

Railroad Employees National

Health Flexible Spending Account Plan

2013



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I

IMPORTANT NOTICE TO EMPLOYEES

This booklet describes the basic features of the Railroad Employees National Health Flexible Spending Account Plan (the "**Plan**"). The **Plan** is a "cafeteria plan" under Section 125 of the Internal Revenue Code. It was established and is maintained pursuant to collective bargaining agreements between various freight railroads and railway labor organizations. Although the National Carriers' Conference Committee is the **Administrator** of the **Plan**, UnitedHealthcare has been designated to perform most of the **Administrator's** functions and duties.

This booklet is the summary plan description required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA") for the **Plan** and is also part of the official **Plan** document.

The words "you" and "your," when used in this booklet, refer to a **Participant** who has elected benefits under the **Plan**, and not to the **Spouse** or a **Dependent** of such a person. In addition, some of the terms used in this booklet are in **bold print**. These terms have a special meaning under the **Plan** that is set forth in the "Definitions" section of the booklet at pages 23 through 25.

II OVERVIEW OF THE PLAN

Benefits Offered

The **Plan** allows **Participants** to use pre-tax wage deductions to pay for certain medical care expenses that satisfy requirements established by the Internal Revenue Service (“IRS”) through a Health Flexible Spending Arrangement (“**Health FSA**”). Subject to the rules outlined in this booklet, a **Participant** may elect whether or not to receive **Health FSA** benefits in any given **Plan Year**.

- A **Participant** who elects to receive **Health FSA** benefits agrees before the start of the **Plan Year** to have a certain amount (up to \$2,500) withheld from wages during the **Plan Year**. Amounts withheld will be remitted to a **Health FSA** trust fund. The **Health FSA** will then reimburse the **Participant** for qualifying **Medical Care Expenses** incurred within his or her **Period of Coverage**, up to the total amount the **Participant** has agreed to have withheld from wages for the **Plan Year**.

Participants generally will not have to pay federal income or payroll taxes either on the amounts that are withheld from their wages under the **Plan** or on any amounts they receive as reimbursement from the **Health FSA**. Such amounts may also be nontaxable under state law, depending on where the **Participant** pays state taxes. As a result, **Participants** who elect **Health FSA** benefits may be able to achieve a significant tax savings. Neither the **Plan**, the National Carriers’ Conference Committee, nor any employer makes any guarantee or commitment, however, that such amounts will be tax exempt. Please consult a tax advisor if you have any questions about whether benefits or wage deductions under the **Plan** are taxable.

Note, too, that since Railroad Retirement taxes are not withheld on your pre-tax contributions to the **Plan**, a reduction in your future Railroad Retirement benefits is possible.

Health FSA benefits and the rules that govern them are described in more detail in Part III of this booklet.

Effective Date of Plan

The **Plan's** effective date is January 1, 2013.

Participation

To be eligible to participate in the **Plan**, you must (a) reside in the United States and (b) be employed by a railroad under the terms of a collective bargaining agreement that provides for benefits under the **Plan** and, if the collective bargaining agreement is not a national agreement, that is approved for participation in the **Plan** by the National Carriers' Conference Committee. If you meet these requirements on both September 30 and December 31 prior to the start of a **Plan Year**, you will be a **Participant** for that **Plan Year** provided that, on the first day of the **Plan Year**, you are employed by a railroad under the terms of a collective bargaining agreement that provides for benefits under the Railroad Employees National Health and Welfare Plan or the National Railway Carriers and United Transportation Union Health and Welfare Plan.

Important Note: Being a **Participant** for a **Plan Year** does not necessarily mean that you will receive **Health FSA** benefits for that **Plan Year**. You can receive **Health FSA** benefits only if you make a valid election for them by completing and returning the enrollment materials (as described at pages 4 through 5).

Termination of Participation

If you are a **Participant** for a **Plan Year**, that status will continue to the end of the **Plan Year** unless one of the following events happens:

- The **Plan** terminates;
- You cease to reside in the United States;
- You cease to be employed by a participating railroad (for example, because of death or retirement);
- Your railroad or union ceases to participate in the **Plan**; or

- You change jobs and are no longer subject to a collective bargaining agreement that provides for benefits under the **Plan**.

If any of these events happens during the **Plan Year**, your status as a **Participant** will automatically terminate on the date of the event. There is one significant exception to this rule. If there is a temporary change in your employment status that would cause your status as a **Participant** to terminate, and you are restored to your original employment status within 30 days, the temporary change will be disregarded and you will continue to be a **Participant**.

- *Example:* On May 1, Employee Smith is a **Participant** employed under a collective bargaining agreement with a railroad that provides for benefits under the **Plan**. On May 2, he takes a non-agreement job. On May 30, he goes back to his original job. Smith continues to be a **Participant** for the entire month of May, because the change in his employment status lasted less than 30 days.

If your status as a **Participant** terminates before the end of the **Plan Year**, all wage deductions for you under the **Plan** will cease, and your **Period of Coverage** for the **Health FSA** will terminate, unless **COBRA Coverage** is elected and required contributions are paid in a timely manner as described at pages 20 through 22.

Electing Benefits

Several months before the start of each **Plan Year**, UnitedHealthcare will mail out information about open enrollment for the **Plan** to all persons whom its records indicate are eligible to become **Participants** for that **Plan Year**. The materials will include information about the **Plan**, and instructions for enrolling in the **Plan** online. Upon request, UnitedHealthcare will mail a copy of the enrollment materials free of charge to any person eligible to participate in the **Plan** for that **Plan Year** who does not want to, or is not able to, enroll online. To request a paper copy of the enrollment materials, contact UnitedHealthcare at 1-888-298-9754.

For a benefit election to be effective, the online enrollment must be completed by the enrollment deadline specified by UnitedHealthcare in the open enrollment materials. If paper enrollment forms are being used, then the enrollment forms must be filled out completely, all requested information must be provided, and must either be actually received by UnitedHealthcare on or before the enrollment deadline specified by UnitedHealthcare in the enrollment materials or sent by first-class mail to UnitedHealthcare and postmarked by that date.

If you are eligible to participate in the **Plan** and you do not complete and submit/return all required enrollment forms before the enrollment deadline specified by UnitedHealthcare in the enrollment materials, you will be deemed to have elected to receive your full wages during the next **Plan Year**, and will not receive any **Health FSA** benefits for that **Plan Year**.

Because elections must be made before the start of a **Plan Year**, it is possible that in some cases, a person who properly fills out and timely returns the enrollment forms will not become a **Participant** at the start of the **Plan Year**. (This would occur, for example, if the person is no longer employed on the first day of the **Plan Year**, or is employed but no longer subject to a collective bargaining agreement that provides for benefits under the **Plan**). In these circumstances, the person's benefit election will be void, and he or she will not receive any **Health FSA** benefits.

Irrevocability of Election

Once you have made an election to receive **Health FSA** benefits (or not to receive them) for a **Plan Year**, that decision is irrevocable for the duration of the **Plan Year**. You cannot change the amount that is deducted from your wages. An election will not carry over to the next **Plan Year**; however, if you will be a **Participant** for the next **Plan Year**, you will have an opportunity to make a new election during the open enrollment period for that **Plan Year**.

Contributions and Wage Deductions

Benefits under the **Plan** are funded by **Participant** contributions and are typically made through pre-tax wage deductions. But if a **Participant** has insufficient wages available to cover his or her

contribution to the **Health FSA** through a pre-tax wage deduction, the **Participant** must make that contribution directly to the **Health FSA** trust fund on an after-tax basis in order to continue **Health FSA** benefits. See page 9.

Each employer participating in the **Plan** will designate certain paydays during the year on which it will make wage deductions. Employers may use different systems, depending on how frequently they pay their employees. For example, employers may make wage deductions every week, every two weeks, once a month, or twice a month. Employers will remit the amounts deducted from wages to the **Health FSA** trust fund.

Fraud

The **Administrator** regularly evaluates claims to detect fraud or false statements. If a claim has been submitted for payment or paid by the **Plan** as a result of fraudulent or false representations, such as enrolling or not disenrolling a dependent who is not eligible for coverage, then, in addition to pursuing all available legal remedies, the **Plan** reserves the right to recover fully all amounts, with interest, improperly paid or costs incurred by the **Plan** by reason of any person's fraud or false statement, to seek repayment for all costs incurred by the **Plan** to collect these amounts, including attorney's fees and court costs, and to cancel or rescind coverage under the **Plan**.

