December 5, 2017

Health and Welfare Contract Summary

Changes to the Plan's health and welfare provisions will be made under the Managed Medical Care Program (MMCP), Comprehensive Health Care Benefits (CHCB); Mental Health and Substance Abuse (MHSA); the Plan's Prescription Drug Card and Mail Order Prescription Drug Programs and the National Vision Plan (Vision Plan). There are no changes to the National Dental Plan (Dental). Finally, there are no changes to the retiree benefits under the Early Retiree Major Medical Benefit Program (ERMA).

Cost Sharing

FROZEN AT $228.89

The current monthly employee contribution will remain frozen at $228.89 until the next agreement and must be mutually agreed upon at the conclusion of negotiations in the next round of bargaining that begins on January 1, 2020.

As a result of this freeze, employees will be paying significantly less than 15% of Plan costs by 2020. It is estimated that without the freeze, the 15% formula would have resulted in employees paying as much as $3,600 a year, depending on the rate of medical inflation.

Changes to the in-network and out-of-network services under MMCP and services under CHCB annual deductibles and annual out-of-pocket maximums are as follows:

Plan Design Changes	New Plan Benefits	Previous Plan Benefits
Drug Co-Pays		
Retail:		
Generic	$ 10	$ 5
Formulary	$ 30	$25
Non-Formulary	$ 60	$45
Mail:		
Generic	$ 10	$ 5
Formulary	$ 60	$50
Non-Formulary	$120	$90
MMCP Copays: (MMCP = Managed Care)		
Primary Care Visits	$ 25	$20
Specialist Visits	$ 40	$35
Convenience Care Clinics	$ 10	$10
Urgent Care Visits	$ 25	$20
Emergency Room Visit	$100	$75
Telemedicine (New)	$ 10	N/A

Annual Deductible

Annual deductibles for *in-network* services under MMCP where a fixed copay does not apply will be phased in as shown below:

- Effective February 1, 2018, $325 per individual and $650 per family
- Effective January 1, 2019, $350 per individual and $700 per family

Annual deductibles for *out-of-network* services under MMCP will be phased in as shown below:

- Effective February 1, 2018, $650 per individual and $1,300 per family
- Effective January 1, 2019, $700 per individual and $1,400 per family

Annual deductibles for *CHCB* will be phased in as shown below:

- Effective February 1, 2018, $325 per individual and $650 per family
- Effective January 1, 2019, $350 per individual and $700 per family

For all Plans, the annual family deductible applies no matter how many covered family members there are.

What is the annual individual deductible?

The annual individual deductible is the maximum amount an individual will have to pay in a calendar year before the Plan applies payments. For "in-network" services under MMCP the annual individual deductible applies where a fixed copayment does not apply (i.e., $25/$40 copay per office visit).. This amount applies separately to each Covered Family Member each calendar year. The amounts are based on the contracted "in-network" provider discount charge with your insurance company (United Healthcare, Aetna or Blue Cross Blue Shield Highmark).

Separate annual individual deductibles apply to "out-of-network" services provided under MMCP and services under CHCB for each Covered Family Member each calendar year.

What is the annual family deductible?

The annual family deductible is the maximum amount the employee and his/her eligible dependents will have to pay in any calendar year before the Plan applies payments. For "in-network" services under MMCP, the annual family deductible applies where a fixed copayment does not apply, (i.e., $25/$40 copay per office visit). The amounts are based on the contracted "in-network" provider discount charge with your insurance company (United Healthcare, Aetna or Blue Cross Blue Shield Highmark).

Separate annual family deductibles apply to "out-of-network" services under MMCP and the services under CHCB for each Covered Family Member each calendar year.

The annual family deductible applies no matter how many covered family members there are.

