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**Rick Gibbons**  
General Chairman  
BNSF (SLSF)-MNA

## Brotherhood of Locomotive Engineers and Trainmen

IBT Rail Conference

All BNSF / BLET Local Chairmen

October 3, 2007

**Re: Flexible Spending Account**

Sent via Email

Dear Sirs and Brothers,

Recently while the four of us were out on the property in our educational efforts involving the 2007 BLET National and On-Property Settlements, it became quite evident that a large portion of our membership was not very well acclimated to the provisions set forth and available in Article II of the 2003 Alternative Compensation Package; more specifically, the "Flexible Spending Account".

Once we recognized the problem, we pledged to our Committees to provide a concerted effort to oblige each of our respective local chairmen and subsequently each of our members with additional information in an attempt to further educate all involved as to what you are receiving via the United States Postal System with regard to this matter. We are enclosing several documents for distribution which will hopefully work to this end.

We suggest you take a few moments to review the material and to consider what you have at your disposal in accordance with the collective bargaining agreement. Pay particular attention to the items identified which are eligible for the Plan. We feel you will be very surprised at the possible savings you may realize by becoming involved in this program.

Further, BNSF posted information about the FSA on their Labor Relations website dated November 15, 2004 and October 3, 2005.

Fraternally,

BLET General Chairman

BLET General Chairman

BLET General Chairman

BLET General Chairman

# **Railroad Employees National Flexible Benefits Program For BNSF Engineers For 2008**

You are receiving this material because you may be eligible to enroll for benefits in the Flexible Benefits Program ("FBP") for BNSF Engineers for 2008. This package explains how the FBP will work. You should review these materials closely, to make sure that you understand whether you are eligible to participate in the FBP and decide whether you want to enroll for benefits.

**If you enrolled in the Flexible Benefits Program for 2007, and want to participate in 2008, you must enroll again; your 2007 enrollment will not be carried over to 2008.**

## **Enrolling**

Use the enclosed FBP enrollment form to make an election to participate in the Health FSA and/or the DCAP program. **You must return this form no later than October 26, 2007.**

## **General Information About the FBP**

### **What is the FBP?**

The FBP is a "cafeteria plan" established under Section 125 of the Internal Revenue Code. It is designed to allow you to use pretax dollars to pay for certain medical or dependent care expenses that cannot be reimbursed through insurance (including coverage under a railroad Health and Welfare Plan or hospital association) or from any other source.

In essence, when you enroll in the FBP, you agree to have a certain amount deducted from the wages that would otherwise be paid to you during the program year. As a result, you will not have to pay income taxes on these wages. The FBP will then reimburse you for certain medical care or dependent care expenses incurred within the program year, up to the amount you have chosen to have deducted from your wages. In general, you do not have to pay income tax on the amounts that you receive as reimbursement. The program year will start on January 1, 2008 and end on December 31, 2008.

The plan has two components: a Health Flexible Spending Arrangement ("Health FSA"), which provides reimbursement for medical care expenses, and a Dependent Care Assistance Program ("DCAP"), which provides reimbursement for dependent care expenses. You can choose to participate in either, both, or neither of these FBP components.

Although the Health FSA and the DCAP are similar in some respects, there are important differences between them. You should read these materials carefully to make sure that you understand the way each component works.

Health FSA accounts and DCAP accounts must remain separate. You cannot transfer money from one type of account to the other.

Once you decide whether to participate in the Health FSA and/or the DCAP, you cannot change your decision or the amount you have chosen to contribute for any reason until the end of the calendar year (December 31, 2008).

### **Pros and Cons of Participating in the FBP**

By participating in the FBP, you will likely be able to save money on income taxes, because you will be using pretax dollars to pay for qualified medical care and dependent care expenses. Some persons, however, may gain greater tax savings by claiming a dependent care credit on their federal income tax returns than by participating in the DCAP.

There is also a risk to participating in the FBP:

- Once you agree to have an amount deducted from your wages, you can't change your decision at any time during 2008.
- Although you will get this money back if you submit valid claims for reimbursement, **any amounts for which you do not submit valid claims for reimbursement will be forfeited.**
- In addition, since Railroad Retirement taxes are not withheld on your before-tax contributions, it is possible that your future retirement benefits could be reduced.