III

HEALTH FSA BENEFITS

Overview of the Health FSA

The **Health FSA** allows **Participants** to pay for qualifying **Medical Care Expenses** through pre-tax wage deductions. To elect **Health FSA** benefits for a **Plan Year**, you must choose the amount that you want to have deducted from your wages and contributed to the **Health FSA** over the course of the **Plan Year**. The election must be made during the open enrollment period before the start of the **Plan Year**. The amount that you choose to have deducted from your wages is known as your **Total Annual Health FSA Benefit**.

As long as you continue to work and earn enough wages throughout the **Plan Year** to permit your employer to do so, your employer will deduct an amount equal to your **Total Annual Health FSA Benefit** in equal installments through wage deductions made on designated paydays and will remit those amounts to the **Health FSA** trust fund. If you cease to work and earn wages, then, in order to continue your **Health FSA** benefits, you will generally be required to make after-tax contributions equal to the amounts your employer would otherwise have remitted (see page 9).

So long as contributions continue to be made to the **Health FSA** trust fund (either for you through pre-tax wage deductions made by your employer or by you on a self-pay basis during periods when you are not earning sufficient wages), the **Health FSA** will reimburse you up to the amount of your **Total Annual Health FSA Benefit** for any **Medical Care Expenses** incurred within your **Period of Coverage**, regardless of how much has actually been contributed to the **Health FSA** on your behalf.

Any portion of your **Total Annual Health FSA Benefit** that is not used for reimbursement of **Medical Care Expenses** incurred within a **Period of Coverage** will be forfeited. Any amounts not used within the **Period of Coverage** cannot be carried over to the

next **Plan Year**. As a result, it is very important that you do not elect a **Total Annual Health FSA Benefit** greater than the amount of **Medical Care Expenses** you expect to incur within the **Period of Coverage**.

- *Example 1.* Before the start of the 2013 **Plan Year**, Employee Jones elects a **Total Annual Health FSA Benefit** of \$2,400. Jones's employer makes wage deductions twice a month. Jones continues to work and earn wages throughout 2013. As a result, on designated paydays in 2013, Jones's employer will deduct \$100 from her wages. The **Health FSA** will reimburse Jones for up to \$2,400 in **Medical Care Expenses** incurred in 2013 and, if Jones has not used all of her **Total Annual Health FSA Benefit** for reimbursement of **Medical Care Expenses** by December 31, 2013, those funds can be used to reimburse **Medical Care Expenses** incurred during the **Grace Period** (January 1, 2014 through January 30, 2014).
- *Example 2.* Same facts as in Example 1. During 2013, Jones incurs and is reimbursed for \$2,000 in **Medical Care Expenses**. She does not incur any **Medical Care Expenses** during the **Grace Period** (January 1, 2014 through January 30, 2014). Jones has forfeited \$400 (the \$2,400 withheld from her wages during 2013, minus the \$2,000 she was reimbursed).

Eligibility

All **Participants** are eligible to participate in the **Health FSA**. **Participants** are only eligible to receive **Health FSA** benefits, however, for **Medical Care Expenses** incurred during a **Period of Coverage** (see pages 11 through 15).

Maximum and Minimum Benefit

The maximum **Total Annual Health FSA Benefit** that you may elect for any **Plan Year** is \$2,500. The minimum is \$120.

Contributions and Wage Deductions

If you elect to receive **Health FSA** benefits, then in general, on each designated payday within the **Plan Year** (or, if shorter, your **Period of Coverage**) your employer will make a deduction from your wages equal to your **Total Annual Health FSA Benefit** divided by the number of designated paydays within the **Plan Year**. The employer will remit this amount to the **Health FSA** trust fund.

Your employer will not make a wage deduction for **Health FSA** benefits, however, on any designated payday on which you do not have sufficient wages available to allow the appropriate deduction to be made in full. If the employer does not make a wage deduction because you have insufficient wages, then, in order to continue your **Health FSA** coverage (except in the special case of **FMLA Leave**, discussed below at pages 12 through 14), you must make a contribution to the **Health FSA** trust fund equal to the wage deduction that your employer would otherwise have made. Any such contribution by the **Participant** is made on an after-tax basis.

If you are required to make an after-tax contribution in order to continue **Health FSA** coverage, UnitedHealthcare will send you a notice containing instructions for payment and stating the amount due, the date by which payment must be received, and the date on which your **Period of Coverage** will terminate if payment is not received.

Health FSA Accounts

If you elect to receive **Health FSA** benefits, UnitedHealthcare will establish a **Health FSA Account** for you in order to keep track of the amounts you are reimbursed for **Medical Care Expenses** incurred within the **Period of Coverage**. This **Health FSA Account** will merely be a recordkeeping device. It will not be funded, and you won't earn any interest on amounts credited to it.

At any given time, the balance in your **Health FSA Account** will be equal to your **Total Annual Health FSA Benefit** for the **Plan Year** minus any amounts for which you have already been reimbursed for **Medical Care Expenses** incurred within the

applicable **Period of Coverage**. The amount of reimbursement for **Medical Care Expenses** available to you at any given time will be equal to the balance in your **Health FSA Account**, but will not depend on the amounts actually remitted to the **Health FSA** on your behalf.

- *Example.* Employee Smith elects a **Total Annual Health FSA Benefit** of \$2,400 for the 2013 **Plan Year**. Consequently, Smith's employer deducts a total of \$200 per month from Smith's wages in 2013 and remits that amount to the **Health FSA**. On February 2, Smith incurs a **Medical Care Expense** of \$1,000, and submits it for reimbursement. Assuming that the **Medical Care Expense** meets all the criteria for reimbursement, the **Health FSA** will reimburse Smith for the entire \$1,000, even though only \$200 has been remitted to the **Health FSA** as of February 2. Once the reimbursement is made, Smith will have \$1,400 remaining in his **Health FSA Account**, and will be entitled to be reimbursed up to that amount for qualifying **Medical Care Expenses** incurred within his **Period of Coverage**.

Medical Care Expenses

For purposes of the **Health FSA**, a **Medical Care Expense** must be an expense incurred by you, your **Spouse** or your **Dependents** for "medical care" as defined in Section 213(d) of the Internal Revenue Code during the **Period of Coverage**. **Medical Care Expenses** do not include any expenses that have been or can be reimbursed through insurance or any other health plan (including a railroad health and welfare plan or hospital association, another employer's group health plan, Medicare or Medicaid).

Following are some examples of expenses that may qualify as **Medical Care Expenses**:

- Deductibles or co-payments under a medical, prescription drug, dental or vision plan;

- Medical expenses for persons who qualify as your **Dependents** but who are not covered under your health insurance or any other plan; and
- Medical expenses that are not covered by your medical plan or any other plan.

Some types of expenses, however, do not qualify as **Medical Care Expenses** and are not eligible for reimbursement under any circumstances. These include expenses for which a federal itemized deduction is taken for federal income tax purposes; premiums or employee contributions for health, dental or vision coverage; over-the-counter drugs for which you do not have a prescription; health or fitness club membership for general health; laetrile; weight reduction programs for general health; personal care items; cosmetic services and supplies; cosmetic surgery or other cosmetic procedures that do not qualify as medical care under federal tax law; hair transplants; and marriage or family counseling. You can get more information about eligible and ineligible expenses online at www.myuhc.com or at www.rriinfodepot.com or by calling UnitedHealthcare toll free at 1-888-298-9754.

Period of Coverage

A **Medical Care Expense** is only reimbursable if it is incurred within your **Period of Coverage**. In general, your **Period of Coverage** will start on the first day of the **Plan Year** and end on the last day of the **Plan Year**. In addition, if you have unused amounts in your **Health FSA Account** and remain a **Participant** or COBRA qualified beneficiary on the last day of the **Plan Year**, your **Period of Coverage** will continue through January 30 of the year immediately following the **Plan Year**. Thus, the **Period of Coverage** generally includes the **Plan Year** and a 30-day **Grace Period**.