Coinsurance – Out-of-Pocket Maximums

In-Network MMCP Annual Out-of-Pocket Maximums (applicable when there is no fixed copay)

Coinsurance of 10% will apply for "*in-network*" services under MMCP once the annual deductible is met and where a fixed copayment does not apply (i.e., $25/40 per office visit), up to the below annual out-of-pocket maximums, on a phased in basis:

- Effective February 1, 2018, $1,800 per individual and $3,600 per family
- Effective January 1, 2019, $2,000 per individual and $4,000 per family

Out-of-Network MMCP Annual Out-of-Pocket Maximums

Coinsurance of 30% will apply for "*out-of-network*" services under MMCP once the annual deductible is met, up to the below annual out-of-pocket maximums, on a phased in basis:

- Effective February 1, 2018, $3,600 per individual and $7,200 per family
- Effective January 1, 2019, $4,000 per individual and $8,000 per family

Comprehensive Health Care Benefit (CHCB) Annual Out-of-Pocket Maximums

Coinsurance of 20% will apply for services under *CHCB*, once the annual deductible is met, up to the below annual out-of-pocket maximums, on a phased in basis:

- Effective February 1, 2018, $2,800 per individual and $5,600 per family
- Effective January 1, 2019, $3,000 per individual and $6,000 per family

For all Plans once the annual out-of-pocket maximum is reached, no further coinsurance will be applied.

The annual family out-of-pocket maximum applies no matter how many covered family members there are.

What are the annual out-of-pocket maximums?

There are two annual out-of-pocket maximum amounts. There is an annual individual out-of-pocket maximum and an annual family out-of-pocket maximum. For "in-network" services under MMCP, these amounts apply where a fixed copayment does not apply, (i.e., $25/40 per office visit). The amounts are based on the contracted "in-network" provider discount charge with your insurance company (United Healthcare, Aetna or Blue Cross Blue Shield Highmark).

Copayments and annual deductible amounts do not apply towards the annual out-of-pocket maximums -- they must be paid in addition. Only the 10% "in-network" MMCP coinsurance applies towards the annual out-of-pocket maximum amount.

As with the "in-network" services, there are two separate annual out-of-pocket maximum amounts for "out-of-network" services under MMCP and services under CHCB. There is an annual individual out-of-pocket maximum and an annual family out-of-pocket maximum.

Deductible payments or charges in excess of the reasonable and customary amounts do not apply to the annual out-of-pocket maximums for out-of-network for CHCB services -- they must be paid in addition. Only the 30% out-of-network MMCP coinsurance or the 20% for CHCB apply towards the annual out-of-pocket maximum amounts.

The annual family out-of-pocket maximum applies no matter how many covered family members there are.

Telemedicine (new program)

Telemedicine is a service through TeleDocs that will provide virtual doctor visits online (mobile device, computer or telephone consultations) 24-hours a-day/7-days a week/365 days per year. Visits are for non-emergency, non-life threatening treatments for general medical conditions, including but not limited to, colds/flu, allergies, pink eye; dermatology services such as skin infection, skin abrasions, moles/warts, or rashes.

Access to Teledoc will be available through a member's current medical vendor's (United Healthcare, Aetna or Blue Cross/Blue Shield Highmark) online website.

A program description is attached to the Agreement as Exhibit B.

Mental Health and Substance Abuse Benefits (MHSA)

Separate annual deductible and the annual out-of-pocket maximum amounts will be eliminated for covered health services under the Mental Health Care or Substance Abuse Care (MHSA). Services incurred under the MHSA benefits will be applied towards the same annual deductible and annual out-of-pocket maximum amounts as required under MMCP and CHCB.

This means instead of having two sets of maximums, now all services, regardless of the type-mental health/substance abuse or medical-will be applied to one annual deductible and one annual out-of-pocket maximum amount determined by the level of benefits the member has chosen for the year, MMCP or CHCB.

For example, a member covered under MMCP seeks services from an in-network mental health specialist. For services rendered where the fixed copay does not apply, such as the $40/visit, the charges will be applied towards the same annual deductible as medical expenses

The Railroad Employees National Vision Plan (currently rolling 12- or 24- month schedule)

Effective 2/1/2018 the Plan will be changed as follows:

- One eye exam per **calendar** year
- One Prescription pair of eyeglass Lenses (or two Prescription separate eyeglass Lenses) every two **calendar** years
- One pair of eyeglass frames for Prescription Lenses every two (2) **calendar** years

Flexible Spending Accounts

- Starting with Plan Year 2019 and each year thereafter, the contribution allowance will increase by $500 or an amount allowed by law, if lower than $500
- Starting with Plan Year 2019 annual contributions will be capped at $3,000 or an amount allowed by law, if lower than $3,000
- Starting with Calendar Year 2020 and each year thereafter, the grace period for submitting the prior year's charges will be extended until March 15.