Consequently, it is very important that you do not elect to deduct more from your wages than you expect to incur in qualified medical care and dependent care expenses during 2008.

### **FBP Administrator**

UnitedHealthcare is the administrator for the FBP and the Health FSA and DCAP components. If you decide to enroll for Health FSA or DCAP benefits, then based on your election, BNSF will make deductions from your wages and forward those amounts to a bank account established for this purpose. UnitedHealthcare will process your claims and issue reimbursement checks to you from this account.

UnitedHealthcare is the claim fiduciary for the FBP. This means all claim decisions by UnitedHealthcare are final.

### **Who Is Eligible to Participate in the FBP?**

To be eligible to participate in FBP, you must meet all of the following requirements:

- In both August 2007 and December 2007, you must
  - (a) reside in the United States, and
  - (b) be shown as having a preponderant of earnings as an engineer in the period from July 1, 2006 through June 30, 2007

Even if you submit an enrollment form, your enrollment will not be effective if you do not meet these requirements. If this occurs, you will be notified.

## Termination of Participation

Your participation in the FBP will automatically terminate if any of the following events happens during the program year:

- You cease to reside in the United States;
- You cease to be employed by a BNSF (for example, because of death or retirement); or
- You become an exempt employee or leave the operating crafts.

If your participation terminates, then all wage deductions and contributions to the DCAP and the Health FSA will cease. You will still be eligible to receive reimbursement for qualifying dependent care expenses under the DCAP that are incurred before the end of the Program Year, but your period of coverage under the Health FSA will cease as of the date of termination, unless you (or your spouse or a dependent child) elects COBRA coverage as described below.

You may change or terminate your contributions after your initial election if, and only if, you have a family status event, which is defined as one or more of the following:

1. your marriage, legal separation, divorce or annulment;
2. the birth, placement for adoption or adoption of a child;
3. the death of a dependent (including your spouse);
4. the termination or commencement of your spouse's employment, a change in hours worked,  
or an unpaid leave of absence taken by you or your spouse resulting in a change in eligibility  
for medical or dental coverage;
5. a dependent satisfies or ceases to satisfy eligibility requirements;
6. you are served with a Qualified Medical Child Support Order (QMCSO) issued under  
ERISA Section 609, as approved by the Plan Administrator.

## Use It or Lose It Rule

**You must use all the money in your Health FSA and/or DCAP accounts for expenses incurred during the program year or you will forfeit the unused portion.** You have until March 31, 2009 to file claims for your expenses incurred between January 1, 2008 and December 31, 2008. You must cash all checks issued to you within one year from the date of issue. You may not receive a refund of unused money from your account, obtain reimbursement for expenses incurred during another year, or carry balances forward to the next program year.

## The Dependent Care Assistance Program (DCAP)

The DCAP enables you to use pretax dollars to pay for certain types of dependent care expenses that meet requirements established by the IRS and that are not reimbursed from any other source. If you're eligible to participate in the DCAP, you can choose to have up to \$5,000 deducted from your wages during the program year and placed in a DCAP trust account. The DCAP will then reimburse you from that account for any qualifying dependent care expenses incurred during the program year. You will not pay federal income tax on the amounts that are deducted from your wages. You also will not

pay federal income tax on the amounts that you receive as reimbursement, as long as you don't receive more than the IRS allows you to exclude from your income.

### **Special Requirements for Participate in DCAP**

To participate in the DCAP in 2008, your total compensation for 2007 (including all amounts deferred under a 401(k) plan or reduced from your salary under a cafeteria program) must be less than or equal to a threshold established by the IRS (currently \$95,000). If you elect DCAP benefits and your total compensation for 2007 exceeds this threshold, your election will be null and void.

### **What Dependent Care Expenses Can Be Reimbursed Under the DCAP?**

The DCAP will only reimburse you for expenses incurred for care of someone who is:

- A child under age 13 for whom you are entitled to claim as a dependent on your federal income tax return (or, if you are a divorced or separated parent, a child who is in your legal custody, even if you cannot claim a dependency exemption);
- Your spouse, if he or she is physically or mentally incapable of self-care; or
- Any other person who qualifies as your dependent under federal tax law (regardless of whether you can claim a dependency exemption for that person), if that person is physically or mentally incapable of self-care.