There are several important exceptions to this rule, however. First, if your status as a **Participant** terminates during the **Plan Year**, your **Period of Coverage** will automatically terminate at that time, unless you make a valid election for **COBRA Coverage** and timely pay for that coverage.

Second, if no contribution is made to the **Health FSA** with respect to a designated payday (either for you through a wage deduction made by your employer or by you on an after-tax basis), then your **Period of Coverage** will terminate effective on the last designated payday on which a contribution was made. If no contribution is made to the **Health FSA** with respect to the first designated payday in a **Plan Year**, your **Period of Coverage** will be deemed not to have commenced at the beginning of the **Plan Year**. Thus, in effect, you will have no **Period of Coverage** and will not be entitled to receive **Health FSA** benefits (unless your **Period of Coverage** starts at a later date because you return from **Military Leave**, as discussed below).

This second exception won't apply, however, if the reason that no wage deduction is made by the employer is that you are on or are returning from **FMLA Leave**. If you have sufficient wages available during a period of **FMLA Leave**, your employer will make wage deductions in the ordinary manner. If not, you may remit contributions on a self-pay, after-tax basis, just as you would if you were on some other type of unpaid leave. If you do not remit these contributions, however, your **Period of Coverage** will not terminate. Instead, the employer will make supplemental wage deductions equal to the amount of your missed contributions when you return to work.

Third, there are special rules that apply to **Participants** who are absent from work because of **Military Leave**. If you are absent because of **Military Leave**, you have the same right as other **Participants** to continue **Health FSA** benefits by making contributions on a self-pay, after-tax basis. If you fail to make such contributions, your **Period of Coverage** will terminate (or will not commence) as provided above. But if you return from **Military Leave** during the **Plan Year**, your **Period of Coverage** will automatically resume (or commence, if it did not commence on the first day of the **Plan Year**), regardless of whether you made self-pay contributions during the period of your absence.

Finally, if you make a valid election of **COBRA Coverage** and timely pay for that coverage (see pages 20 through 22), the **Period of Coverage** will extend through the date on which

COBRA Coverage terminates (plus the **Grace Period**, if applicable).

The following examples illustrate the way these rules work:

- *Example 1.* Employee Smith elects a **Total Annual Health FSA Benefit** of \$2,400. Smith's employer makes wage deductions twice a month, on the 15th day and the last day of each month. Smith works from January into April, and his employer deducts \$100 from each paycheck on each designated payday during this period. During April, Smith is furloughed. As a result, he has no wages payable on May 15, the next designated payday. UnitedHealthcare will send Smith a notice informing him that he is required to remit the \$100 to the **Health FSA** on a self-pay, after-tax basis in order to continue coverage. If Smith fails to remit the \$100 contribution to the **Health FSA** by the payment deadline, his **Period of Coverage** will be terminated effective April 30.
- *Example 2.* Same facts as in Example 1, except that Smith is furloughed before the beginning of the **Plan Year** and does not have any wages payable on January 15, the first designated payday in the **Plan Year**. UnitedHealthcare will send Smith a notice informing him that he is required to remit the \$100 to the **Health FSA** on a self-pay, after-tax basis in order to commence coverage. If Smith fails to remit the \$100 contribution to the **Health FSA** by the payment deadline, his **Period of Coverage** will be deemed not to have commenced on January 1, and he will not be able to receive **Health FSA** benefits for that **Plan Year**.
- *Example 3.* Same facts as Example 1, except that Smith goes on **FMLA Leave** during April, and returns to work June 1, has no wages payable on May 15, a designated payday, and no wage deduction is made for him. UnitedHealthcare will send Smith a notice offering him the opportunity to remit his \$200 contribution for the month of May (\$100 on May 15, plus \$100 on May 31) on a self-pay, after-tax basis. Even if Smith fails to remit the \$200, however, his **Period of Coverage** will not terminate. Instead, Smith's employer will make an additional \$200

pre-tax deduction from Smith's wages after he returns to work.

- *Example 4.* Same facts as Example 1, except that Smith goes on **Military Leave** in late January and that the last designated payday on which he has sufficient wages available to permit his employer to make the appropriate wage deduction is January 31. During the period of his absence, Smith does not remit contributions to the **Health FSA** because of **Military Leave**. Consequently, his **Period of Coverage** terminates on January 31, the last designated payday for which a contribution was made. Smith returns to work on December 1, and works through the end of the **Plan Year**. His **Period of Coverage** resumes on December 1 and will extend through December 31. Under these circumstances, the **Health FSA** will only reimburse Smith for **Medical Care Expenses** incurred from January 1 to January 31 and December 1 to December 31 of the **Plan Year**, plus the **Grace Period**. The **Health FSA** will not reimburse Smith for expenses incurred from February 1 to November 30, because that time period is not part of his **Period of Coverage**. Moreover, his **Total Annual Health FSA Benefit** is reduced from \$2,400 to \$400 because he did not remit contributions for ten months (\$200 for each of the months of February through November) while he was on **Military Leave**.
- *Example 5.* Employee Jones elects a **Total Annual Health FSA Benefit** of \$2,400. On January 31 of the **Plan Year**, Jones voluntarily terminates her employment, and thus ceases to be a **Participant**. Jones thereafter makes a valid election for **COBRA Coverage**. She makes monthly payments of \$204 in February and March, but fails to make one for April. As a result, her **COBRA Coverage** is terminated for nonpayment effective March 31. Jones's **Period of Coverage** extends from January 1 to March 31, and she can only be reimbursed for **Medical Care Expenses** incurred within this period.

When Medical Care Expenses Are Incurred

A **Medical Care Expense** is only reimbursable if it is “incurred” within your **Period of Coverage**. An expense is “incurred” when the care giving rise to that expense is provided, not when you are billed or charged for the care or when you pay for the care.

- *Example.* Employee Smith did not elect **Health FSA** benefits for the 2013 **Plan Year**, but did elect **Health FSA** benefits for the 2014 **Plan Year**. Smith has unreimbursed medical bills from visits to a doctor on December 15, 2013, and January 15, 2014. Smith receives both bills in January 2014 and pays them both promptly. The December bill was not “incurred” within the 2014 **Plan Year**, and is not reimbursable. The January bill was “incurred” within the 2014 **Plan Year**, and is potentially reimbursable (provided that it meets all the other requirements for reimbursement).

Submission of Claims

To receive reimbursement for **Medical Care Expenses**, you must complete a claim form and return it to UnitedHealthcare along with all required documentation of the expense (including documentation from an independent third party stating that the expense has been incurred and the amount of the expense). You must also provide all certifications that are required on the claim form to ensure that the expense is reimbursable under the **Health FSA**.

UnitedHealthcare will provide claim forms with the enrollment materials and will provide additional copies of the claim form free of charge upon request to all **Participants** who have elected **Health FSA** benefits. Copies of the claim form can be obtained online at www.myuhc.com or www.rinfodepot.com or by calling UnitedHealthcare toll free at 1-888-298-9754.

The general deadline for submitting claim forms to UnitedHealthcare is March 31 after the end of **Period of Coverage** in which the expenses were incurred. However, if your **Period of Coverage** ends prior to December 31 of the **Plan Year**, then the deadline for submitting claim forms to UnitedHealthcare is 90 days after the date your **Period of Coverage** ends. To be

effective, the claim form must either be received by UnitedHealthcare by March 31 or, if applicable, 90 days after your **Period of Coverage** ends, or mailed to UnitedHealthcare by first-class mail and postmarked on or before that date. Late claims will be denied.

Important Note: If you are a **Participant** who receives medical or prescription drug benefits under the Railroad Employees National Health and Welfare Plan or the National Railway Carriers and United Transportation Union Health and Welfare Plan, or who receives vision benefits under the Railroad Employees National Vision Plan or dental benefits under the Railroad Employees National Dental Plan, you may take advantage of a “single bill submission” feature. The “single bill submission” feature allows **Participants** who receive medical, prescription drug, vision or dental benefits under those plans to be reimbursed for some **Medical Care Expenses** without submitting a separate claim to the **Health FSA**. Each of the companies administering benefits under those other plans will automatically forward any claims they process under those plans to UnitedHealthcare for processing under the **Health FSA**. This will be treated as a claim for reimbursement for any unpaid covered medical expenses (e.g. deductibles, coinsurance or co-payments) that qualify as **Medical Care Expenses** under the **Health FSA**.

