

Form **5500**Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).

► **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089**2010****This Form Is Open to
Public Inspection.****Part I Annual Report Identification Information****For the calendar plan year 2010 or fiscal plan year beginning and ending**

- A** This return/report is for: (1) ☒ a multiemployer plan; (3) ☐ a multiple-employer plan; or
(2) ☐ a single-employer plan; (4) ☐ a DFE (specify)
- B** This return/report is: (1) ☐ the first return/report; (3) ☐ the final return/report;
(2) ☒ an amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ► ☒
- D** Check box if filing under: ☒ Form 5558; ☐ automatic extension; ☐ the DFVC program;
☐ Special extension (enter description)

Part II Basic Plan Information — enter all requested information.

| | |
|---|--|
| 1a Name of plan THE RAILROAD EMPLOYEES NATIONAL VISION PLAN | 1b Three-digit plan number (PN).... ► 509 |
| 2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) NATIONAL CARRIERS' CONFERENCE COMMITTEE 1901 L STREET, NW, SUITE 500 WASHINGTON, DC 20036 | 1c Effective date of plan 01/01/1999 |
| | 2b Employer Identification Number (EIN) 52-2084181 |
| | 2c Sponsor's telephone number 202-862-7200 |
| | 2d Business code (see instructions) 482110 |

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct, and complete.

| | | | |
|----------------------|------------------------------------|------|--|
| SIGN HERE | | | A. K. GRADIA |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | | | |
| | Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |
| SIGN HERE | | | |
| | Signature of DFE | Date | Enter name of individual signing as DFE |

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.Form **5500** (2010)

v.092307.1

3a Plan administrator's name and address (If same as plan sponsor, enter 'Same')

NATIONAL CARRIERS' CONFERENCE
COMMITTEE
1901 L STREET, NW, SUITE 500
WASHINGTON, DC 20036

3b Administrator's EIN

52-2084181

3c Administrator's telephone number

202-862-7200

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:**b** EIN**c** PN**a** Sponsor's name**5** Total number of participants at the beginning of the plan year **5** 151905**6** Number of participants as of the end of the plan year (welfare plans complete only lines **6a**, **6b**, **6c**, and **6d**)**a** Active participants **6a** 147760**b** Retired or separated participants receiving benefits **6b****c** Other retired or separated participants entitled to future benefits **6c****d** Subtotal. Add lines **6a**, **7b**, and **6c** **6d** 147760**e** Deceased participants whose beneficiaries are receiving or are entitled to receive benefits **6e****f** Total. Add lines **6d** and **6e** **6f** 147760**g** Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) **6g****h** Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested **6h****7** Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) **7** 46**8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
| | | | | | | | | | |

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

| | | | | | | | | | |
|----|--|--|--|--|--|--|--|--|--|
| 4E | | | | | | | | | |
| | | | | | | | | | |

9a Plan funding arrangement (check all that apply)

- (1) ☒ Insurance
 (2) ☐ Code section 412(e)(3) insurance contracts
 (3) ☐ Trust
 (4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☒ Insurance
 (2) ☐ Code section 412(e)(3) insurance contracts
 (3) ☐ Trust
 (4) ☐ General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)**a Pension Schedules**

- (1) ☐ **R** (Retirement Plan Information)
 (2) ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) – signed by the plan actuary
 (3) ☐ **SB** (Single-Employer Defined Benefit Plan Information) – signed by the plan actuary

b General Schedules

- (1) ☐ **H** (Financial Information)
 (2) ☐ **I** (Financial Information – Small Plan)
 (3) ☒ **1 A** (Insurance Information)
 (4) ☐ **C** (Service Provider Information)
 (5) ☐ **D** (DFE/Participating Plan Information)
 (6) ☐ **G** (Financial Transaction Schedules)

**SCHEDULE A
(Form 5500)**Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation**Insurance Information**This schedule is required to be filed under section 104 of the
Employee Retirement Income Security Act of 1974.► **File as an attachment to Form 5500.**► Insurance companies are required to provide this information
pursuant to ERISA Section 103(a)(2).

