services	Covered at 50%, no deductible to \$2,000 lifetime maximum.

What The Aetna Dental Plan Does Not Cover

The Aetna Dental Plan does not cover expenses for the following dental services:

- Injury or sickness for which you or your dependents are entitled to benefits under any workers' compensation law, employer's liability law or similar law;
- Injury or sickness that results from war or an act of war (declared or undeclared);
- A service furnished by or for the federal or any state government (unless payment of the service is required), or a service covered under a governmental program (except Medicare). However, the plan will pay benefits for covered dental expenses that you or your family member incur if you are receiving state or local medical assistance or services for:
 - Mentally retarded, epileptic or emotionally handicapped children in a licensed 24-hour facility;
 - Child care in a group foster care facility;
 - Treatment for children with social, physical or emotional problems requiring foster care placement;
 - Public child welfare programs; or
 - Any other form of public welfare;
- Cosmetic services, including facings on crowns or pontics behind the second bicuspid (this exclusion does not apply to services needed to treat accidental injuries);
- Replacement of a lost or stolen appliance (including retainers) or prosthesis;
- Replacement or modification of a full or partial denture, a removable or fixed bridge, adding teeth to a bridge or denture, or replacement of a crown or gold restoration within five years of the date the denture, bridge or crown is installed;
- A denture or bridge if it replaces teeth that are missing before coverage begins under this plan (however, the plan covers teeth removed while coverage under this plan is in effect or teeth that are not an abutment to a denture or bridge installed within the last five years);
- Replacement at any time of a bridge or denture that meets or can be made to meet commonly held dental standards of functional acceptability;
- Appliances or restorations, other than full dentures, when the primary purpose is to alter vertical dimension, stabilize periodontally involved teeth or restore occlusion;
- Unnecessary care or treatment;
- Charges that exceed a usual and prevailing charge;
- Veneers or similar properties of crowns and pontics placed on or replacing teeth other than the six upper or six lower anterior teeth;
- Dental services that do not have uniform professional endorsement;
- Orthodontic services for you or family members age 20 or older;
- Dental services where an alternative procedure will produce a professionally and functionally acceptable result (e.g., composite fillings in posterior teeth);

What The Aetna Dental Plan Does Not Cover

- Treatment of temporal mandibular joint (TMJ) dysfunction, including any procedures prerequisite or incidental to such treatment after reaching the maximum lifetime benefit of \$750;
- Replacement of teeth (including their abutments) which are missing on the effective date of a participant's coverage under one of Travelers' dental plan options;
- Any expenses associated with dental treatment in progress (including orthodontia) which began before the effective date of a participant's coverage under one of Travelers' dental plan options;
- Routine chest X-rays and medical exams which are conducted before oral surgery;
- Charges made for educational procedures, such as oral hygiene, plaque control or diet planning;
- Charges made for completing claim forms or missed dental appointments;
- Expenses incurred for personal supplies or equipment such as a water pik, toothbrush, or floss holder;
- Duplicate copies of X-rays;
- Cranial adjustments;
- Hospital charges for room, supplies or emergency room expenses;
- Dental implants and related services;
- Myofunctional therapy (treatment of habits harmful to the teeth, such as teeth grinding or thumb sucking);
- Prescription drugs;
- Treatment for accidental injury to sound and natural teeth, which is covered under the Medical Plan, subject to all other plan provisions;
- Services not specifically covered under the Aetna Dental Plan;
- Charges for claims initially filed more than 12 months after the expense was incurred; or
- Charges inconsistent with Aetna's established dental policies.

Note: You may be eligible for benefits if you receive treatment for dental services, such as implants, that are not covered by the plan but for which there are suitable alternative covered services. In that case, the plan pays benefits the same way as an alternate covered service producing a similar result. In addition, two or more listed services could be applicable for a specific condition under standard dental practice. If a charge is incurred for one of those services, Aetna may consider the charge to have been incurred for another service which would have produced a more acceptable result. Contact Aetna for further details.

Claim And Appeal Procedures

Eligibility Claims And Appeal Procedure

If you believe that you should be eligible to participate in the plan, or if you believe that your participation should be on certain terms (for example, that you are eligible for subsidized coverage), you should contact the Employee Services Unit at 800.441.4378. Your contact will be treated as an informal inquiry regarding your eligibility. If the Employee Services Unit informs you that you are not eligible to participate in the plan, and you disagree with this response, or if you believe that your instructions have not been followed or that the plan's terms or procedures (as they relate to eligibility) have been violated in any way, you or your authorized representative must file a written claim under this claim procedure at the following address. You must file your claim within 30 days of the date the Employee Services Unit responds to your informal inquiry.

