

**NATIONAL EMPLOYEES
HEALTH PLAN**

August 22, 2008

Dear

This notice contains important information about your right to continue your health care coverage in the National Employees Health Plan (the Plan).

Please read the information contained in this notice very carefully. This notice provides important information concerning your rights and what you have to do to continue your health care coverage under the Plan for you and your covered dependents, if any, as defined on the enclosed Family Member Enrollment Form. If you have any questions concerning the information in this notice or your rights to coverage, you should contact the COBRA Administrator (ABS, Inc.) at:

AUTOMATED BENEFIT SERVICES, INC.
ABS COBRA COMPLIANCE DEPARTMENT
P.O. BOX 37511
OAK PARK, MI 48237
ph: (586) 693-4748

If you do not elect to continue your health care coverage by completing the enclosed "Enrollment Form" and returning it to us, your coverage under the Plan will end on 07/01/2008 due to: Termination

Each of the following qualified beneficiaries is being offered continuation under the Plan:

Because of the above event that will end your coverage under the Plan, you are entitled to continue your health care coverage for up to 18 months. If you elect to continue your coverage under the Plan, your continuation coverage will begin on 07/01/2008 and can last until 01/01/2010.

IMPORTANT – To elect continuation coverage, you must complete the enclosed Enrollment Form and return it to us. You may mail it to the address shown on the Enrollment Form. The completed Enrollment Form must be post-marked by 08/31/2008. If you do not submit a completed Enrollment Form by this date, you will lose your right to elect continuation coverage.

Each covered dependents has the equal right to accept or decline the coverage being offered to the. If all the members of your family who are eligible for the coverage offered wish to continue coverage, please indicate that as well on the Family Member Enrollment Form, if applicable. If you have any questions regarding dependent coverage or premium, you are welcome to contact the COBRA Administrator (ABS Inc.) at (586) 693-4748.

The total premium due each month is shown on the Enrollment Form and on the Premium Computation Form. You should pay the total premium due at the time you send in the Enrollment Form, in order to complete your enrollment and continue your coverage. However, you are allowed to delay the premium payment for up to forty-five days after you have signed, dated and submitted your Enrollment Form. Any claims submitted for expenses incurred following the date of the Qualifying Event may be held in suspense until all premiums which are due have been paid.

Future premiums are due on the first of each month thereafter, and should be mailed on or before the due date. Failure to pay premiums by premium due dates may terminate your participation in the Health Benefits Continuation Plan.

If you have any questions about the coverage, its length or the premiums due, please contact the COBRA Administrator (ABS, Inc.) at (586) 693-4748.

Sincerely,

ABS COBRA Compliance Department

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse, and dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan. The persons listed on page one of this notice have been identified by the Plan as qualified beneficiaries entitled to elect continuation coverage. Specific information describing continuation coverage can be found in the Plan's summary plan description (SPD), which can be obtained from Automated Benefit Services, Inc (ABS, Inc.)

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months. Page one of this notice shows the maximum period of continuation coverage available to the listed qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Administrator of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify the COBRA Administrator of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries listed on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the COBRA Administrator of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months from the original qualifying event date. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify the COBRA Administrator within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Each qualified beneficiary listed on page one of this notice has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Enrollment Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Secondly, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special

enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of the continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

What if I am eligible for trade adjustment assistance?

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

When and how must payment for continuation coverage be made?

First premium payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Enrollment Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Enrollment Form is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date the Enrollment Form is post-marked, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of the continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

Your first monthly premium payment in the form of a check/money order should be made payable to National Employees Health Plan and mailed to:

AUTOMATED BENEFIT SERVICES, INC.
ABS COBRA COMPLIANCE DEPARTMENT
P.O. BOX 37511
OAK PARK, MI 48237

Monthly premium payment for continuation coverage

After you make your first payment for continuation coverage, you will be required to make monthly payment for each subsequent coverage period. Under the Plan, this monthly payment for continuation coverage is due on the first day of each month. If you make a monthly payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. Once the Enrollment Form is received by the COBRA Administrator, an Enrollment Confirmation Form, along with remittance premium coupons will be sent to you. You may receive other correspondence regarding your premium payment if necessary.

Grace period for monthly premium payment

Although monthly payment is due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a monthly payment later than its due date but during its grace period, your coverage under the Plan may be suspended as of the due date and then retroactively reinstated (going back to the due date) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Your monthly premium payment in the form of a check/money order should be made payable to National Employees Health Plan and mailed to:

AUTOMATED BENEFIT SERVICES, INC.
ABS COBRA COMPLIANCE DEPARTMENT
P.O. BOX 37511
OAK PARK, MI 48237

If information is available about alternative coverage (coverage in lieu of continuation coverage, or individual conversion rights), it will appear here: NONE AVAILABLE

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. You can get a copy of your summary plan description from Automated Benefits Services, Inc.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you sent to the COBRA Administrator.