In addition, the expenses must be incurred in order to enable you and your spouse, if any, to be gainfully employed (or, subject to rules established by the IRS, to attend a full-time educational institution). The expenses cannot be reimbursed or reimbursable from any other source.

The expenses must be incurred within the program year. An expense is incurred when the service is performed, not when you are billed for the service or when you pay for it.

Finally, you must submit appropriate documentation, showing that the expense was incurred and that it meets all the requirements for reimbursement under the DCAP and IRS rules.

Following are some types of expenses that may be eligible for reimbursement under the DCAP (provided that all of the other DCAP and federal tax law requirements are satisfied):

- Licensed nursery schools
- Qualified child-care centers
- Adult day care facilities
- After school programs
- Baby-sitters inside or outside the home while you are at work (as long as the baby-sitter is not your child under age 19, or anyone you or your spouse can claim as a dependent for federal income tax purposes)
- FICA and other taxes you pay on behalf of a day care provider
- Day camps for dependent children under age 13
- Preschool tuition
- Meal and lodging expenses provided for your care-giver

The following expenses are not eligible for reimbursement under the DCAP:

- Any amounts that are eligible for reimbursement from another source
- Any expenses for which you claim a dependent care tax credit on your federal income tax return
- Sleep-away or overnight camps
- Tuition fees for private or boarding schools
- 24 hour nursing home care
- Weekend or evening baby sitting that is not necessary for you (or your spouse) to work
- Care provided by your child under age 19 or by someone you claim as a dependent on your income tax return
- Transportation between your home and the place care is provided
- Finder's fees for placement of an au pair

Other types of expenses not listed here may also be ineligible for reimbursement. You can get a more detailed list of eligible expenses online at [www.myuhc.com](http://www.myuhc.com) or by calling UnitedHealthcare toll free at 877-311-7849.

Keep in mind that the IRS establishes the expenses for which you can be reimbursed and can modify this list from time to time. In the case of an IRS audit, it is your responsibility to establish that the expenses for which you receive reimbursement meet IRS rules.

### **How Much Can You Contribute to the DCAP?**

The minimum amount you can contribute to the DCAP for the first program year is \$120. The maximum amount is \$5,000.

Keep in mind, however, that the IRS sets limits on how much of the money you receive from the DCAP you are allowed to exclude from your income for tax purposes. You can't exclude more than the smallest of the following amounts:

- \$5,000 if you are single or married and file a joint return, or \$2,500 if you are married and file separate returns;
- Your earned income for 2008; or
- Your spouse's earned income for 2008.

You should not elect to contribute more than the smallest of these amounts to the DCAP. If you do, United Healthcare may reduce the amount of your contribution to the maximum amount you are eligible to exclude from income.

In addition, you should not elect more than the amount of qualifying dependent care expenses you expect to incur between January 1, 2008 and December 31, 2008.

### **Terminating Participation**

In general, DCAP contributions will continue to be deducted from your wages and forwarded to the DCAP account on a regular basis as long as you continue to work. If you stop working, and thus cease to earn wages, no contribution will be made, and your total DCAP benefit (*i.e.*, the maximum amount you can be reimbursed) will automatically

be reduced. If you resume work, and thus start to earn wages again before the end of the program year, the wage deductions and contributions will automatically resume.

Even if you stop working, you can still be reimbursed for any dependent care expenses that are incurred during the program year, provided that they meet all of the requirements for reimbursement.

### **Amount of Reimbursement Available**

Under the DCAP, you can only be reimbursed at any given time up to the amount of your current DCAP balance (*i.e.*, the total amount you have contributed during the program year minus the total amount you have been reimbursed). If you submit a claim that exceeds your DCAP balance, you will be reimbursed up to your balance, and will be reimbursed for any excess later on if you make additional contributions to the DCAP.

### **Special Tax Filing Requirements**

If you participate in the DCAP, you are required to complete IRS Form 2441 when you file your federal income tax return for 2008 (or Schedule 2 if you file your taxes on Form 1040A). In general, you will need to provide the name, address, and taxpayer identification number (TIN) of any person who provides the dependent care for which you are reimbursed. You should ask any provider of dependent care services to fill out a copy of IRS Form W-10 and keep it for your records. Copies of these forms are available on the IRS website ([www.irs.gov](http://www.irs.gov)).