OMB No. 1210-0110

2010**This Form is Open to
Public Inspection.**

For calendar year 2010 or fiscal plan year beginning and ending

| | |
|--|---|
| A Name of plan THE RAILROAD EMPLOYEES NATIONAL VISION PLAN | B Three-digit plan number . ► 509 |
| C Plan sponsor's name as shown on line 2a of Form 5500 NATIONAL CARRIERS' CONFERENCE COMMITTEE | D Employer Identification Number 52-2084181 |

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

| 1 Coverage: | | | | | |
|---|----------------------|--|--|-------------------------|---------------|
| (a) Name of insurance carrier VISION SERVICE PLAN | | | | | |
| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
| | | | | (f) From | (g) To |
| 06-1227840 | 39616 | 12093046 | 147760 | 01/01/2010 | 12/31/2010 |
| 2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid. | | | | | |
| (a) Total amount of commissions paid | | | (b) Total amount of fees paid | | |
| 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). | | | | | |
| (a) Name and address of the agent, broker or other person to whom commissions or fees were paid | | | | | |

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|--|---------------------------------|--------------------|------------------------------|
| | (c) Amount | (d) Purpose | |
| (a) Name and address of the agent, broker or other person to whom commissions or fees were paid | | | |

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|--|---------------------------------|--------------------|------------------------------|
| | (c) Amount | (d) Purpose | |

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2010
v.092308.1

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

| | | |
|--|--------------|--|
| 4 Current value of plan's interest under this contract in the general account at year end. | 4 | |
| 5 Current value of plan's interest under this contract in separate accounts at year end. | 5 | |
| 6 Contracts With Allocated Funds | | |
| a State the basis of premium rates ▶ | | |
| b Premiums paid to carrier. | 6b | |
| c Premiums due but unpaid at the end of the year. | 6c | |
| d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. | 6d | |
| Specify nature of costs. ▶ | | |
| e Type of contract (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶ | | |
| f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ <input type="checkbox"/> | | |
| 7 Contracts with Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) | | |
| a Type of contract (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶ | | |
| b Balance at the end of the previous year. | 7b | |
| c Additions: (1) Contributions deposited during the year. | 7c(1) | |
| (2) Dividends and credits | 7c(2) | |
| (3) Interest credited during the year | 7c(3) | |
| (4) Transferred from separate account. | 7c(4) | |
| (5) Other (specify below). | 7c(5) | |
| ▶ | | |
| (6) Total additions. | 7c(6) | |
| d Total of balance and additions (add b and c(6)). | 7d | |
| e Deductions: | | |
| (1) Disbursed from fund to pay benefits or purchase annuities during year. | 7e(1) | |
| (2) Administration charge made by carrier. | 7e(2) | |
| (3) Transferred to separate account | 7e(3) | |
| (4) Other (specify below). | 7e(4) | |
| ▶ | | |
| (5) Total deductions. | 7e(5) | |
| f Balance at the end of the current year (subtract e(5) from d). | 7f | |

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes on this report.

8 Benefit and contract type (check all applicable boxes)

- | | | | |
|--|--|---|--|
| a <input type="checkbox"/> Health (other than dental or vision) | b <input type="checkbox"/> Dental | c <input checked="" type="checkbox"/> Vision | d <input type="checkbox"/> Life Insurance |
| e <input type="checkbox"/> Temporary disability (accident and sickness) | f <input type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug |
| i <input type="checkbox"/> Stop loss (large deductible) | j <input type="checkbox"/> HMO contract | k <input type="checkbox"/> PPO contract | l <input type="checkbox"/> Indemnity contract |
| m <input type="checkbox"/> Other (specify) ▶ | | | |