Processing of Claims and Reimbursements

If you submit a claim for reimbursement of **Medical Care Expenses**, UnitedHealthcare will ordinarily notify you within 30 days after receiving the claim whether it is approved or denied. This time period may be extended for an additional 15 days if UnitedHealthcare determines that such an extension is necessary due to matters beyond its control (including cases where additional information or documentation is required to decide the claim). If this happens, UnitedHealthcare will notify you of the reason for the extension and the date by which it expects to decide the claim.

If additional information or documentation is required to decide the claim, the notice will contain a specific description of the required information or documentation. You will have 45 days from receipt

of this notice to submit the documentation or information. UnitedHealthcare's time period for processing the claim shall be suspended either until you submit the information or until the 45-day period expires.

If the claim is approved, you will be sent a reimbursement check. Reimbursement checks will be sent out when the aggregate amount you are owed is at least \$25 (except for the last reimbursement check with respect to a **Period of Coverage**, which will be for whatever sum should be reimbursed, even if it is less than \$25), provided that UnitedHealthcare will issue reimbursement checks at least bi-monthly. If you would rather have your reimbursements deposited directly into your bank account, UnitedHealthcare offers a direct deposit feature under the **Plan**. You can enroll in direct deposit online at www.myuhc.com.

If your claim is denied, UnitedHealthcare will mail you a notice explaining the specific reasons for the denial and explaining your right to appeal the denial and the steps that you must take to do so.

Appeals Procedure

If your claim for reimbursement of **Medical Care Expenses** is denied by UnitedHealthcare, you have two formal appeals levels:

1. The first level of appeal, which is required for all claims, must be made to UnitedHealthcare.
2. The second level of appeal, to an external independent review organization, is a right that is available to you if you so choose.

Each part of the process is explained more fully below.

First Level of Appeal

You may formally appeal a claim denial by sending a letter in writing to UnitedHealthcare, explaining why you believe that UnitedHealthcare's claim denial was wrong. This letter must be

sent within 180 days after you receive notice of the claim denial. It should be sent to the following address:

UnitedHealthcare Appeals
Attn Appeals
P.O. Box 981512
El Paso, TX. 79998-1512

UnitedHealthcare will review claims without affording any deference to the initial decision by UnitedHealthcare. The individual who decides the appeal will not be the same person who initially decided the claim, nor a subordinate of that person.

You may attach to or include in the letter any documents, records or other information that you believe UnitedHealthcare should consider in connection with the appeal. UnitedHealthcare will consider all such documents, records or other information attached to or included in the letter, regardless of whether that material was submitted or considered in connection with UnitedHealthcare's initial decision.

In connection with an appeal, you have the right to obtain reasonable access to and copies of all documents, records, and other information that is relevant to your claim for **Health FSA** benefits under applicable law. UnitedHealthcare will provide you with reasonable access to or copies of such documents, records, or other information free of charge upon request.

UnitedHealthcare will decide each appeal within 30 days after receiving the written appeal letter. If UnitedHealthcare grants your appeal (or grants it in part), you will be sent a reimbursement (in the manner described above). If UnitedHealthcare denies your appeal (or denies it in part), you will be notified of the decision in writing or electronically. The written or electronic notice will specify the reasons for the decision and will be written in a manner calculated to be understood by you, and will contain a reference to specific **Plan** provisions relevant to the decision, as well as a statement that you may receive, upon request and at no charge, reasonable access to and copies of documents and information relevant to your claim for benefits. The notice will also include a description of your right to bring an action under ERISA Section

502(a), along with any rule, guideline, or protocol relied on in deciding your appeal, or an offer to provide such rule, guideline or protocol at no charge upon request. You may appeal an adverse decision on your formal first level appeal as described below.

Final (Second Level) Appeal

The **Plan** has engaged an independent review agency to handle further appeals of claims. If you are dissatisfied with the result of any initial appeal of your claim denial to UnitedHealthcare, you may file an additional appeal with the independent review agency. Your request for an appeal to the independent review agency must be submitted within 90 days after you receive the results from your initial appeal, and the process for filing an appeal to the independent review agency will be included with the results from your initial appeal. A decision will be sent to you within 30 days from the day your appeal is received by the independent review agency.

Judicial Actions

A decision on your formal second level appeal will be final, except that you may appeal that decision to a court. Before you go to court, however, you must exhaust the entire appeals processes described above (i.e., both the first level of appeal to UnitedHealthcare and the final level of appeal to the independent review agency). If you file a lawsuit over a claim without completing the entire appeals processes, the **Health FSA** will ask that your lawsuit be dismissed. You may not sue on your claim more than three years from the time proof of claim is required.

Forfeiture of Uncashed Benefit Checks

Any benefit checks that you receive from the **Health FSA** must be cashed within 90 days of the date on which the check is issued, or you will forfeit any right to reimbursement for the **Medical Care Expenses** for which the check was issued, unless, within one year from the date the check was issued, you demonstrate to the **Administrator's** satisfaction that you did not receive the check.

COBRA Coverage

Under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you would otherwise lose your **Health FSA** benefits because of a reduction in your work hours (*e.g.*, because of a furlough) or termination of your employment for any reason other than gross misconduct, you may be entitled to elect **COBRA Coverage**, which is a temporary extension of **Health FSA** benefits up until the end of the **Plan Year** (plus the **Grace Period**, if applicable). Your **Spouse** or a **Dependent** child may also have a right to elect **COBRA Coverage** if they would lose entitlement to **Health FSA** benefits as a result of your death, your divorce or legal separation from your **Spouse** or your **Dependent** child ceasing to be a **Dependent**.

You may be familiar with some of the rules and principles governing COBRA continuation coverage from other types of group health plans in which you or your family participate. But there are several special COBRA rules that apply to the **Health FSA** that do not apply to other types of group health plans. You should read the following discussion carefully to make sure that you understand your rights. If you have any questions or require further information, contact UnitedHealthcare toll-free at 1-888-298-9754.

How COBRA Coverage Works

COBRA Coverage allows you (or your **Spouse** or a **Dependent** child) to extend your **Health FSA** benefits beyond the time when they would otherwise terminate, but not beyond the end of the **Plan Year** (plus the **Grace Period**, if applicable), by electing **COBRA Coverage** and timely paying a premium equal to 102% of your monthly contribution (*i.e.*, 102% of your **Total Annual Health FSA Benefit** divided by the number of calendar months in the **Plan Year**). The premium must be paid on an after-tax basis. In exchange for timely payment of premiums, the **Period of Coverage** applicable to the person making the election (and in most cases his or her **Spouse** and **Dependents**) will continue in effect so long as premiums continue to be paid, but not beyond the end of the **Plan Year** (plus the **Grace Period**, if applicable).

Subject to applicable COBRA rules, the **Health FSA** will continue to provide reimbursement for **Medical Care Expenses** incurred within the **Period of Coverage**.

Notifying UnitedHealthcare of a Qualifying Event

You (or your **Spouse** or a **Dependent** child) must notify UnitedHealthcare in writing if you want to elect **COBRA Coverage** as a result of your divorce or legal separation from your **Spouse**, or your **Dependent** child ceasing to be a **Dependent**. The written notification must be mailed to UnitedHealthcare within 60 days of the qualifying event date at the following address:

UnitedHealthcare
Railroad Administration (COBRA)
P.O. Box 150453
Hartford, CT 06115-0453

Effect of a COBRA Coverage Election

Some kinds of qualifying events (reduction of hours of employment, termination of employment, and death) do not result in the creation of a new family unit for COBRA purposes. For these types of qualifying events, an election by a qualified beneficiary to receive **COBRA Coverage** will not result in the creation of a new **Health FSA Account**, but will simply continue your single account, i.e., the account that existed before the qualifying event.

Other kinds of qualifying events (divorce, separation, or your **Dependent** child's ceasing to be a **Dependent**) result in the creation of two different family units for COBRA purposes. For these qualifying events, an election by a qualified beneficiary in the new family unit results in the creation of a second **Health FSA Account**. The balance in this new, second, account will be the same as the remaining balance in the original account. The new account can be used for reimbursement of **Medical Care Expenses** for qualified beneficiaries in the new family unit.

