UNITEDhealthcare®
RAILROAD ACCOUNTS
PO BOX 150453
HARTFORD, CT 06115-0453

07/11/08

J Q RAILROADER
AND SPOUSE AND DEPS IF APPLICABLE
1400 ANY STREET
ANYTOWN, NE 00000-0000

The Railroad Employees National Health and Welfare Plan
The Railroad Employees National Dental Plan
The Railroad Employees National Vision Plan

We have been informed that you have ceased rendering compensated service. This may lead to termination of coverage under the above Plans. If your coverage does terminate, a federal law called COBRA may give you and your eligible dependents the right to continue that coverage, at your own cost.

Here are some questions and answers that may help you:

Q. When will my coverage end?

A. This depends on the reason why you stopped rendering compensated service. Your employee booklets describe when your coverage ends based on this reason. If you are unsure when your coverage ends, **ask** your supervisor or union representative, or **call** your benefits administrator. Your booklets have the toll-free numbers for these administrators.

Q. How long can I continue COBRA coverage?

A. You and any of your Eligible Dependents can continue coverage as follows:

- Up to 18 months following the date you last rendered compensated service.
- Up to 29 months following the date you last rendered compensated service if you or any of your Eligible Dependents is awarded an annuity under either the Railroad Retirement Act or the Social Security Act by reason of total and permanent disability, and
  - the total and permanent disability began at any time before the end of 60 days from the date you last rendered compensated service,
    and
  - you or your Eligible Dependent notified United HealthCare of the total and permanent disability not later than 60 days from the date the Railroad Retirement Board or the Social Security Administration made its determination, and before the end of the 18-month period following the date you last rendered compensated service.
- If you were already entitled to Medicare when you last rendered compensated service, you may still continue your employee coverage for up to 18 months. Your Eligible Dependents can continue coverage until the later of:
  - 18 months from the date you last rendered compensated service, or
  - 36 months from the date you became entitled to Medicare.

You or your Eligible Dependents may be covered without enrolling for COBRA continuation coverage for all or part of this 18, 29 or 36 month period depending on the reason why you last rendered compensated service. If this happens, these months of coverage are part of the COBRA 18, 29 or 36 month continuation period. When that coverage ends, you may purchase COBRA continuation coverage for any months that remain in the 18, 29 or 36 month period following the date you last rendered compensated service.

Q. Can COBRA coverage ever end sooner than the period described above?

A. Yes. COBRA coverage can end sooner when:
- an individual first becomes covered under another employer's group health plan after your election for COBRA coverage, unless that other plan has a pre-existing condition limitation that applies to the individual;
- an individual first becomes entitled to Medicare after your election for COBRA coverage;
- the required payment for COBRA coverage is not made;
- your employer ceases to provide any group health plan for any employee.

Q. How do I enroll for COBRA coverage?

A. To enroll for COBRA continuation coverage, complete and return the enclosed Election Form within 60 days of the later of:
- the date Plan coverage ends as a result of your ceasing to render compensated service, or
- the date this notice is sent.

Q. How much does COBRA coverage cost?

A. The cost for COBRA continuation coverage is shown on the enclosed Election Form.

Q. When must I make my first payment for COBRA coverage?

A. If you elect COBRA continuation coverage, you must pay for this coverage retroactive to the date your coverage would have otherwise ended. You have up to 45 days after your election to pay for all retroactive COBRA coverage. We recommend, however, that you include a minimum of one month's payment with your Election Form, since claims will not be paid until after payment for coverage has been received.

Q. What should I do if I do not want COBRA coverage?

A. Give this letter and Election Form to your spouse. He or she has a right to enroll for COBRA continuation coverage even if you do not enroll.

Q. If I have additional questions, where can I get more information?

A. Call United HealthCare toll-free at 1-800-842-5252 for any additional assistance you require.

IMPORTANT NOTICE IF YOU "OPTED OUT" OF MEDICAL BENEFITS

Some employees have the right to "opt out" of medical benefits. If you are one of these and elected to "opt out" of medical benefits, you remain covered for on-duty injuries. You have the right to continue this coverage under COBRA, but you should be aware that benefits will be payable only for injuries that occur at work. If you wish to continue medical benefits for on-duty injuries under COBRA, you can obtain the monthly rates by calling United HealthCare at 1-800-842-9905.

Your election to "opt out" terminated all of your dependents' coverage and you cannot continue any medical benefits for them under COBRA.

If you did "opt out," you and your dependents remain covered for dental and vision benefits and you can continue those benefits by checking the appropriate boxes on the COBRA Election Form.

United HealthCare

ELECTION FORM for COBRA
Continuation of Group Health and/or Dental and/or Vision Coverage

See INSTRUCTIONS on back before completing form.