The increased contribution amounts will allow an individual to put more funds aside for the year's anticipated medical expenses. In addition, since these contributions are pre-tax, this means more take-home pay.

Care Coordination/Medical Management Programs

The Care Coordination/Medical Management (CCMM) programs will be rebid to allow one of the current vendors, United Healthcare, Aetna or Blue Cross Blue Shield Highmark, to be the sole administrator.

The designated Labor and Management representatives will schedule meetings as soon as practical to develop the necessary member communications and administrative guidelines to assure that individuals maintain the continuity of care being received from their current administrator until such time as it is practical to transition to the new CCMM programs.

Pharmacy Benefit Manager

The Plan shall promptly solicit Pharmacy Benefit Manager (PBM) bids from Express Scripts, OptumRx, and CVS/Caremark to provide pharmacy benefit management services to the Plan.

New Voluntary Programs

The following programs are voluntary and at the Plan participant's discretion to use:

Centers of Excellence (COE) Resource Services

This voluntary program expands the current Bariatric, Cancer, Kidney, Transplant and Congenital Heart Disease programs available to members and their eligible dependents.

The program promotes Quality of Care, by encouraging treatment at an institution with demonstrated favorable clinical outcomes and that has a high volume of procedures and patients within the specific disease or condition.

Two new options under the COE will include:

Cleveland Clinic's Heart Benefit - available beginning in 2018
Cleveland Clinic's Orthopedic and Spine Benefit – available beginning in 2019

Benefits currently available under the existing COE Specialty Resource program, such as travel benefits and cost-sharing waivers, will also apply to the Cleveland Clinic COE program. For example, costs could be waived for a surgical procedure if an individual enrolls in Cleveland Clinic's programs. Office visits and related exams or tests would still be subject to copays or coinsurance, but the actual surgical procedure costs could be waived. A program description is attached to the Agreement as Exhibit B.

Expert Second Opinions

This voluntary program is at no cost to the member.

Members who have either recently been diagnosed or are undergoing medical treatment for a condition will be able to seek advice from medical experts at Best Doctors who will review their medical records and provide an opinion on the accuracy of the diagnosis or treatment plan. Best Doctors has over 50,000 medical experts specializing in over 450 medical fields and is one of the world's leading second opinion vendors.

A member who contacts Best Doctors will be asked a series of questions relevant to his/her condition or treatment plan and will be requested to provide copies of his/her medical records. Best Doctors will collaborate with experts in that field around the world, and provide the member with an opinion as to whether they believe the current diagnosis is correct; appropriate, or provide recommendations for other services or treatments.

The advice can resolve conflicting information or alleviate confusion that a member may be experiencing. Members may receive an alternative diagnosis or optional treatment plan; get advice on the best care if admitted to the hospital for an acute trauma or service; receive advice on surgery or other medical procedures/treatment; or get answers to general medical questions from someone other than his/her insurance company, the internet, or his/her personal physicians.

Best Doctors opinions have led to a change or refinement of diagnosis in 37% of cases that the company reviewed, as well as a change or improvement of treatment plans in 75% of cases.

A program description is attached to the Agreement as Exhibit B.

Health Advocacy

This voluntary, no-cost, online/telephonic program is available 24/7 through Health Advocate.

Seasoned registered nurses or experienced benefits specialists will assist members and their eligible dependents with services such as, finding the right in-network doctors and hospitals; scheduling appointments; coordinating expert second opinions; resolving insurance claims and medical billing issues; obtaining approvals for needed services from insurance companies; and more.

To receive any of these services, a member can call Health Advocate. A program description is attached to the Agreement as Exhibit B.

End-of-Life Counseling

This voluntary, no-cost program through Vital Decisions provides effective ways of communication and shared decision-making processes for members with an advanced illness (life expectancy of one year or less), and their family and physicians when end-of-life decisions are needed.

Individuals suffering from a terminal illness are often times unable to effectively communicate their desires or wishes due to fear, anxiety or denial, etc.. This program provides the member with the opportunity to talk with an expert who can be a liaison between the family/caretaker and physicians to relay the member's wishes either during treatment or after death.