## **The Health Flexible Spending Arrangement (Health FSA)**

The Health FSA enables you to use pretax dollars to pay for certain types of health care expenses that are not reimbursable from any other source. You can choose to have up to \$3,600 deducted from your wages during the first program year and placed in a special Health FSA trust account. The Health FSA will then reimburse you for any qualifying health care expenses incurred during the program year, up to the total amount that you decide to have deducted from your wages. You will not pay federal income tax on the amounts that are deducted from your wages or that you receive as reimbursement.

### **Eligibility for Health FSA Participation**

Anyone who is eligible to participate in the FBP can participate in the Health FSA.

### **What Health Care Expenses Can Be Reimbursed Under the Health FSA?**

The Health FSA will only reimburse you for expenses for you, your spouse, or persons who are your dependents under federal tax law. The expenses must be for "medical care" as that term is defined by the IRS, and must not be for a kind of care that is excluded under the terms of the Health FSA. In addition, the expenses cannot be reimbursed or reimbursable under any other insurance (including coverage under a railroad Health and Welfare Plan or hospital association) or from any other source.

The expenses must be incurred within your period of coverage. In general, the period of coverage is the program year, but as discussed below, your period of coverage may terminate early if you stop working and making contributions to the Health FSA. An expense is incurred when the service is performed, not when you are billed for the service or when you pay for it.

Finally, you must submit appropriate documentation, showing that the expense was incurred and that it meets all the requirements for reimbursement under the Health FSA and IRS rules.

Following are some types of expenses that may be eligible for reimbursement under the Health FSA (provided that all of the other Health FSA and federal tax law requirements are satisfied):

- Deductibles or co-payments under your medical, prescription drug, dental or vision plan
- Medical expenses for persons who qualify as your dependents under federal tax law but who are not covered under your plan
- Medical expenses that are not covered by your medical plan or any other plan.

Remember, however, that an expense will only be reimbursable if it is considered a medical care expense under federal tax law and is not specifically excluded from coverage under the terms of the Health FSA.

The following kinds of expenses are not eligible for reimbursement under FSA:

- Any amounts that are eligible for reimbursement from another source, such as insurance or Medicare
- Any expenses for which a federal itemized deduction is taken
- Premiums or employee contributions for health, dental or vision coverage
- 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
- Marriage/family counseling

Other expenses not listed here may also not be eligible for reimbursement. You can get a more detailed list of eligible expenses online at [www.myuhc.com](http://www.myuhc.com) or by calling UnitedHealthcare toll free at 877-311-7849.

As with the DCAP, keep in mind that the IRS establishes rules for what can be reimbursed under a Health FSA and may modify those rules from time to time. In the case of an IRS audit, it is your responsibility to establish that the expenses for which you received reimbursement meet IRS rules.

### **How Much Can You Contribute to the Health FSA?**

The minimum amount you can contribute to the Health FSA for the first program year is \$120 and the maximum amount is \$3,600. You should not elect more than the amount of qualifying un-reimbursed medical care expenses you expect to incur between January 1, 2008 and December 31, 2008.

### **Health FSA Period of Coverage**

As long as you continue to work and make contributions the entire program year, your period of coverage for purposes of the Health FSA will extend from January 1, 2008 to December 31, 2008, *i.e.*, the entire program year. But your period of coverage may terminate early if you cease to work or don't work enough to make FSA contributions.

BNSF will only make wage deductions and contributions, however, so long as you are earning sufficient wages to enable the appropriate wage deductions to be made in full.

If BNSF ceases to make wage deductions and contributions because you are not earning wages, you can elect to continue your coverage on a self-pay, after tax basis by sending your contributions directly to the Health FSA. UnitedHealthcare will send you a bill letting you know how much you are required to pay and when payments are due. If you fail to make any required contribution on time, your period of coverage will terminate as of the first day for which no contribution was received. But if you make all of the required after-tax payments, and you begin earning wages again before the end of the program year, your employer will resume making pretax wage deductions and contributions, and your period of coverage will not terminate.