IV DEFINITIONS

These definitions apply when the following terms are used in this booklet.

Administrator

The National Carriers' Conference Committee. The **Administrator** can be contacted at the following address and telephone number:

1901 L Street, N.W.
Suite 500
Washington, D.C. 20036
Telephone: (202) 862-7200

COBRA Coverage

A temporary extension of **Health FSA** benefits up until the end of the **Plan Year** (plus the **Grace Period**, if applicable) under COBRA.

Dependent

A person who is treated as your dependent under Section 105(b) of the Internal Revenue Code, whether or not you are entitled to claim a dependent exemption for that person on your federal income tax return. Such a person who is your child under Section 152(f)(1) of the Internal Revenue Code is a **Dependent** only if the child is under age 26. You should contact UnitedHealthcare or consult a tax advisor if you have any questions about whether someone qualifies as your **Dependent**.

FMLA Leave

Authorized leave under the Family and Medical Leave Act of 1993, as amended.

Grace Period

For a **Participant** who has **Health FSA** coverage on the last day of a **Plan Year** or qualified beneficiary who has **COBRA Coverage** on the last day of a **Plan Year**, the 30-day period beginning on January 1 immediately following the end of the **Plan Year** and ending on January 30 immediately following the end of the **Plan Year**, during which a **Participant** may incur **Medical Care Expenses** and be reimbursed for such expenses from the **Total Annual Health FSA Benefit** for the **Plan Year**.

Health FSA Account

A recordkeeping account established for a **Participant** who elects to receive **Health FSA** benefits. See pages 9 through 10.

Health FSA

The Railroad Employees National Health Flexible Spending Account Plan that provides reimbursement for **Medical Care Expenses** as described in this booklet.

Medical Care Expense

An expense described on pages 10 through 11.

Military Leave

Absence from your employment due to service in the uniformed services within the meaning of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Participant

A person who meets the participation requirements described on page 3.

Period of Coverage

The period of time, which may include a **Grace Period**, during which a **Medical Care Expense** must be incurred in order to be reimbursable by the **Health FSA**. See pages 11 through 15.

Plan

The Railroad Employees National Health Flexible Spending Account Plan described in this booklet.

Plan Year

The twelve-month period beginning January 1 and ending December 31 of the same year.

Spouse

A person who is your husband or your wife, and who is treated as your spouse under the Internal Revenue Code.

Total Annual Health FSA Benefit

The amount (if any) you choose to have deducted from your wages in a **Plan Year** to pay for **Health FSA** benefits. See pages 7 through 9.

V

ADDITIONAL INFORMATION

Your Rights Under ERISA

The **Health FSA** is an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). As a **Health FSA** participant, you are entitled to certain rights and protections under ERISA. ERISA provides that all **Health FSA** participants shall be entitled to:

- **Receive Information About the Health FSA and Its Benefits**
 - Examine, without charge, at the **Administrator's** office (the office of the National Carriers' Conference Committee), at the headquarters office of the labor organization that represents you, at each employer establishment in which 50 or more employees covered by the **Health FSA** customarily work, and at the meeting hall or office of each union local in which there are 50 or more members covered by the **Health FSA**, all documents governing the **Health FSA**, including the collective bargaining agreements pursuant to which the **Health FSA** was established and is maintained, a list of the employers that participate in the **Health FSA**, and a copy of the latest **Health FSA** annual report (Form 5500 Series) filed by the **Health FSA** 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 **Administrator**, copies of documents governing the operation of the **Health FSA**, including collective bargaining agreements, a list of the employers that participate in the **Health FSA**, and copies of the latest **Health FSA** 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 **Health FSA's** annual financial report. The **Administrator** is required by law to furnish each **Health FSA** participant with a copy of this summary financial report.
- Receive, without charge, from the **Administrator**, upon written request to its address, information as to whether a particular railroad participates in the **Health FSA** (and if so, its or their addresses), and with respect to what labor organizations the railroad is a participating employer in the **Health FSA**.

- **Continue Group Health Plan Coverage**

You may have a right to continue health care coverage for yourself, your **Spouse**, or your **Dependents** if there is a loss of coverage under the **Health FSA** as a result of a qualifying event as defined in COBRA. A person electing **COBRA Coverage** will be required to pay a monthly premium for such coverage. Pages 20 through 22 of this booklet and the documents governing the **Health FSA** describe the rules governing your **COBRA Coverage** rights.

- **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for **Health FSA** participants, ERISA imposes duties upon the people who are responsible for its operation. The people who operate the **Health FSA**, called its “fiduciaries”, have a duty to do so prudently and in the interest of you and other **Health FSA** participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a **Health FSA** benefit or exercising your rights under ERISA.

In carrying out their respective responsibilities under the **Plan**, the **Administrator** and other **Plan** fiduciaries shall have discretionary authority to ascertain facts, to interpret the terms of the **Plan**, and to determine entitlements to benefits in accordance with the terms of the **Plan**. Any interpretation or determination made pursuant to such

discretionary authority shall be given full and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

- **Enforce Your Rights**

If your claim for a **Health FSA** 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 **Health FSA** plan documents or the latest annual report from the **Health FSA** 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 **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, you may file suit in a state or Federal court, but not until you exhaust the **Health FSA** appeals process described in this booklet and only if you file the lawsuit within three years from the time proof of claim is required. If it should happen that **Health FSA** fiduciaries misuse its 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 the **Health FSA**, you should contact UnitedHealthcare or the **Administrator**. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining

documents from the **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.

Other Information Required By ERISA

Following is additional information that it is required to provide under ERISA.

- **Name of Plan:**

The Railroad Employees National Health Flexible Spending Account Plan, commonly known as the **Plan** or the **Health FSA**.

- **Plan Identification Numbers:**

Employer Identification Number (EIN): 74-3139935

Plan Number (PN): 512

- **Administrator:**

National Carriers' Conference Committee
1901 L Street, N.W.
Suite 500
Washington, D.C. 20036
Telephone (202) 862-7200

The **Administrator** has authority to control and manage the operation and administration of the **Health FSA** and is the agent for service of legal process. Service of process upon the **Health FSA** may also be made by serving its Trustee.

The **Health FSA** was established and is maintained pursuant to collective bargaining agreements between certain railroads and labor organizations.

- **Type of Administration:** Trusteed and Self-Administered.

The **Health FSA** is administered by the **Administrator**. The **Health FSA's** benefits are not insured. They are funded by employee contributions.

The administration of the **Health FSA** is governed by the terms of the document creating the **Plan** (the “Plan Document”). The **Health FSA's** Summary Plan Description, contained in this booklet, provides a description of the **Health FSA** benefits.

The entities that administer the **Health FSA** on behalf of, and pursuant to, contracts with the **Administrator** have full discretion to construe and interpret the terms of the **Health FSA**. If you do not agree with a determination made by any of those entities, you may request a review of your claim. See pages 17 through 20 for a description of the appeal procedure.

- **Trustee:**

SunTrust Bank
919 East Main Street, 7th Floor
Richmond, VA 23219

- **Source of contributions to the Health FSA:** Employee contributions.

Employee contributions are deducted from wages on certain paydays designated by employers during the **Plan Year**. The amount of an employee's contribution is the appropriate fraction of the **Total Annual Health FSA Benefit** selected by the employee. See pages 7 through 9 of this booklet. If an employee does not have sufficient wages available on a designated payday to enable the appropriate wage deduction to be made in full, the employee will generally be required, in order to continue coverage, to make an after-tax contribution to the **Health FSA** trust fund equal to the wage deduction that would otherwise have been made. See page 9.

Benefits under the **Health FSA** are payable from funds that are held in trust and invested by the Trustee until needed to pay such benefits.

- **Date of the end of the Plan Year:**

Each **Plan Year** ends on December 31.

- **Claims Procedures:**

See pages 17 through 20 for information about **Health FSA** claim procedures.

- **Plan Termination:**

The **Administrator** may by resolution consistent with any applicable collective bargaining agreement amend or terminate the **Plan** at any time.

In the event of termination of the **Plan**, its assets will be used toward payment of its obligations, and any remaining surplus will be distributed in the manner determined by the **Administrator** to best effectuate the purposes of the **Plan** in accordance with the applicable regulations under ERISA.

APPENDIX A

NOTICE OF HEALTH FSA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice is effective January 1, 2013.