Address your claim to:

Travelers Administrative Committee
c/o Employee Services Unit
The Travelers Companies, Inc.
385 Washington Street, 9275-SB02L
St. Paul, MN 55102
Or by e-mail: 4-ESU@travelers.com

Travelers makes a form available for your use in preparing and submitting your claim. Claims can be most meaningfully reviewed when you understand the plan and clearly express why you believe you are entitled to participate in the plan as you are claiming, taking the plan's terms into consideration. The claim form assists you in this process. Travelers strongly recommends that you use the claim form, which is available on myHR or by calling the ESU, when you submit your claim.

You will not be considered to have filed your claim until Travelers receives, at the address above, your written explanation of why you believe you are entitled to a benefit. Your written explanation must contain a certification and statement that read as follows:

"By my signature, I certify that to the best of my knowledge, the information set out in my written claim is true and correct. I understand that false statements made in this claim could lead to disciplinary action, up to and including termination of my employment with Travelers. I understand that my claim will be reviewed under the terms of the plan documents and will be processed according to the plan's claims procedures."

Your certification and statement must be accompanied by your handwritten or electronic signature. Again, you are strongly encouraged to use Travelers' claim form (which includes the required certification language).

Initial Review Procedure

Your formal request for eligibility to participate in the plan is considered a "claim for benefits" and will be fully and fairly reviewed by the Administrative Committee. If your request is wholly or partially denied, the Administrative Committee will furnish you with a written notice of this denial which will cover:

- Specific reasons for the denial
- Plan provisions on which the denial is based
- Additional material or information needed to make the request acceptable and the reason it is necessary
- The procedure for appealing the denied request for benefits.

Claim And Appeal Procedures

The Administrative Committee has 30 days to respond to your written claim. This deadline may be extended for an additional 15 days if necessary. If the Administrative Committee determines that an extension is necessary, you will be furnished with a written notice indicating the special circumstances requiring an extension of time and the date by which the Administrative Committee expects to make a determination.

Appeal Procedure

If your claim is denied, in whole or in part, and you want to pursue the matter further, you or your authorized representative must appeal the decision and request further review. You must file your written appeal with the Administrative Committee at the address above no later than 180 days after you receive written notification of the denial of your claim. Your written appeal must describe all the reasons why you believe the claim denial was in error, and should include copies of any documents you want to have considered in support of your appeal. Your claim will be decided based on all available information, and the information you submit will be considered even if it wasn't considered in the initial determination. So you should make sure that your submission is complete.

Travelers makes a form available for your use in preparing and submitting your appeal. Appeals can be most meaningfully reviewed when you understand the plan and clearly express why you believe your claim was incorrectly denied, taking the plan's terms into consideration. The appeal form assists you in this process. Travelers strongly recommends that you use the appeal form, which is available on myHR or by calling the ESU, when you submit your appeal.

You will not be considered to have filed your appeal until Travelers receives, at the address above, your written explanation of why you believe the decision to deny your claim was not correct. Your written explanation must contain a certification and statement that read as follows:

“By my signature, I certify that to the best of my knowledge, the information set out in my written appeal is true and correct. I understand that false statements made in this appeal could lead to disciplinary action, up to and including termination of my employment with Travelers. I understand that my appeal will be reviewed under the terms of the plan documents and will be processed according to the plan's claims procedures.”

Your certification and statement must be accompanied by your handwritten or electronic signature. Again, you are strongly encouraged to use Travelers' appeal form (which includes the required certification language).

During the 180-day period you have to file your appeal, you will have the opportunity to review upon request documents, records, and other information relevant to your claim for benefits. You may also request copies (free of charge).

A decision on the appeal will normally be made within 60 days of the date your appeal is received. You will receive a written decision including the specific reason(s) and plan references on which the decision is based. If special circumstances require a review period longer than 60 days, the time for making a final decision may be extended. If the Administrative Committee determines that an extension is necessary, you will be furnished with a written notice of the extension prior to the end of the initial 60-day response period. The total review period on an appeal cannot be longer than 120 days.

Note Regarding Timelines

If your claim for eligibility to participate involves urgent care or care for which pre-authorization is required, the timelines for decision of your claim may be expedited.

Claim And Appeal Procedures

Legal Action

If your appeal is denied in whole or in part, you have the right to file a lawsuit challenging the denial. The claims procedures described above are required by federal law and are designed to ensure that disputes regarding the plan are decided by the Administrative Committee. Therefore, courts almost always require that a claimant exhaust a plan's claims procedures before filing suit (both filing the initial claim and appealing a denied claim). If you fail to do so, the court will likely dismiss your lawsuit. In a lawsuit, the court generally will review the decision the Administrative Committee made based on the evidence and arguments that were presented. Except in rare circumstances, the court will not allow you to introduce new evidence or arguments to support your claim. Thus, you should make sure that everything that you believe supports your position is submitted to the Administrative Committee during the claims process.