There are special rules applicable to persons who are on leave under the Family and Military Leave Act (FMLA). Your period of coverage will automatically continue during any period in which you are on FMLA leave, and you will not have to make self-pay contributions to maintain coverage. But when you return to work, an additional deduction will be made from your wages to pay for coverage during the period of leave.

There are also special rules applicable to persons who are absent from their employment because of service in the military. If you are absent because of military service, and return to work before the end of the program year, your period of coverage will automatically resume, regardless of whether you elected self-pay or COBRA coverage or whether your coverage previously terminated.

### **Amount of Reimbursement Available**

Under the Health FSA, the amount available for reimbursement at any given time is the full amount you have elected to have deducted from your wages during the program year, minus any amounts for which you have already been reimbursed, regardless of how much you have contributed to the Health FSA.

### **Submitting Claims**

Use one of the enclosed claim forms to submit claims under FSA or DCAP. You can print additional copies from [www.myuhc.com](http://www.myuhc.com). You can also obtain additional claims forms by calling United Healthcare toll free at 877-311-7849. The claim form explains what documentation is needed for reimbursement.

A reimbursement check will not be issued until the total expenses claimed reach \$25.

You have until March 31, 2009 to submit claims for expenses incurred between January 1, 2008 and December 31, 2008.

### **Single Bill Submission**

Under the Health FSA, the single bill submission feature allows employees who have benefits administered by UnitedHealthcare, or Medco to be reimbursed for non-covered health expenses without having to re-submit the claim to FSA. Both of these companies will automatically forward any claims they process for processing under FSA. The amount of any unpaid covered medical expenses (e.g. deductibles or co-payments) covered under the FSA, will be deducted from your FSA account and a check will be issued to you.

If you have benefits provided by Aetna, Highmark Blue Cross Blue Shield, VSP or United Behavioral Health, you will need to mail a claim for any unpaid expenses to UnitedHealthcare. A copy of the Explanation of Benefits from the other insurance company along with the FSA claim form is all that is required.

If an expense is not covered by any benefit plan, send a copy of an itemized receipt that includes the date of service, service rendered, and total charge.

### **Confirmation of your Election**

You will receive a notice confirming your FSA and/or DCAP elections.

If you elected to participate in FSA and/or DCAP and you do not receive a confirmation notice, or you receive a notice but the amounts elected are not correct, call UnitedHealthcare at 1-800-842-9905.

**You must call prior to December 7, 2007 to make corrections. If you do not call before December 7th, changes in amounts, or changes in FBP participation will not be allowed.**

### **COBRA Continuation Coverage**

You, your spouse, or a child who is your dependent under the federal tax laws may have a right to elect continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 if the Health FSA coverage for the person making the election would otherwise terminate as a result of one of the following “qualifying events.”

- (1) Reduction in your hours of work;
- (2) Termination of your employment for any reason other than gross misconduct
- (3) Your death;
- (4) Divorce or legal separation from your spouse; or
- (5) A dependent child ceases to be a dependent.

BNSF will notify UnitedHealthcare if any of the events described in (1) – (3) above occurs. **You are responsible for notifying UnitedHealthcare in the event of a divorce or legal separation from your spouse or if a dependent child ceases to be a dependent.** You must provide the notice within **60 days** of the date on which the event occurs. The notice 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 1-800-842-9905. The call will not be accepted as notice.

UnitedHealthcare will send the appropriate COBRA election form to any “qualified beneficiary” (*i.e.*, you, your spouse, or a dependent child) who is eligible to elect COBRA Coverage within 14 days of receiving notice of a qualifying event. The qualified beneficiary will have 60 days to elect COBRA Coverage. The 60-day period begins on the later of:

- the date that Health FSA coverage would have terminated due to the qualifying event (if COBRA coverage had not been elected), or
- The date the election form is sent to the qualified beneficiary.

To protect your family’s rights under COBRA, you should keep United Healthcare 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.

The monthly premium for COBRA Coverage is the same as the monthly premium for self-pay coverage: 102% of your monthly contribution, based on the total amount you elect to contribute to the Health FSA for the year. For example, if you elect to contribute \$2,400, or \$200 per month, in 2008, the premium for one month of COBRA coverage would be \$204.