HEALTH BENEFITS CONTINUATION PLAN ENROLLMENT FORM

**AUTOMATED BENEFIT SERVICES
NATIONAL EMPLOYEES HEALTH PLAN**

PQB NAME:
ADDRESS:

EMPLOYEE:

QUALIFYING EVENT: Termination

LIST ALL ELIGIBLE PERSONS TO BE COVERED UNDER THE COBRA PLAN: (PERSONS PREVIOUSLY COVERED ONLY, INCLUDING EMPLOYEE)

NAME LAST	FIRST MIDDLE	BIRTH DATE	SEX	SOC. SEC. #
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Plan Description	Coverage Level	Premium
-----	-----	-----
	QOB AND FAMILY	\$1,730.28

Total Monthly Premium:		\$1,730.28

***PQB - Principal Qualified Beneficiary**

I HEREBY REQUEST ENROLLMENT IN THE HEALTH BENEFITS CONTINUATION PLAN FOR MYSELF AND ELIGIBLE QUALIFIED DEPENDENTS LISTED ON THIS FORM AND AGREE TO PAY THE PREMIUM AS REQUIRED. I UNDERSTAND THAT CONTINUATION COVERAGE WILL TERMINATE UNDER SEVERAL CIRCUMSTANCES, INCLUDING: THE DATE I OR A CONTINUED DEPENDENT BECOME COVERED UNDER ANOTHER GROUP HEALTH/DENTAL PLAN, BECOME ENTITLED TO MEDICARE, OR ON THE DATE ON WHICH THE GROUP HEALTH/DENTAL PLAN ENDS. I ALSO UNDERSTAND THAT IF I WAS DISABLED AT THE TIME OF MY QUALIFYING EVENT, I MAY BE ELIGIBLE FOR EXTENDED CONTINUATION COVERAGE AND THAT ANY BREAK IN CONTINUED COVERAGE OF MORE THAN SIXTY-THREE DAYS MAY CAUSE LOSS OF COVERAGE "PORTABILITY".

Signature of _____ DATE: _____

NOTE: In order to be enrolled in the Health Benefits Continuation Plan this ENROLLMENT FORM must be received no later than 08/31/2008. Please mail to the address listed below:

AUTOMATED BENEFIT SERVICES, INC.
ABS COBRA COMPLIANCE DEPARTMENT
P.O. BOX 37511
OAK PARK, MI 48237

Please make your check or money order payable to National Employees Health Plan and mail to the address listed above. Please do not mail your check/money order to your previous employer.

Thank you

PREMIUM COMPUTATION FORM

**AUTOMATED BENEFIT SERVICES, INC.
NATIONAL EMPLOYEES HEALTH PLAN**

Principal Qualified Beneficiary (PQB):

The Health Benefits Continuation Plan requires you to pay premiums according to the schedule shown below. The premium for the first partial month, if applicable, has been calculated for the remaining number of days in the month the Qualifying Event occurs.

Subsequent premiums are due each month, as shown. You must pay all initial premiums due within forty-five days of the day you sign and date the Enrollment Form.

Your Qualifying Event Date: 06/30/2008
Your Last Enrollment Date: 08/31/2008

Plan Description	Coverage Level	Premium
-----	-----	-----
	PQB AND FAMILY	\$1,730.28
-----	-----	-----
Total Monthly Premium:		\$1,730.28

Schedule Of First Payment	Premium
Amount Due if Enrollment Form Signed And Received In Our Office: 07/31/2008	\$1,730.28
Amount Due if Enrollment Form Signed And Received In Our Office: 08/31/2008	\$3,460.56
Amount Due if Premium Paid By.....:09/30/2008	\$5,190.84
Amount Due if Premium Paid By.....:10/31/2008	\$6,921.12

**Please make your check or money order payable to National Employees Health Plan and mail to
ABS COBRA Compliance Department.**

Thank you

FAMILY MEMBER ENROLLMENT FORM

**AUTOMATED BENEFIT SERVICES, INC.
NATIONAL EMPLOYEES HEALTH PLAN**

ATTN: All eligible family members of

Please elect the coverage you desire under our Health Benefits Continuation Plan by circling the appropriate selection (ACCEPT or DECLINE) and signing in the space provided.

The Principal Qualified Beneficiary (PQB) may accept coverage for all his/her dependents, but only the dependents or responsible party(s) may elect to accept or decline coverage which the Principal Qualified Beneficiary (PQB) has declined for himself/herself. Please return this form with the Health Benefits Continuation Plan Enrollment Form.

FAMILY MEMBER COVERAGE

Name	Relationship	Signature
<hr/>		
	Husband	
	ACCEPT/DECLINE	_____
	Child	
	ACCEPT/DECLINE	_____
	Child	
	ACCEPT/DECLINE	_____

PLEASE MAKE CHECK/MONEY ORDER PAYABLE TO NATIONAL EMPLOYEES HEALTH PLAN

Mail All Payments To:

Due Date:

Amount: \$

AUTOMATED BENEFIT SERVICES, INC.
ABS COBRA COMPLIANCE DEPARTMENT
P.O. BOX 37511
OAK PARK, MI 48237

Have you become covered by Medicare/other group plan? _____

Change of Address:

Code: NEHP

Signature: _____

Date: _____

*****PLEASE SEND COUPON WITH EACH PAYMENT, PLEASE PAY STATED AMOUNT*****

>>===== <<

PLEASE MAKE CHECK/MONEY ORDER PAYABLE TO NATIONAL EMPLOYEES HEALTH PLAN

Mail All Payments To:

Due Date:

Amount: \$

AUTOMATED BENEFIT SERVICES, INC.
ABS COBRA COMPLIANCE DEPARTMENT
P.O. BOX 37511
OAK PARK, MI 48237

Have you become covered by Medicare/other group plan? _____

Change of Address:

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Signature: _____

Date: _____

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PLEASE MAKE CHECK/MONEY ORDER PAYABLE TO NATIONAL EMPLOYEES HEALTH PLAN

Mail All Payments To:

Due Date:

Amount: \$

AUTOMATED BENEFIT SERVICES, INC.
ABS COBRA COMPLIANCE DEPARTMENT
P.O. BOX 37511
OAK PARK, MI 48237

Have you become covered by Medicare/other group plan? _____

Change of Address:

Code: NEHP

Signature: _____

Date: _____

*****PLEASE SEND COUPON WITH EACH PAYMENT, PLEASE PAY STATED AMOUNT*****