

2009

**Employee
Benefits Program**

Vision

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Important Information

This Is Only A Summary

This booklet is a summary of the Vision Plan (“plan”), which is a component benefit program under the Travelers Non-Trusteed Employee Benefit Plan. The plan operates under a detailed legal document and a group insurance contract. 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 (see the section titled “Role of Insurer” later in this summary for more information).

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 “Claims and Appeal Procedure.”

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 provide access to comprehensive vision screenings, glasses, and contacts, 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 pay for the entire cost of the plan. The amount you pay depends on your coverage level (employee only, employee/spouse, etc.).

Coverage

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

Retirees

Retirees are not eligible for coverage.

About This Summary

The Vision Plan described in this summary is administered by EyeMed Vision Care and insured by Combined Insurance Company of America. EyeMed Vision Care provides a certificate of coverage describing the plan. The plan is summarized in the “What The Plan Covers” section 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 “What The Plan Covers” section conflicts with the summary prepared by EyeMed Vision Care, the summary prepared by EyeMed Vision Care will govern.

Employees

You are eligible to participate in the Vision Plan (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; or
 - A local national employee – that is, citizen of another country who is not working in the United States (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 the company
- 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

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 plan, call the Employee Services Unit (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
- 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. 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

Employees

Your coverage begins on the latest of the following days:

- 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 of this publication 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 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, 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. The effective date of that person's coverage will be the day of the Qualified Status Change.

When adding a dependent you must notify the ESU and complete the online enrollment within 31 days of the event, and complete the Benefits Affidavit. 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 them 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 Order

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 QMSCO, you must notify Travelers when you are hired or within 31 days after 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 QMSCO procedures from Corporate Employee Benefits by contacting the ESU.

Cost

You pay the entire cost of this plan, generally with pre-tax payroll deductions. The cost is determined by the level of coverage you select.

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.

Choosing Your Vision Coverage

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 domestic partner and one or more children)

If you are a new employee, you may choose vision coverage when you are first hired. If you do not enroll for vision coverage within 31 days of hire and are defaulted to “waive” or you waive 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 Vision Coverage

Once you choose to participate in the vision plan, 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 of this publication 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.

What The Plan Covers

The plan covers your vision care needs and those of your eligible, enrolled dependents. It is important to note that all the covered services described in this section are in addition to the eye exam benefit that may be offered through your Medical Plan. Please see the Medical summary for more information.

The plan is administered by EyeMed Vision Care and insured by Combined Insurance Company of America. If there are any discrepancies between the information in this summary and the certificate of coverage issued by these entities, the certificate of coverage will govern.

In-Network Benefits

You may choose to receive your plan care within the network, or use the provider of your choice. Services may have an applicable copay (an amount you must pay before the plan begins to cover expenses) and/or an applicable coinsurance amount (coinsurance refers to the percent of covered expenses you must pay). If you use an EyeMed Vision participating network provider, the following services are covered:

SERVICE	YOUR COPAY & COINSURANCE
Eye Exam with dilation	\$10
Standard Contact Lens Fit and follow-up exam (e.g., disposable, frequent replacement, etc.)	\$0, paid in full fit and up to two follow-up visits
Premium Contact Lens Fit and follow-up exam (e.g., toric, multifocal, etc.)	\$0, plus 90% of the retail cost less a \$40 allowance
Standard Frames*	\$0, plus 80% of the amount over the \$130 retail allowance limit
Lenses (Standard uncoated plastic or polycarbonate):*	
Single Vision	\$10
Bifocals	\$10
Trifocals	\$10
Lenticular	\$10
Contact Lenses:*	
Cosmetic Conventional	\$10, plus 85% of the amount over the \$130 retail allowance limit
Cosmetic Disposable	\$10, plus balance over \$130 retail allowance limit
Medically Necessary	\$0

* You and your covered dependents may receive an eye exam and either one complete pair of glasses or contact lenses every calendar year.

What The Plan Covers

Other Available Benefits

The Vision Plan also provides access to the following discounts for you and your covered dependents through EyeMed network providers:

Premium lens options at 20% to 60% discount **in addition to the standard lens copay including:**

- Polycarbonate lenses \$0 copay
- UV coating \$15 copay
- Scratch resistant lenses \$15 copay
- Standard anti-reflective coating \$35 copay
- Standard progressive lenses \$50 copay
- Premium progressive lenses 20% off retail price
- Other lens options at 20% off retail
- The Contact Lens Replacement Program, available through the mail (www.eyemedcontacts.com)
- U.S. Laser Network discount of 15% or 5% off lowest advertised price for network provider for LASIK or PRK procedures (www.eyemedlasik.com)

Out-Of-Network Benefits

If you choose a provider who does not participate in the EyeMed Vision network, the following services are covered and paid to you directly:

SERVICE	YOUR REIMBURSEMENT
Eye Exam (Glasses or Contacts)*	Up to \$35
Frames*	Up to \$65
Lenses (Standard Uncoated plastic):*	
Single Vision	Up to \$25
Bifocals	Up to \$40
Trifocals	Up to \$55
Lenticular	Up to \$55
Contact Lenses: *	
Cosmetic	Up to \$104
Medically Necessary	Up to \$200
Contact Lens Fit and Follow-Up Exam**	Up to \$40

* You and your covered dependents may receive an eye exam and either one complete pair of glasses or contact lenses every calendar year.