Not all qualified beneficiaries who experience a qualifying event are eligible to elect COBRA coverage. A qualified beneficiary may elect COBRA coverage if, and only if, as of the date of the qualifying event, he or she may become entitled to receive during the remainder of the program year a benefit that exceeds the sum of all COBRA premiums that would be payable for the remainder of Program Year if COBRA Coverage were to be elected.

Example 1: You elect to contribute \$2,400 or \$200 per month to the Health FSA in 2008. As of March 31, you have incurred and been reimbursed \$300 for medical care expenses. On July 31, you voluntarily terminate your employment and cease to be a participant in the FBP. You would be eligible to elect COBRA Coverage, because your remaining benefit (\$2,100) exceeds the total amount that you would be required to pay for another five months of coverage (\$1,000).

Example 2: Same facts as example 1, except that you have incurred and been reimbursed for \$1500 in medical care expenses as of March 31. You would not have any right to COBRA coverage, because your remaining benefit (\$900) is less than the total amount that you would be required to pay for another seven months of coverage (\$1,000).

Any qualified beneficiary may elect COBRA coverage, but such coverage cannot be extended beyond the end of the program year. In addition, if a qualified beneficiary elects COBRA coverage and fails to make the required payments, COBRA coverage will terminate as of the first day for which timely payment is not received.

## Welcome to myuhc.com

UnitedHealthcare provides a personalized web site, [www.myuhc.com](http://www.myuhc.com), for employees and dependents for whom we provide health benefits. If UnitedHealthcare provides your medical benefits under the Railroad Employees National Health and Welfare Plan you may already be familiar with this website. If you are not, we encourage you to take a minute and register. The site offers a wealth of information on medical topics and can be personalized to fit your interests. It also provides a way to check the eligibility information in our files and to review claim history and the status of claims currently being processed.

### **Myuhc.com available to those who enroll in the Flexible Benefit Plan for BNSF Engineers**

myuhc.com also is a source of information on Flexible Spending Accounts (called the Flexible Benefits Program for BNSF Engineers). You can download a claim form, check the balance in your health FSA account and DCAP account, determine the status of submitted claims and review claim history.

Access to myuhc.com is available to anyone who enrolls in FSA even if Aetna or Highmark Blue Cross Blue Shield provides your medical benefits.

#### **Please note:**

Some services offered on myuhc.com are not available to you if you do not have your health benefits provided by UnitedHealthcare.

If you do have your health benefits through UnitedHealthcare, you must register on myuhc.com using your FSA policy number (708536) if you want FSA information. You must register and sign on using your medical policy number if you want information about medical claims, coverage, eligibility, etc.

If you do not have medical benefits provided by UnitedHealthcare you will not be able to register until January 1, 2008

#### **How to Register on myuhc.com for your FSA account**

1. Go to [www.myuhc.com](http://www.myuhc.com)
2. At the home page click on "Register Now" on the right side of the page.
3. On the **Register: Step 1 of 2** page, click on "Register with ID card information". (You do not need to fill in the Social Security Number and Date of Birth on this page.)
4. On the **Register: Step 1 of 2 (use ID card)** page, enter
  - The employee's SSN as an ID number. Do not use the ID number from your ID card.
  - The FSA group number --708536
  - The employee's name and date of birth

You can ignore the diagram and instructions related to the ID card. Click on “Continue”

5. On the **Register: Step 2 of 2** page, select a user name, password and security question and check the box agreeing to the privacy statement and service agreement request. If you disagree, you will not be registered. Click on the “Submit” button at the bottom of the page.

## Flexible Benefits Program for BNSF Engineers Election Form/Wage Reduction Agreement

Return this form (and the HIPAA authorization) in the envelope that you received with this form. Your completed form (and HIPAA authorization) must be mailed by October 26, 2007 for your election to be effective

I elect to have the following deductions taken from my wages under the Flexible Benefits Program for BNSF Engineers for the Program Year that begins January 1, 2008 and ends on December 31, 2008 (*check all that apply*):

\_\_\_ **Health FSA:** I elect to have:

\$ \_\_\_\_\_ deducted from the first paycheck I receive each month.

\$ \_\_\_\_\_ deducted from the second paycheck I receive each month.