Name of Employee	Employee SSN	Employee Date of Birth	HA IND: N Run Date: 07/11/08 Event: DISB DLW: 05/01/08
Address (street)			Date form received
City	State	Zip Code	Phone Number ( )
Name of Employer	Date last worked		Name of Union (Which represented you)

REASON FOR LEAVING WORK (CHECK ONE)

☐ Furloughed ☐ Leave of Absence ☐ Pregnancy Leave ☐ Suspended

☐ Resigned ☐ Dismissed ☐ Disabled ☐ Terminated (Give Reason Below)

☐ Retirement (Supply Information Below)

Date Applied for Annuity - ____________

Type: ☐ Age ☐ Disability

Months of Service: ____________

COVERAGE AND MONTHLY AMOUNT

You can continue only the benefits you had when you lost coverage. You can elect employee, spouse, children coverage individually or in any combination. Please check the box next to the benefits you had and want to continue.

	Health Benefits (see reverse side)		Dental Benefits (see reverse side)		Vision Benefits (see reverse side)
	MMCP OR CHCB	BHCB	New Level	Old Level	
Employee	☐ $ 552.17	☐ $ 441.74	☐ $ 23.85	☐ $ 24.89	☐ $ 5.04
Spouse	☐ $ 552.17	☐ $ 441.74	☐ $ 23.85	☐ $ 24.89	☐ $ 5.04
Children	☐ $ 340.51	☐ $ 272.41	☐ $ 40.35	☐ $ 42.11	☐ $ 1.11

If spouse is covered:	Spouse's Name	Date of Birth
Signature		Date Signed

INSTRUCTIONS FOR COMPLETING THE ELECTION FORM

General Instructions

1. Please print all entries.
2. Please complete all required entries on the form.
3. You can choose to continue either group health benefits, dental benefits, vision benefits, or any combination of the three. You can also choose to cover the employee only, spouse only or all dependent children only or any combination. Be sure to check the appropriate block for each of the coverages you want.
4. To determine the amount of your payment add the amounts next to each block you checked.
5. Mail the Election Form and your payment to:

    UNITED HEALTHCARE
    RAILROAD ACCOUNTS
    PO BOX 150453
    HARTFORD, CT 06115-0453

Health Benefits

You can continue only the benefits (MMCP, CHCB, BHCB) you had at the time coverage was lost. Check the box(s) under the column for your benefits.

Dental Benefits

Dental benefits do not begin until after the employee has completed one year of service. If coverage ends during the first 12 months of service, only group health benefits can be continued.

Dental benefits have been improved under many collective bargaining agreements. If your collective bargaining agreement calls for improved benefits, check the box on the reverse side under "New Level". If your collective bargaining agreement does not call for improved benefits, check the box on the reverse side under "Old Level".

If you do not know whether you have new level or old level dental benefits, ask your supervisor or union representative.

Vision Benefits

Vision benefits do not begin until after the employee has completed one year of service. If coverage ends during the first 12 months of service, this benefit cannot be continued.

Not all railroads and labor organizations have reached agreement to provide vision benefits to employees. Your supervisor can tell you if you have this benefit. If you choose to continue vision benefits and are not eligible, we will advise you by letter. This will not affect the continuation of other benefits.

Employee's SSN: ______________

Re: Disability Letter

We are in receipt of information from your employer indicating that you stopped working because you are disabled. In order for your health coverage to continue, we must have the proof of your disability statement below completed by your attending physician.

The completed form should be mailed or faxed to the Health Care Company administrating your benefits. The mailing addresses and fax numbers are:

UnitedHealthcare/Railroad Acco
P.O. Box 5500
Kingston, NY 12402-5500
Fax #: (845) 382-6699

Aetna
P.O. Box 981106
El Paso, TX 79998-1106
Fax #: (859) 455-8650

Highmark
P.O. Box 890381
Camp Hill, PA. 17089-0381
Fax #: (304) 424-3180

IF THIS PROOF OF DISABILITY IS NOT RECEIVED, YOUR COVERAGE WILL BE TERMINATED.

If you are unsure who your Health Care Company is, please check your ID Card or call United HealthCare at (800)842-9905.

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TO BE COMPLETED BY ATTENDING PHYSICIAN:

I certify that ______________________ has been disabled from performing his/her regular occupation from ______________________ (Date) to ______________________ (Date)

due to the following condition(s):

____

____

Is the employee permanently disabled from his/her regular occupation? YES NO (Please circle one.)

If no, please give us an estimated return to work date ______________________ , or the date of his/her next appointment with you ______________________

____

Physician's Signature Date