THIS NOTICE APPLIES TO THE RAILROAD EMPLOYEES NATIONAL HEALTH FLEXIBLE SPENDING ACCOUNT PLAN.

As used in this section of your booklet, “**Health FSA**”, “**Plan**”, “we”, “our”, or “us” refers not only to the **Health FSA** itself, but also to any agents or contractors acting on our behalf, including those entities that have been retained to administer the benefits that **Health FSA** provides.

INTRODUCTION

During the course of providing you with health FSA benefits, the **Health FSA** will have access to health information about you that constitutes health information that is protected (referred to in this Notice as “Protected Health Information”) pursuant to privacy rules issued under the Health Insurance Portability and Accountability Act of 1996, commonly known as “HIPAA.” This Notice describes the medical information practices of the **Health FSA** and explains the **Health FSA’s** obligations and your rights regarding the use and disclosure of your Protected Health Information.

OUR PLEDGE REGARDING MEDICAL INFORMATION

The **Health FSA** understands that medical information about you is personal information that should be kept in confidence, and is committed to maintaining the privacy of your Protected Health Information. The Protected Health Information that is maintained by or for the **Health FSA** about you includes any

individually identifiable information (including your name, address, date of birth, employee ID number, and Social Security number) that is linked to your past, present or future physical or mental health, the health care that you have received or payment for your health care. The provisions of this Notice apply to Protected Health Information that is created by the **Health FSA** or received by the **Health FSA** from others.

The **Health FSA** is required by law to:

- Make sure your Protected Health Information is kept private;
- Provide you with this Notice of the **Health FSA's** legal duties and privacy practices with respect to your Protected Health Information; and
- Comply with the terms of the Notice (as set forth below or as subsequently amended).

HOW THE HEALTH FSA MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Uses and Disclosures for Treatment, Payment and Health Care Operations—Without Your Authorization

- For Treatment: Although the **Health FSA** does not provide treatment, the **Health FSA** may use or disclose your Protected Health Information in connection with the provision, coordination or management of your health care treatment. For example, if, in the event of an emergency, you are unable to provide your medical history to your physician, the **Health FSA** may advise an emergency room physician about the types of prescription drugs you currently take.
- For Payment: The **Health FSA** may use or disclose your Protected Health Information for the **Health FSA's** payment activities or the payment activities of another health plan.

“Payment” includes all activities in connection with processing claims for your health care (including billing, claims management, eligibility, coordination of benefits, adjudication of claims, subrogation, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the **Health FSA** may use or disclose your Protected Health Information to your health care provider to determine whether a particular surgery is medically necessary, or to determine whether the **Health FSA** will cover that surgery.

- For Health Care Operations: The **Health FSA** may use or disclose your Protected Health Information as part of the general administrative or business functions that the **Health FSA** must perform in order to function as a health plan. For example, the **Health FSA** may use your Protected Health Information to analyze trends in the coverage it provides. Other ways in which your Protected Health Information may be used for health care operations include quality assessment and improvement activities, audits of performance, cost management and planning-related analyses, administration of the **Health FSA** activities in general, and arrangement for medical review or legal services. The **Health FSA** may disclose your Protected Health Information to others for the purpose of conducting health care operations.
- Disclosure To Third Parties: In any circumstance where the **Health FSA** discloses Protected Health Information to a third party that performs a service on behalf of the **Health FSA** (*i.e.*, a Business Associate), the **Health FSA** will have a written contract with that entity requiring the entity to protect the privacy of your Protected Health Information.
- Communications with You: The **Health FSA** may contact you to provide information about health related products or services. The **Health FSA** may use your Protected Health Information to identify programs and treatments that would be most beneficial to you. For example, the **Health FSA**

may use your Protected Health Information to provide you with reminders.

- Treatment Alternatives: The **Health FSA** may use your Protected Health Information to inform you about treatment alternatives.
- Health-Related Benefits and Services: The **Health FSA** may use or disclose your Protected Health Information to inform you about other health-related benefits and services that may be of interest to you.

Disclosures to the Plan Administrator and Your Representatives

- Disclosure to the Administrator: The **Health FSA** is governed by the National Carriers' Conference Committee. The Committee is the **Administrator** of the **Health FSA**. The **Health FSA** may share statistical information about usage under the **Health FSA** and enrollment and disenrollment information with the National Carriers' Conference Committee. In addition, the **Health FSA** may share other Protected Health Information with the National Carriers' Conference Committee solely for purposes of administration of the **Health FSA**. Neither the **Health FSA** nor the National Carriers' Conference Committee will share your Protected Health Information with your employer without your express written authorization or as may be permitted under applicable law.

In addition, the **Health FSA** may disclose "summary health information" to obtain premium bids or modify, amend or terminate the **Health FSA**. Summary health information summarizes the claims history, claims expenses or type of claims experienced under a group health plan, and does not include information that would identify any individual.

- Disclosure to Your Personal Representatives: The **Health FSA** may disclose your Protected Health Information to your

personal representative in accordance with applicable state law (*e.g.*, to parents if you are an unemancipated child under 18, to those with unlimited powers of attorney, etc.).

- Individual Involved in Your Care or Payment For Your Care: Unless you notify the **Health FSA** in writing that you object, the **Health FSA** may disclose Protected Health Information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.

Other Permitted Uses and Disclosures

The **Health FSA** may also use or disclose your Protected Health Information without your consent or authorization for any of the following purposes:

- Required By Law: The **Health FSA** may use or disclose your Protected Health Information to the extent that the **Health FSA** is required to do so by federal, state or local law. For example, the **Health FSA** must respond to a request for disclosure of Protected Health Information if the Secretary of the U.S. Department of Health and Human Services is investigating or determining the **Health FSA's** compliance with the federal privacy rules.
- School Immunization Records: The **Health FSA** may disclose immunization records to a school if the school is required by law to obtain such records prior to admission and the **Health FSA** obtains and documents the agreement to disclose.
- Public Health: The **Health FSA** may disclose your Protected Health Information for public health and safety purposes to a public health authority that is permitted by law to collect or receive the information. For example, your Protected Health Information may be used or disclosed for the purpose of preventing or controlling disease (including communicable diseases), injury or disability.

- Health Oversight: The **Health FSA** may disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and legal actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Abuse or Neglect: The **Health FSA** may disclose your Protected Health Information to any public health authority authorized by law to receive information about abuse, neglect or domestic violence if the **Health FSA** reasonably believes that you have been a victim of abuse, neglect or domestic violence. In this case, the **Health FSA** will inform you that such a disclosure has been or will be made unless that notice will cause a risk of serious harm.
- To Avert a Serious Threat to Health or Safety: The **Health FSA** may use or disclose your Protected Health Information when reasonably necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone reasonably able to help prevent or lessen the threat.
- Legal Proceedings: The **Health FSA** may disclose your Protected Health Information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal. In addition, the **Health FSA** may disclose your Protected Health Information under certain conditions in response to a subpoena, court-ordered discovery request or other lawful process, in which case reasonable efforts must be undertaken by the party seeking the Protected Health Information to notify you and give you an opportunity to object to the disclosure.
- Law Enforcement: The **Health FSA** may disclose your Protected Health Information if requested by a law

enforcement official as part of certain law enforcement activities.

- Coroners, Funeral Directors, and Organ Donation: The **Health FSA** may disclose your Protected Health Information to a coroner or medical examiner for identification purposes, or other duties authorized by law. The **Health FSA** may also disclose your Protected Health Information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. The **Health FSA** may disclose such information in reasonable anticipation of death. The **Health FSA** may also disclose Protected Health Information for cadaveric organ, eye or tissue donation purposes, if you are an organ donor.
- Research: The **Health FSA** is permitted to disclose your Protected Health Information to researchers when their research has been approved by an institutional review board or privacy board that has established protocols to ensure the privacy of your Protected Health Information. When a compound authorization is used, and the provision of research-related treatment is conditioned on the provision of an authorization, the compound authorization must differentiate between conditioned and unconditioned components.
- Military Activity and National Security: When the appropriate conditions apply, the **Health FSA** may use or disclose Protected Health Information of individuals who are Armed Forces personnel: (i) for activities deemed necessary by military command authorities; or (ii) to a foreign military authority if you are a member of that foreign military service. The **Health FSA** may also disclose your Protected Health Information to authorized federal officials conducting national security and intelligence activities.
- Workers' Compensation: The **Health FSA** may disclose your Protected Health Information to comply with workers'

compensation laws and other similar legally established programs.