*You can elect to have the same or different amounts deducted from each paycheck. **You must elect to have some amount deducted from each paycheck** The total deduction for the year must be no less than \$120 and no more than \$3600.*

\_\_\_ **DCAP:** I elect to have:

\$ \_\_\_\_\_ deducted from the first paycheck I receive each month.

\$ \_\_\_\_\_ deducted from the second paycheck I receive each month.

*You can elect to have the same or different amounts deducted from each paycheck. **You must elect to have some amount deducted from each paycheck** The total deduction for the year must be no less than \$120 and no more than \$5000. (Important: You may be subject to a lesser maximum, depending on your marital and tax filing status and your spouse's earned income. Refer to the materials included with this form or contact United Healthcare for further information).*

Employee: \_\_\_\_\_ SSN: \_\_\_\_\_ RRCODE: \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date: \_\_\_\_\_

**YOU MUST COMPLETE THE HIPAA AUTHORIZATION ON THE OTHER  
SIDE OF THIS FORM IF YOU HAVE ELECTED TO RECEIVE HEALTH FSA  
BENEFITS**

**Return this form in the envelope provided or mail to: UnitedHealthcare, 450 Columbus Blvd.- 13NA, Hartford, CT 06103**

## **HIPAA AUTHORIZATION FOR HEALTH FSA**

**(January 1, 2008 to December 31, 2008)**

I hereby authorize United Healthcare (“UHC”), acting on behalf of the Flexible Benefits Program (“FBP”) for BNSF Engineers, to disclose to BNSF any election I may make now or in the future to make contributions to the Health FSA component of the FBP, through wage deductions or otherwise. I understand that UHC will disclose the following individually identifiable health information to BNSF: name, social security number, and the amounts I have chosen to contribute to the Health FSA. This information will be used only to determine the amount to be deducted from my wages or for other purposes related to the administration of the Health FSA component.

I understand that I can refuse to sign this authorization, in which event I shall not be entitled to participate in the Health FSA.

I understand that I may inspect or copy the information disclosed by UHC to my employer pursuant to this authorization.

I understand that I may revoke this authorization at any time by notifying UHC in writing, except to the extent action has been taken in reliance on this authorization.

I understand that I have a right to request and receive a Notice of Privacy Practices from the FBP.

I understand that information disclosed to my employer is no longer protected by the federal medical information privacy rule issued pursuant to the Health Insurance Portability and Accountability Act.

This authorization expires on January 1, 2009.

Employee Signature \_\_\_\_\_ Date: \_\_\_\_\_

**MAIL CLAIM FORM TO:**

United Healthcare

PO Box 981178

El Paso, TX 79998-1178

Fax: (915) 781-1085;

Customer Service Phone: (877) 311-7849

**FLEXIBLE BENEFITS PROGRAM  
FOR BNSF ENGINEERS  
Claim Form**



Complete Part 1 entirely and legibly.

Complete Part 2 if you are claiming medical, dental, vision, prescription or over-the-counter drug expenses.

Complete Part 3 if you are claiming dependent care expenses. Carefully read and follow the directions below regarding the Provider's Certification of Services Rendered.

**DO**

**DO NOT**

- Separate expense types by individual name.
- Complete the total requested amount.
- Send original copies on white paper. Carbon copies and colored paper are not legible when scanned.
- Circle names and dollar amounts on receipts - especially important for OTC items.
- Tape small receipts to a standard 8.5" x 11" sheet of blank paper. Ensure print is legible.
- Attach itemized receipts/documentation to the form.
- Read Certification for Reimbursement, sign and date form.
- Make a copy of form and documentation for your personal records.

- Do not submit cancelled checks or credit card receipts alone. These are *not* adequate documentation without supporting itemization.
- Do not highlight names, prices or dates on receipts. They are not legible when scanned.
- Do not handwrite item names on receipts. These are not acceptable.
- Do not submit handwritten receipts for RX or OTC.
- Do not submit pre-treatment estimates or estimated insurance statements.

For **Medical, Dental, Vision and Hearing Expenses**, submit your insurance carriers explanation of benefits (EOB) statement with your completed form. When applicable your insurance claim must be finalized prior to submitting for reimbursement.