You may pursue legal action only after you have completed the claims process described above. In addition, if you have completed the claims process above and want to bring a lawsuit, you must do so within one (1) year of the final denial of your claim. Failure to file a lawsuit within the applicable one (1) year period will cause your rights to expire.

The Administrative Committee Has The Authority To Determine Whether You Are Eligible To Participate Under The Plan

Travelers is the administrator of the plan, generally acting through its Administrative Committee and ESU. As administrator, Travelers and its Administrative Committee have the discretionary authority to interpret all terms of the plan and make factual determinations as to whether you are eligible to participate in the plan. The decisions made by Travelers and the Administrative Committee are final and binding, subject to your right to file a lawsuit under ERISA. The decision-making authority is very broad and is limited only by the duties under ERISA, and the decisions of Travelers and the Administrative Committee are intended to be given deference by courts to the maximum extent allowed under ERISA.

Benefit Claims And Appeal Procedure – Aetna Dental Plan

In order to receive a benefit from the Aetna Dental Plan, you or your dentist must file a claim. You can obtain Aetna Dental Plan claim forms from the Forms database in myHR by clicking on *myHR*, then clicking on HR Forms on the right-hand navigation bar. You can also contact the ESU to request a form at 800.441.4378. Send completed benefit claim forms to:

Aetna Dental Claims
P.O. Box 14094
Lexington, KY 40512-4094

If you have concerns about a claim, call Aetna Dental Plan customer service at 800.741.4781. For full details about the benefit claims and appeals procedures for the Aetna Dental Plan, you should refer to the Aetna Dental Plan booklet.

Fraud/Misrepresentation

If you knowingly and with intent to defraud the plan file a claim that contains any materially false information including eligibility information, conceal information in order to mislead, or commit a fraudulent act, you may be subject to disciplinary action, up to and including termination of employment, and possible criminal and civil penalties.

Other Important Information

Coordination Of Benefits

If you participate in the Travelers dental plan and another group dental plan, the plan uses coordination of benefits rules. The purpose of these rules is to prevent over-insurance. According to coordination of benefits rules, you send your claim to the primary plan first. After the primary plan has paid benefits, you send your claim, along with the primary plan's explanation of benefits, to the secondary plan.

Travelers' dental plan is primary for:

- You (unless you work more hours for another employer); and
- Any family member who is not covered as an employee under another dental plan.

If your children are covered under this plan and your spouse's plan, their primary plan is determined by the spouse whose birthday falls earlier in the year. For example, if your birthday is in March and your spouse's birthday is in May, your plan is primary.

If Travelers' dental plan is secondary, it may pay benefits after the other plan has paid, but only if there are allowable expenses that exceed the primary plan's payment. Payment works as follows:

- The Travelers plan claims administrator determines the amount the Travelers plan would have paid if it were primary.
- If there is a difference between the amount actually paid by the primary plan and the amount the Travelers plan would have paid as the primary plan, the Travelers plan will pay the difference.

For more information on how coordination of benefits works, please refer to the booklet issued by Aetna.

Third-Party Liability (Subrogation)

Third-party liability rules cover situations where you or your dependents did not pay for some or all your covered dental expenses. Instead, they were paid by a source other than the Travelers' dental plan (e.g. workers compensation, or fault auto insurance, liability settlements, etc.). This other source is referred to as the "third party."

In such situations, if the plan has made any dental expense payments on your or your family members' behalf, the plan is entitled to recoup the amount paid or the value of the service from any recovery or settlement amount you or a family member received from or on behalf of the third party. You or your family member may be asked to sign a Reimbursement Agreement in advance of receiving any benefits under this plan.

When Coverage Ends

Employee Coverage

Your dental coverage ends on the earliest of the following:

- The day the plan terminates or is amended so that you are no longer covered;
- The end of the period for which you made the last required contribution;
- The last day of the month immediately following receipt of your written request to terminate coverage (due to a Qualified Status Change);
- The last day of the month in which you enter the armed forces of any country other than the United States or the service of any government agency;
- The last day of the month in which you cease to be actively employed in an eligible position covered under this plan unless you retired prior to January 1, 2005 and remained eligible, begin an approved leave of absence, or begin a disability leave of absence in accordance with the company's disability leave policy (contact the ESU for information on continuing coverage in these situations) unless your employment terminates within the first five (5) business days of your initial hire date or your date of rehire;
- If you are an eligible retiree, the end of the month in which you reach age 65 (this is not a COBRA qualifying event);
- The last day of the current coverage year if you elect to waive coverage during the annual benefits enrollment period;
- If you elect to discontinue coverage during a leave of absence, the later of the date your leave begins or the date during your leave as of which you elect to discontinue coverage;
- If at the conclusion of a leave of absence (including a disability leave of absence) you fail to resume active employment in an eligible position covered under this plan, the last day of the month in which your leave of absence ends;
- The day your employment terminates if you have elected coverage and your employment terminates (voluntarily or involuntarily) within the first five (5) business days of your initial hire date (or your date of rehire).