- **Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, the **Health FSA** may disclose your Protected Health Information to the institution or official if the Protected Health Information is necessary for the institution to provide you with health care; to protect the health and safety of you or others; or for the security of the correctional institution.
- **Fundraising:** The **Health FSA** may disclosure your Protected Health Information to a business associate or to an institutionally related foundation for the purpose of raising funds for its own benefit including: (i) demographic information related to an individual, including name, address, other contact information, age, gender, and date of birth, (ii) dates of health care service provided to an individual, (iii) department of service information, (iv) treating physician, (v) outcome information, and (vi) health insurance status. The **Health FSA** may not condition treatment or payment on your acceptance of fundraising materials. You may opt out of receiving fundraising communications.
- **Marketing:** The **Health FSA** may use or disclosure your Protected Health Information for marketing purposes if the **Health FSA** does not receive financial remuneration for making the communication. The **Health FSA** must obtain written authorization if the **Health FSA** or a business associate receives financial remuneration for making the communication from a third party whose product or service is being promoted. Financial remuneration does not include nonfinancial benefits such as in-kind payments, and payments for a purpose other than making a communication, such as payments to implement a disease management program. Refill reminders are permitted without written authorization so long as the remuneration for making such a communication is reasonably related to the **Health FSA's** cost for making the communication.

Communications about generic equivalents and reminders to take medication as directed are both considered refill reminders and do not require written authorization. In addition, self-administered drugs and biologics communications about all aspects of the delivery system (i.e. insulin pump) are considered to be refill reminders and do not require written authorization. Face-to-face marketing communications are permitted without written authorization.

Other Uses and Disclosures of Protected Health Information

Other uses and disclosures of your Protected Health Information not covered by this Notice or federal privacy laws and rules, or other laws that apply to the **Health FSA**, will only be made with your written authorization. For example, a written authorization from you would be necessary to disclose your Protected Health Information for purposes of obtaining disability benefits, or to disclose information to an employee of the **Administrator** who is not involved in administering the **Health FSA**, or in connection with litigation, unless otherwise permitted or required as outlined above.

If you provide the **Health FSA** with written authorization to use or disclose your Protected Health Information for purposes other than those set forth in this Notice, you may revoke that authorization in writing at any time. If you revoke your authorization, the **Health FSA** will no longer use or disclose your Protected Health Information for the reasons covered by your written authorization. However, you should understand that the **Health FSA** will be unable to take back any disclosures already made with your authorization, and that the **Health FSA** is required to retain records of the care provided to you.

Special privacy protections may apply to certain sensitive information, such as genetic information, HIV-related information, alcohol and substance abuse treatment information, and mental health information. The **Health FSA** is prohibited by law from using genetic information for underwriting purposes, such as

eligibility determinations and the computation of premiums. If you have any questions, please contact the **Health FSA** privacy compliance officer listed below.

YOUR RIGHTS

You have the following rights regarding the Protected Health Information that the **Health FSA** maintains:

- Right to Request a Restriction on the Use and Disclosure of Your Protected Health Information: You may ask the **Health FSA** to restrict the uses and disclosures of your Protected Health Information to carry out treatment, payment or health care operations. You may also request that the **Health FSA** restrict uses and disclosures of your Protected Health Information to family members, relatives, friends or other persons identified by you who are involved in your care. However, the **Health FSA** is not required to agree to a restriction that you request. If the **Health FSA** does agree to the request, the **Health FSA** will not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment or the **Health FSA** terminates the restriction with or without your agreement.
- Right to Request to Receive Confidential Communications by Alternative Means or at an Alternative Location: The **Health FSA** will accommodate your reasonable written request to receive communications of Protected Health Information from the **Health FSA** by alternative means or at alternative locations (e.g., send your EOB to the office, instead of at home) if the request includes a statement that disclosure using the **Health FSA's** regular communications procedures could endanger you.
- Right to Inspect and Copy: As long as the **Health FSA** maintains it, you may inspect and obtain a copy of your Protected Health Information that is in a record set maintained by the **Health FSA** - including information about

your plan eligibility, claims, claims and appeals records, and billing records. In certain very limited circumstances, the **Health FSA** may deny your request for access and copies of your records. The **Health FSA** may impose a fee to cover the costs of copying and postage.

- Right to Access Electronic Protected Health Information: For Protected Health Information stored electronically, the **Health FSA** must provide access in the form and format required if readily producible or if not in a readable electronic form and format agreed to by the **Health FSA** and you. The **Health FSA** may impose a reasonable, cost-based fee for the supplies used in creating the electronic media if the individual requests that the electronic copy be provided on portable media.
- Right to Amend Your Protected Health Information: If you believe that the Protected Health Information records that the **Health FSA** has about you are incorrect or incomplete, you may request that your records be amended, if you provide a reason that supports your request. The **Health FSA** may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the **Health FSA** may deny your request if you ask the **Health FSA** to amend information that did not originate with the **Health FSA**; is not contained in the records maintained by the **Health FSA**; is not part of the information that you would legally be permitted to inspect and copy; or is accurate and complete.
- Right to an Accounting of Disclosures: You have the right to request an accounting (*i.e.*, a list) of certain non-routine disclosures of your Protected Health Information made within six years (or less) of the date on which the accounting is requested. In general, the list will NOT include disclosures made (i) in connection with your receiving treatment, payment for such treatment and for the **Health FSA**'s health care operations; (ii) to you regarding your own Protected Health Information; (iii) pursuant to your written

authorization; (iv) to a person involved in your care or for other similar permitted; or (v) for national security. The first accounting you request within a 12-month period will be free of charge. For additional requests within the 12-month period, the **Health FSA** will charge you for the costs of providing the accounting.

How to Exercise Any of These Rights

If you would like to exercise any of the above-described rights with respect to **Health FSA's** records, please contact the **Health FSA's** privacy compliance officer (identified below).

CHANGES TO THIS NOTICE

The **Health FSA** reserves the right to change this Notice at any time and to make the revised or changed notice effective for Protected Health Information that the **Health FSA** already has about you, as well as any information the **Health FSA** receives in the future. If the **Health FSA** changes its privacy practices, it will provide notice of the change to you within 60 days by direct mail.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a written complaint with the **Health FSA's** privacy compliance officer at the address below or with the Secretary of the U.S. Department of Health and Human Services. The **Health FSA** will not take any action against you for filing a complaint.

FOR QUESTIONS OR REQUESTS

If you have any questions regarding this Notice or the subjects addressed in it, please contact the **Health FSA's** privacy compliance officer:

Director Employee Benefits
National Railway Labor Conference
1901 L Street, N.W., Suite 500
Washington, D.C. 20036
Tel: (202) 862-7200

- Exercising Your Rights With Respect to Your Protected Health Information: You are entitled to inspect, copy or amend your Protected Health Information maintained by or on behalf of the **Health FSA**, to request an accounting of disclosures of your Protected Health Information, or to ask that communications from the **Health FSA** be made in a confidential manner or place. To do so, please contact:

UnitedHealthcare
Customer Service – Privacy Unit
P.O. Box 30985
Salt Lake City, UT 84130
Tel: 1-888-445-4379

- Right to Obtain a Paper Copy of this Notice: You may request a paper copy of our Privacy Notice at any time, even if you have previously agreed to accept the Notice electronically. Requests for paper copies should be made to the **Health FSA** privacy compliance officer.

INITIAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

****CONTINUATION RIGHTS UNDER COBRA****

Railroad Employees National Health Flexible Spending Account Plan

You are receiving this notice because you have recently become covered under the Railroad Employees National Health Flexible Spending Account Plan (the "Plan"). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. **This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** Any bolded terms in this notice have the meaning defined in the Summary Plan Description of the Plan.

COBRA Coverage

Under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you would otherwise lose your **Health FSA** benefits because of the occurrence of certain "qualifying events," you may be entitled to elect **COBRA Coverage**, which is a temporary extension of **Health FSA** benefits up until the end of the **Plan Year** (plus the **Grace Period**, if applicable). Your **Spouse** or a **Dependent** child may also have a right to elect **COBRA Coverage** if they would lose entitlement to **Health FSA** benefits as a result of a "qualifying event."