9 Experience-rated contracts

| | | | |
|---|-----------------|----------|----------|
| a Premiums: (1) Amount received | 9a(1) | 17069485 | |
| (2) Increase (decrease) in amount due but unpaid | 9a(2) | | |
| (3) Increase (decrease) in unearned premium reserve | 9a(3) | | |
| (4) Earned ((1) + (2) - (3)) | 9a(4) | | 17069485 |
| b Benefit charges: (1) Claims paid | 9b(1) | 16924947 | |
| (2) Increase (decrease) in claim reserves | 9b(2) | -96701 | |
| (3) Incurred claims (add (1) and (2)) | 9b(3) | | 16828246 |
| (4) Claims charged | 9b(4) | | |
| c Remainder of premium: (1) Retention charges (on an accrual basis) — | | | |
| (A) Commissions | 9c(1)(A) | | |
| (B) Administrative service or other fees | 9c(1)(B) | 1194865 | |
| (C) Other specific acquisition costs | 9c(1)(C) | | |
| (D) Other expenses | 9c(1)(D) | | |
| (E) Taxes | 9c(1)(E) | | |
| (F) Charges for risks or other contingencies | 9c(1)(F) | | |
| (G) Other retention charges | 9c(1)(G) | | |
| (H) Total retention | 9c(1)(H) | | 1194865 |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) | 9c(2) | | |
| d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | 9d(1) | | |
| (2) Claim reserves | 9d(2) | | 4231237 |
| (3) Other reserves | 9d(3) | | |
| e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) | 9e | | |

10 Nonexperience-rated contracts:

| | | |
|---|------------|--|
| a Total premiums or subscription charges paid to carrier | 10a | |
| b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount | 10b | |
| Specify nature of costs ▶ | | |

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is 'Yes,' specify the information not provided ▶

**Application for Extension of Time
To File Certain Employee Plan Returns**

OMB No. 1545-0212

► For Privacy Act and Paperwork Reduction Act Notice, see instructions.

File With IRS Only**Part I Identification**

| | |
|---|---|
| A Name of filer, plan administrator, or plan sponsor (see instructions) NATIONAL CARRIERS' CONFERENCE <small>Number, street, and room or suite number (If a P.O. box, see instructions)</small> 1901 L STREET, NW, SUITE 500 <small>City or town, state, and ZIP code</small> WASHINGTON, DC 20036 | B Filer's Identifying Number (see instructions). <input checked="checked" type="checkbox"/> Employer identification number (EIN). 52-2084181 <input type="checkbox"/> Social security number (SSN) |
|---|---|

| C | Plan name | Plan number | Plan year ending | | |
|---|---|-------------|------------------|----|------|
| | | | MM | DD | YYYY |
| 1 | THE RAILROAD EMPLOYEES NATIONAL VISION PLAN | 509 | 12 | 31 | 10 |
| 2 | | | | | |
| 3 | | | | | |

Part II Extension of Time to File Form 5500 Series, and/or Form 8955-SSA

- 1 I request an extension of time until 10/15/2011 to file Form 5500 series (see instructions).
Note. A signature IS NOT required if you are requesting an extension to file Form 5500 series.

- 2 I request an extension of time until _____ to file Form 8955-SSA(see instructions).
Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.

The application **is automatically approved** to the date shown on line 1 and/or line 2 (above) if: **(a)** the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested, and **(b)** the date on line 1 and/or line 2 (above) is no more than the 15th day of the third month after the normal due date.

You must attach a copy of this Form 5558 to each Form 5500 and 5500-EZ filed after the due date for the plans listed in C above.

Note: A signature is not required if you are requesting an extension to file Form 5500 or Form 5500-EZ.

Part III Extension of Time to File Form 5330 (see instructions)

- 2 I request an extension of time until _____ to file Form 5330.
 You may be approved for up to a six (6) month extension to file Form 5330, after the normal due date of Form 5330.

| | | | | |
|--|---|---|--|--|
| a Enter the Code section(s) imposing the tax..... | ► | a | | |
| b Enter the payment amount attached | ► | b | | |
| c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amentment date | ► | c | | |