For expenses not covered by your medical, dental or vision insurance plan and for co-payments you must submit documentation which includes the following information:

\* Name and Address of Provider \* Dollar amount charged \* Date of service \* Patient's name \* Type of Service \*Reason for non-coverage

**Prescription** documentation must contain the following:

\*Patient name \*Cost of the drug \*Date the prescription was filled \*Prescription name **or** NDC # **or** the word copay must be printed on the receipt\*(Information usually can be found on prescription tags provided by pharmacies)

**Over-the-Counter (OTC) Drugs**, check the OTC box on the claim form. Documentation must contain the following:

\*Printed receipt \*Name of the over-the-counter item \*Price \*Date of purchase

**Dependent Care Expenses**, if the Dependent Care Provider's Certification on the form is entirely completed and includes your providers' signature, further documentation is not necessary. In place of the above submit a statement that includes:

\*Provider's name, address and Tax identification or social security number \*Dates of service \*Cost of service

Mail (or fax) the form and required documentation to the address (or fax number) provided on this form. All reimbursement requests for a plan year must be postmarked prior to March 31<sup>st</sup> of the following year. A general list of eligible/non-eligible items along with frequently asked questions are available on line at [www.myuhc.com](http://www.myuhc.com). For more coverage information please refer to IRS publication 502, section 213 available at [www.irs.gov](http://www.irs.gov) or by phone at 800-TAX-FORM.

**MAIL CLAIM FORM TO:**

United Healthcare

PO Box 981178

El Paso, TX 79998-1178

Fax: (915) 781-1085;

Customer Service Phone: (877) 311-7849

**FLEXIBLE BENEFITS PROGRAM  
FOR BNSF ENGINEERS  
Claim Form**



**Part 1 Employee Information (Please Print) Please read the instructions on reverse in their entirety before completing form.**

Employee Name (Last and First)	Employee ID	Date of Birth	Daytime Telephone No
Mailing Address	POLICY NUMBER 708536		Employer Name RAILROAD

**Part 2 Health Care Expenses (Please Print) Itemize each expense type using a separate line. Use additional forms as necessary.**

Patient's Name	Type of Services Please Check One Box Below For <b>Each</b> Expense Type MD=Medical RX=Prescription OTC= Over-The-Counter VS=Vision DN=Dental HR=Hearing	Date(s) Of Service mm/dd/yyyy		Request Amount
		From:	To:	
	MD <input type="checkbox"/> RX <input type="checkbox"/> OTC <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> HR <input type="checkbox"/>			
	MD <input type="checkbox"/> RX <input type="checkbox"/> OTC <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> HR <input type="checkbox"/>			
	MD <input type="checkbox"/> RX <input type="checkbox"/> OTC <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> HR <input type="checkbox"/>			
	MD <input type="checkbox"/> RX <input type="checkbox"/> OTC <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> HR <input type="checkbox"/>			
	MD <input type="checkbox"/> RX <input type="checkbox"/> OTC <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> HR <input type="checkbox"/>			
Health Care Expenses Subtotal				\$

**Part 3 Dependent Care Expenses (Please Print) Itemize each expense using a separate line. Use additional forms as necessary.**

Dependent's Name	Date Of Birth mm/dd/yyyy	Type Of Service	Date(s) Of Service mm/dd/yyyy		Request Amount
			From:	To:	
Dependent Care Expenses Subtotal					\$
<b>Total Request For Withdrawal</b>					<b>\$</b>

**Day Care Provider's Certification of Services Rendered (PLEASE PRINT)**

I, the signer below, certify that the services listed in Part 3 above, were rendered by me and charges incurred have been paid for.

Day Care Provider and Company Name:	Day Care Provider's Address:
Day Care Provider's Tax Id#: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Day Care Provider's Signature and Title:

**Certification For Reimbursement**

I certify that any expenses for which I am requesting reimbursement, as itemized above, were incurred by me (and/or my spouse and/or eligible dependents) for medical care and/or dependent care. These expenses have not been reimbursed and I will not seek reimbursement under any other plan or other sources.

I understand that expenses reimbursed through the FBP cannot be used to claim any federal income tax deduction or credit. I certify that my statements are complete and true to the best of my knowledge and belief.

**EMPLOYEE SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_