What The Plan Covers

How To Access Services

Benefits through the EyeMed Vision Network are available at optical departments at Sears, JC Penney, Target, participating Pearle Vision Centers, LensCrafters, and independent Optometrists and Ophthalmologists.

Call EyeMed at 866.723.0514 for a provider directory automated system to find a provider near you, or log on to www.eyemedvisioncare.com. At the provider's office, identify yourself as a Travelers Plan participant.

If you choose to use an out-of-network provider, you must pay the provider at the time of service and submit a copy of your receipt along with a claim form to EyeMed within 90 days to request reimbursement. Claim forms are available at www.eyemedvisioncare.com or by calling 866.723.0514.

What The Plan Does Not Cover

- Orthoptic or vision training and any associated supplemental testing;
- Plano lenses;
- Lost or broken glasses or contact lenses;
- Specialty lens coatings or treatments (other than those specifically listed under “Other available benefits” above);
- Two pairs of glasses, in lieu of bifocals or trifocals;
- Medical or surgical treatment of the eyes;
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
- Any injury or illness when covered under any Workers’ Compensation or similar law, or which is work-related;
- Sub-normal vision aids or non-prescription lenses;
- Charges in excess of the usual and customary charge for service or materials;
- Charges incurred after the policy ends or after your coverage under the policy ends;
- Experimental or non-conventional treatment or devices; and
- High Index lenses of any material type.

When Coverage Ends

Employee Coverage

Your coverage under the plan ends on the earliest of the following:

- The date the plan terminates or is amended so that you are no longer covered;
- The last day of the month 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 end of the month in which you enter the armed forces of any country (other than the armed forces of 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 begin a leave of absence, or begin a disability leave of absence under the company's disability leave policy (contact the ESU for information on continuing coverage in these situations) or your employment terminates within the first five (5) business days of your initial hire date (or your date of rehire);
- 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; or
- 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 coverage ends on the earliest of the following:

- The end of the month in which your spouse, qualified 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 month for which you made the last required contribution for family member coverage;
- The date your family member enters the armed forces of any country or the service of any government agency;

When Coverage Ends

Continuing Coverage Under COBRA

A federal law called COBRA gives you, your spouse and your dependents the right to continue your plan 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. You must pay the entire cost of this coverage, plus a two percent administrative fee. Rates may change each year.

See the COBRA summary for more details on continuing vision coverage.

Role Of Insurer

A federal law called ERISA requires Travelers to disclose certain information about the role of the insurer in the administration and financing of the plan. The plan is administered by EyeMed Vision Care, and insured by Combined Insurance Company of America. Combined Insurance Company of America guarantees payment of benefits for all eligible expenses incurred while the contract is in force.

If you have a question about eligibility, cost, or when coverage begins or ends, you should refer to this summary. If you have a question about covered or excluded benefits or the claims or appeals procedures for the plan, you should refer to the insurance certificate.

If information regarding benefits in this summary conflicts with the insurance certificate, the certificate will govern. Similarly, if information regarding eligibility, cost, or coverage begin or end dates in the certificate conflicts with information in this summary, the summary will govern.

Claims 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 formal 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-SB102L
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.

Claims 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 of the extension prior to the end of the initial 30-day response period. This notice will indicate 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 appeal 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.

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 written appeal is received. You will receive a written decision including the specific reason(s) and the 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.

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).

Claims And Appeal Procedures

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.

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

For full details about the claims and appeals procedures for benefits under the plan, you should refer to the certificate of coverage issued by EyeMed and/or Combined Insurance Company of America.

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.

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 Vision 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 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

Your Rights Under ERISA

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 EyeMed at 866.723.0514. 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 Vision Plan, which is a component program under the Travelers Non-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 Combined Insurance Company of America and EyeMed Vision Care to provide claims administration under the plan. In addition, benefits under the plan are insured by Combined Insurance Company of America. Travelers is responsible for determining who is eligible for coverage, choosing the insurance carrier, deciding the terms of coverage, and collecting and paying premiums. The claims administrator and the insurance carrier – currently EyeMed and Combined Insurance Company of America – are responsible for deciding whether benefits are due and the amount of benefits, and for paying these benefits.

Insurer

Combined Insurance Company of America insures the benefits under the plan. Their address is:
Combined Insurance Company of America
5050 Broadway
Chicago, IL 60640

Medium For Providing Benefits

Benefits under the plan are provided under a group insurance policy issued by Combined Insurance Company of America.

Source Of Contributions

The plan has a group insurance policy with Combined Insurance Company of America. The premiums for this policy are paid by employee contributions.

Plan Year

The plan year is the calendar year.

General Information

Plan Number

The Travelers Non-Trusteed Employee Benefit plan has been assigned the following identification number: 509.

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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