- 3 **State in detail why you need the extension**

| |
|--|
| |
| |
| |
| |
| |
| |
| |
| |
| |
| |

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ►

Date ►

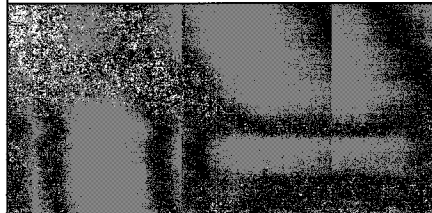
Form **5500**Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan**This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).****► Complete all entries in accordance with the instructions to the Form 5500.**OMB Nos. 1210-0110
1210-0089**2010****This Form Is Open to Public Inspection.****Part I Annual Report Identification Information****For the calendar plan year 2010 or fiscal plan year beginning and ending**

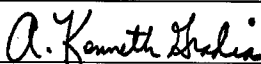
- A** This return/report is for: (1) ☒ a multiemployer plan; (3) ☐ a multiple-employer plan; or
 (2) ☐ a single-employer plan; (4) ☐ a DFE (specify)
- B** This return/report is: (1) ☐ the first return/report; (3) ☐ the final return/report;
 (2) ☒ an amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☒
- D** Check box if filing under: ☒ Form 5558; ☐ automatic extension; ☐ the DFVC program;
☐ Special extension (enter description)

Part II Basic Plan Information — enter all requested information.

| | |
|---|--|
| 1a Name of plan THE RAILROAD EMPLOYEES NATIONAL VISION PLAN | 1b Three-digit plan number (PN).... ► 509 |
| 2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) NATIONAL CARRIERS' CONFERENCE COMMITTEE 1901 L STREET, NW, SUITE 500 WASHINGTON, DC 20036 | 1c Effective date of plan 01/01/1999 2b Employer Identification Number (EIN) 52-2084181 2c Sponsor's telephone number 202-862-7200 2d Business code (see instructions) 482110  |

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct, and complete.

| | | |
|--|--------------------|--|
| SIGN HERE  Signature of plan administrator | 10-13-2011 Date | A. K. GRADIA Enter name of individual signing as plan administrator |
| SIGN HERE Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |
| SIGN HERE Signature of DFE | Date | Enter name of individual signing as DFE |

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.Form **5500** (2010)

v.092307.1

3a Plan administrator's name and address (If same as plan sponsor, enter 'Same')

NATIONAL CARRIERS' CONFERENCE
COMMITTEE
1901 L STREET, NW, SUITE 500
WASHINGTON, DC 20036

3b Administrator's EIN

52-2084181

3c Administrator's telephone number

202-862-7200

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

| | | |
|---|-----------|--------|
| 5 Total number of participants at the beginning of the plan year | 5 | 151905 |
| 6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a , 6b , 6c , and 6d) | | |
| a Active participants | 6a | 147760 |
| b Retired or separated participants receiving benefits | 6b | |
| c Other retired or separated participants entitled to future benefits | 6c | |
| d Subtotal. Add lines 6a , 7b , and 6c | 6d | 147760 |
| e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits | 6e | |
| f Total. Add lines 6d and 6e | 6f | 147760 |
| g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) | 6g | |
| h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested | 6h | |
| 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) | 7 | 46 |

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

| | | | | | | | | | |
|----|--|--|--|--|--|--|--|--|--|
| 4E | | | | | | | | | |
|----|--|--|--|--|--|--|--|--|--|

9a Plan funding arrangement (check all that apply)

- (1) ☒ Insurance
 (2) ☐ Code section 412(e)(3) insurance contracts
 (3) ☐ Trust
 (4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☒ Insurance
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 (3) ☐ Trust
 (4) ☐ General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- (1) ☐ **R** (Retirement Plan Information)
 (2) ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) – signed by the plan actuary
 (3) ☐ **SB** (Single-Employer Defined Benefit Plan Information) – signed by the plan actuary

b General Schedules

- (1) ☐ **H** (Financial Information)
 (2) ☐ **I** (Financial Information – Small Plan)
 (3) ☒ **1 A** (Insurance Information)
 (4) ☐ **C** (Service Provider Information)
 (5) ☐ **D** (DFE/Participating Plan Information)
 (6) ☐ **G** (Financial Transaction Schedules)