You may be familiar with some of the rules and principles governing COBRA continuation coverage from other types of group health plans in which you or your family participate. But there are several special COBRA rules that apply to the **Health FSA** that do not apply to other types of group health plans. You should read the following discussion carefully to make sure that you understand your rights. If you have any questions or require further information, contact UnitedHealthcare, Railroad Administration (COBRA), P.O. Box 150453, Hartford, CT 06115-0453.

How COBRA Coverage Works

COBRA Coverage allows you (or your **Spouse** or a **Dependent** child) to extend your **Health FSA** benefits beyond the time when they would otherwise terminate, but not beyond the end of the **Plan Year** (plus the **Grace Period**, if applicable), by electing **COBRA Coverage** and timely paying a premium equal to 102% of your monthly contribution (*i.e.*, 102% of your **Total Annual Health FSA Benefit** divided by the number of calendar months in the **Plan Year**). The premium must be paid on an after-tax basis. In exchange for timely payment of premiums, the **Period of Coverage** applicable to the person making the election (and in most cases his or her **Spouse** and **Dependents**) will continue in effect so long as premiums continue to be paid, but not beyond the end of the **Plan Year** (plus the **Grace Period**, if applicable). Subject to the rules outlined below, the **Health FSA** will continue to provide reimbursement for **Medical Care Expenses** incurred within the **Period of Coverage**.

What is a “Qualifying Event”?

The following are the “qualifying events” under COBRA that could cause you (or your **Spouse** or **Dependent** child) to lose coverage for **Health FSA** benefits and allow that person to elect **COBRA Coverage**.

- Reduction in your hours of work (*e.g.*, because of a furlough);
- Termination of your employment for any reason other than gross misconduct;
- Your death;
- Divorce or legal separation from your **Spouse**;
- Your **Dependent** child ceases to be a **Dependent**.

Notice of Qualifying Event

If the qualifying event is (a) your divorce or legal separation from your **Spouse**, or (b) your **Dependent** child ceasing to be a **Dependent**, then, to be able to elect **COBRA Coverage**, you (or your former **Spouse** or former **Dependent**) must notify UnitedHealthcare of the qualifying event within 60 days of the date on which the event occurs. The notice, which will satisfy this notification requirement with respect to all persons who would lose **Health FSA** coverage because of the qualifying event, must be in writing and must be sent to:

UnitedHealthcare
Railroad Administration (COBRA) P.O.
Box 150453
Hartford, CT 06115-0453

A form to use for this notice can be obtained by calling UnitedHealthcare toll-free at 1-888-298-9754. The call will not be accepted as notice. Notice must be sent in writing to the address shown above.

Your employer will notify UnitedHealthcare if your hours of work are reduced, your employment is terminated, or you die.

Notice of Address Changes

To protect your family's rights under COBRA, you should keep UnitedHealthcare informed of any changes in the addresses of your family members. You should also keep a copy, for your records, of any notices you send to UnitedHealthcare.

Who Can Make a COBRA Election?

An election to receive **COBRA Coverage** can be made only by a "qualified beneficiary." You, your **Spouse**, and your **Dependent** children are "qualified beneficiaries" for purposes of COBRA.

A qualified beneficiary may only elect **COBRA Coverage** if he or she would otherwise lose **Health FSA** coverage as a result of a "qualifying event." (See page 2 for the definition of "qualifying event".)

Making a COBRA Election

Within 14 days after receiving notice of a qualifying event, UnitedHealthcare will send the appropriate COBRA election form to qualified beneficiaries eligible to elect **COBRA Coverage** because of that qualifying event. A qualified beneficiary will have 60 days to elect **COBRA Coverage**. The 60-day period begins on the later of:

- The date that **Health FSA** benefits would terminate due to the qualifying event if **COBRA Coverage** is not elected, or
- The date the election form is sent to the qualified beneficiary.

Duration of COBRA Coverage

COBRA Coverage lasts only until the end of the **Plan Year** (plus the **Grace Period**, if applicable). Under no circumstances can it be extended beyond this date.

If a qualified beneficiary elects **COBRA Coverage** and fails to timely make any required payments, his/her coverage will terminate as of the first day for which timely payment is not received. (For example, if a payment required for February coverage is due but not paid by March 31, **COBRA Coverage** will terminate as of February 1.) If the qualified beneficiary timely makes all required payments, **COBRA Coverage** will terminate at the end of the **Plan Year** (plus the **Grace Period**, if applicable). His/her **Period of Coverage** will extend through the date on which **COBRA Coverage** terminates.

Effect of a COBRA Coverage Election

Some kinds of qualifying events (reduction of hours of employment, termination of employment, and death) do not result in the creation of a new family unit for COBRA purposes. For these types of qualifying events, an election by a qualified beneficiary to receive **COBRA Coverage** will not result in the creation of a new **Health FSA Account**, but will simply continue your single account, i.e., the account that existed before the qualifying event.

Other kinds of qualifying events (divorce, separation, or your **Dependent** child's ceasing to be a **Dependent**) result in the creation of two different family units for COBRA purposes. For these qualifying events, an election by a qualified beneficiary in the new family unit results in the creation of a second **Health FSA Account**. The balance in this new, second, account will be the same as the remaining balance in the original account. The new account can be used for reimbursement of **Medical Care Expenses** for qualified beneficiaries in the new family unit.

- *Example 1.* Employee Johnson is married and has two **Dependent** children. Johnson has elected a **Total Annual Health FSA Benefit** of \$2,400 for a **Plan Year**, and has incurred and been reimbursed for \$400 prior to April 1. On April 1, Johnson voluntarily terminates his employment, and thus ceases to be a **Participant**. Consequently, if none of Johnson's qualified beneficiaries elects **COBRA Coverage**, **Health FSA** benefits for Johnson and his family will terminate on April 1. Under these

circumstances, Johnson, his **Spouse**, or either of his children can elect **COBRA Coverage**. The effect of an election by any of them will be the same. There will continue to be one **Health FSA Account** with a balance of \$2,000 (\$2,400 minus the \$400 already reimbursed) that can be used for reimbursement for **Medical Care Expenses** for Johnson, his **Spouse**, or his **Dependents**.

- *Example 2.* Same facts as Example 1, except that Johnson continues to be employed throughout the **Plan Year**. On April 1, Johnson is divorced, and his former **Spouse** elects **COBRA Coverage**. A new **Health FSA Account** will be created with a balance of \$2,000 that may be used only to reimburse **Medical Care Expenses** incurred by the former **Spouse** and her **Dependants**.

Self-Pay Coverage vs. COBRA Coverage

If you don't have sufficient wages available on a designated payday to enable your employer to make the appropriate wage deduction for **Health FSA** benefits in full, you will be required to make an after-tax contribution to the **Health FSA** equal to the wage deduction that your employer would otherwise have made in order to continue your **Health FSA** coverage (except in the special case of **FMLA Leave**). If your lack of sufficient wages is due to a reduction in your hours of work, that will also be a qualifying event under COBRA. In that event, you and your qualified beneficiaries may also have a right to elect **COBRA Coverage**.

If you make the required contribution on an after-tax basis, your **Health FSA** benefits will continue. In that event, neither you nor your qualified beneficiaries will be able to elect **COBRA Coverage**, because there will be no termination of your **Health FSA** coverage. But if you do not make the required contribution, then your qualified beneficiaries may elect **COBRA Coverage** if they are otherwise eligible to do so.

- *Example.* Employee Jones elects a **Total Annual Health FSA Benefit** of \$2,400. On February 1, before Jones has incurred any **Medical Care Expenses**, she is furloughed and does not have sufficient wages available on the next designated payday to enable her employer to make the appropriate wage deduction for **Health FSA** benefits. Jones can continue her **Health FSA** benefits without electing COBRA Coverage by making the required contributions of \$200 per month to the **Health FSA**.

If Jones does not make the required contributions, however, her **Spouse** or **Dependent** children may elect **COBRA Coverage**, for a monthly premium of \$204.

UnitedHealthCare
Railroad Accounts
505 Boices Lane
Kingston, NY 12401

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