Spouse (Or Domestic Partner) And Dependent Coverage

Spouse (or domestic partner) and dependent dental coverage ends on the earliest of the following:

- The end of the month in which your spouse, domestic partner, or child no longer qualifies as an eligible dependent;
- The last day of the month immediately following receipt of your written request to terminate family member coverage (due to a Qualified Status Change);
- The end of the period for which you made the last required contribution for dependent family member coverage;
- The day your coverage ends (under any circumstances, including under the company's disability leave policy); or
- If you are a grandfathered surviving spouse, the end of the month in which your deceased spouse would have reached 65.

When Coverage Ends

Right To Terminate

Travelers does not guarantee that it will maintain either active or retiree-spouse or domestic partner coverage for your entire life. The benefits provided by the plan and/or any plan option are not “vested” benefits. Travelers does not promise the continuation of any benefit nor does it promise any specific level of benefits, or cost for such benefits, at any time, including at or during retirement.

Continuing Coverage Under COBRA

A federal law called COBRA gives you, your spouse, and your dependents the right to continue your dental coverage for a limited time in certain situations. Travelers currently extends the same continuation coverage privilege to your domestic partner, but any such continuation would not be required by law and would not be under COBRA. You and your covered family members qualify for continuing coverage if you experience a qualifying event.

The coverage that you and your covered family members may continue is the same that you or your covered family members had under the plan at the time of the qualifying event. However, if the plan changes benefits, premiums, etc., COBRA continuation coverage changes accordingly. You must pay the entire cost of this coverage, plus a two percent administrative fee. These rates may change each year. See the COBRA summary for more details on continuing your dental coverage.

Role Of Insurer

A federal law called ERISA requires Travelers to disclose certain information about the role of each health insurer in the administration and financing of the plan. This information is provided in the table below:

Name of Insurer	Plan Option	Whether Benefits are Guaranteed by the Insurer/	Nature of Services Provided to the Dental Plan
Aetna	Aetna Dental	Aetna does not guarantee payment of benefits under this option. All benefit claims are payable by the Travelers Employee Benefit Trust.	Claims administration, Claim fiduciary

The Travelers Employee Benefit Trust will be credited with any favorable claims experience, or charged for any unfavorable claims experience, during the year for the Aetna Dental Plan. Favorable claims experience will occur when the premiums exceed the amount paid out in benefit claims and administrative expenses (including administrative service fees). Likewise, unfavorable claims experience will occur when the amount paid out in claims and administrative fees exceeds the annual premiums.

Your Rights Under ERISA

Your Rights Under ERISA

As a participant in the plan, you are entitled to certain rights and protections under ERISA - the Employee Retirement Income Security Act of 1974.

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 and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, 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 Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue group health plan coverage

You may be able to continue Dental Plan coverage if there is a loss of coverage under the plan as a result of a qualifying event. You may have to pay for such coverage. Review this summary and the documents governing the plan for the rule 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, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce your rights

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

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted

Your Rights Under ERISA

the claims procedures outlined in this publication, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions

If you have any questions about your plan, you should contact Aetna at 800.843.3661. 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.

General Information

Plan Name

The name of the plan is the Travelers Dental Plan, which is a component program under the Travelers Trusteed Employee Benefit Plan.

Type Of Plan

The plan is a welfare benefit plan.

Plan Sponsor And Administrator

Travelers is the “sponsor” and the “administrator” of the plan for purposes of ERISA. Travelers has contracted with Aetna to provide claims administration under the plan. Travelers acts as administrator through its Administrative Committee. Travelers is responsible for determining who is eligible for coverage, and for paying benefits under the Dental Plan. The claims administrator – currently Aetna – is responsible for deciding whether benefits are due for the Aetna Dental Plan.

Named Fiduciary

Aetna is the named fiduciary for claims purposes for the Aetna Dental Plan. Their address is:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Medium For Providing Benefits

Benefits under the plan are provided through the Travelers Employee Benefit Trust.

Source Of Contributions

There are both employer and employee contributions to the Employee Benefit Trust.

Plan Year

The plan year is the calendar year.

Plan Number

The Travelers Trusteed Employee Benefit Plan has been assigned the following identification number: 508.

General Information

Employer Identification Number

Travelers' federal employer identification number is 41-0518860.

Agent For Service Of Legal Process

Legal process may be served on Travelers at the following address:

Travelers Companies, Inc.
c/o Corporate Secretary
385 Washington Street, 9275-NB16A
St. Paul, MN 55102



The Travelers Indemnity Company
and its property casualty affiliates
One Tower Square
Hartford, CT 06183

travelers.com

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