A Vital Decisions' specialist will contact a member to see if he/she may be interested in participating in the program. If the member agrees to participate, the specialist will explore the barriers that may be preventing the member from communicating his/her wishes or desires with family or physicians. The specialist may also discuss potential clinical trials available; make sure the member has an advance medical treatment directive, and, if needed, will arrange to speak with family members and physicians to assist in expressing the member's needs and desires.

The average number of calls is between 3-5 and each one usually lasts between 20-40 minutes in length. A program description is attached to the Agreement as Exhibit B.

Prescription Drug Plan Changes

To ensure drug safety and that members are correctly taking their medications; certain drug programs will be implemented as described below. Interactions between some drugs can cause harmful side effects or even death. With these programs, members and their doctors will be assured that the patient is taking the appropriate medication at the appropriate dosage; with no adverse drug interactions. The program descriptions are attached to the Agreement as Exhibit C.

Screen Rx

This program ensures that patients are taking medication correctly; timely and as prescribed by the physician. The program also ensures the member is getting refills when needed.

A member may receive a call from a PBM representative if their records reflect the member may have failed to timely renew a prescription or stopped getting refills. The representative will ask a few questions to find out why the member may not be getting their prescriptions, especially if there is no record of a new medication being prescribed.

Sometimes members stop taking a medication due to cost, forgetfulness, or lose their medication, etc. As needed, the representative can assist the member with setting reminders for taking the medication or getting refills. If the drug is cost prohibitive, alternative, lower-cost options may be suggested with advice that the member talk to their doctor.

Medical Channel Management Program

Specialty drugs (as defined by the Plan's PBM) that are currently submitted under the medical plan will no longer be processed as a medical claim. Instead, the specialty medication must be ordered and dispensed under the Plan's pharmacy benefits. An example of the Specialty Drugs involved would be IV infusions received in a doctor's office or outpatient facility.

The physician must contact the specialty pharmacy, Accredo, and obtain the required medication in advance of the patient's treatment.

It is estimated that less than one-half of one-percent (.5%) of members will be impacted by this program.

Fraud, Waste and Abuse

To alleviate potential harmful side effects, abuse and/or addiction that may result from patients taking multiple medications or controlled substances, the Plan's PBM will monitor the prescriptions being dispensed for dosage or duration that may exceed Federal guidelines. If the PBM identifies potential problems, the member will be contacted and informed that he/she will be restricted to a specific retail pharmacy for prescription purchases.

DEFINITIONS

Coinsurance - A stated percentage of medical expenses where there is no "fixed copayment". Services under "in-network"
MMCP are subject to 10% coinsurance after the annual deductible. Coinsurance of 30% will be applied to "out-of-network" services under MMCP and a 20% coinsurance will be applied to services under CHCB.

Copayment (Medical) - A fixed dollar amount for a specific medical service. For example, the Plan provides these services with a fixed copayment amount under the "in-network" MMCP; office visit $25/$40, emergency room $100, urgent care facility $25, and convenient care clinic $10. Other services under the Plan may also have a fixed copayment amount.

Convenient Care Clinics - Facilities typically located in a high-traffic retail store, supermarket, or pharmacy that provide affordable treatment for uncomplicated minor illness and/or preventative care to consumers. Radiological services are not covered under the Plan when performed at a convenient care clinic.

Copayment (Prescription) - A fixed dollar amount for drugs purchased at retail or through mail order based on three tiers - generic, formulary brand name and non-formulary brand name drugs. Retail drugs for generic $10, Formulary Brand Name $30, Non-Formulary Brand Name $60. Mail Order for generic $10 Formulary Brand Name $60, Non-Formulary Brand Name $120.

Deductible - A fixed dollar amount paid for "in-network" and "out-of-network" services under MMCP and services under the CHCB during the benefit year before the Plan starts to make payments for covered medical services. The Plan has both individual and family deductibles.

Formulary drugs - These are drugs approved by the health care provider. Drugs not approved by the PBM are non-formulary drugs.

Generic drugs - These are drugs that are not under patent. Once a drug's patent has expired, the Plan provides for a $10 copayment.

Name-brand drugs - These are drugs that once were, or still are, under patents.

Out-of-pocket Maximum - The maximum dollar amount a member is required to pay out of pocket during a year. Until this maximum is met, the Plan and member shares in the cost of covered expenses which do not have a fixed copayment. After the maximum is reached, the Plan pays all covered expenses subject to coinsurance. Fixed copayments continue to apply where required.