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Important Changes to Your Benefits Under the Railroad Employees National Health and Welfare Plan

Dear Employee,

Pursuant to collective bargaining agreements between certain participating labor organizations represented by the Health and Welfare Committee of the Cooperating Railway Labor Organizations (the Brotherhood of Locomotive Engineers and Trainmen-IBT; American Train Dispatchers Association; National Conference of Firemen and Oilers/SEIU; and Brotherhood of Railroad Signalmen) and railroads represented by the National Carriers' Conference Committee, changes are being made to the benefits provided by the Railroad Employees National Health and Welfare Plan (the "Plan").

Effective January 1, 2018, the following changes will be made to the Plan:

Changes to the Managed Medical Care Program (MMCP)

Annual Deductibles for In-Network Services

Under the Managed Medical Care Program (MMCP), for In-Network Services for which a fixed-dollar co-pay does not apply, for 2018, the annual deductible will change from $200 to $325 per individual per year, and from $400 to $650 per family per year. For 2019 and thereafter, the annual deductible will change from $325 to $350 per individual per year, and from $650 to $700 per family, per year.

Annual Out-of-Pocket Maximums for In-Network Services

Under the MMCP, for 2018, the maximum Out-of-Pocket amount of In-Network coinsurance that must be paid by the employee will change from $1,000 to $1,800 per individual per year, and from $2,000 to $3,600 per family per year. For 2019 and thereafter, the maximum Out-of-Pocket amount of In-Network coinsurance that must be paid by the employee will change from $1,800 to $2,000 per individual per year, and from $3,600 to $4,000 per family, per year.

Coinsurance for In-Network Services

For 2018 and thereafter, Eligible Expenses for In-Network Services will be paid at 90% (changed from 95%) after any applicable deductible is satisfied; and, at 100% following payment of an applicable fixed-dollar co-pay or after the maximum In-Network Out-of-Pocket is met. Eligible Expenses for ACA Preventive Health Services rendered by In-Network Providers will continue to be paid at 100% with no fixed-dollar co-pay, deductible or coinsurance applied.

Annual Deductibles for Out-of-Network Services

Under the MMCP, for 2018, the annual deductible for Out-of-Network Services will change from $300 to $650 per individual per year, and from $900 to $1,300 per family, per year. For 2019 and thereafter, the annual deductible for Out-of-Network Services will change from $650 to $700 per individual per year, and from $1,300 to $1,400 per family, per year.

Annual Out-of-Pocket Maximums for Out-of-Network Services

Under the MMCP, for 2018, the maximum Out-of-Pocket amount of Out-of-Network coinsurance that must be paid by the employee will change from $2,000 to $3,600 per individual per year, and from $4,000 to $7,200 per family per year. For 2019 and thereafter, the maximum Out-of-Pocket amount of Out-of-Network coinsurance that must be paid by the employee will change from $3,600 to $4,000 per individual per year, and from $7,200 to $8,000 per family per year.

Coinsurance for Out-of-Network Services

For 2018 and thereafter, Eligible Expenses for Out-of-Network Services will be paid at 70% (changed from 75%) after any applicable deductible is satisfied; and, at 100% after the Out-of-Network Out-of-Pocket Maximum is met.

Fixed-Dollar Co-payments

Under the MMCP, the Emergency Room fixed-dollar co-payment will change from $75 to $100 for each visit that is deemed an Emergency as defined by the Plan, regardless of the network status of the provider. The fixed copay applies unless admitted to the hospital.

The fixed-dollar co-payment for each visit to an In-Network Provider that is an Urgent Care Center, or, an In-Network Provider who is in general practice, specializes in pediatrics, obstetrics/gynecology, family practice or internal medicine, or who is a Nurse Practitioner, Physician Assistant, Physical Therapist, or Chiropractor, will change from $20 to $25. The fixed-dollar co-payment for each visit to any other In-Network Provider that is not a Convenient Care Clinic will change from $35 to $40.

Note: Current MMCP ID cards display co-pays in effect prior to January 1, 2018. In the future, MMCP ID cards will show the new co-pays. Even if your MMCP ID card shows the old co-pays, you must pay the co-pays effective January 1, 2018 and thereafter.

***Changes to the Comprehensive Health Care Benefit* (CHCB)**

Annual Deductibles

Under the Comprehensive Health Care Benefit (CHCB), for 2018, the annual deductible will change from $200 to $325 per individual per year, and from $400 to $650 per family, per year. For 2019 and thereafter, the annual deductible will change from $325 to $350 per individual per year, and from $650 to $700 per family per year.

Out-of-Pocket Maximum

Under the CHCB, for 2018, the maximum Out-of-Pocket amount of coinsurance that must be paid will change from $2,000 to $2,800 per individual per year, and from $4,000 to $5,600 per family per year. For 2019 and thereafter, the maximum Out-of-Pocket amount of coinsurance that must be paid will change from $2,800 to $3,000 per individual per year and from $5,600 to $6,000 per family per year.

Coinsurance

For 2018 and thereafter, Eligible Expenses will be paid at 80% (changed from 85%) after any applicable deductible is satisfied; and, at 100% after the maximum Out-of-Pocket is met. Eligible Expenses for ACA Preventive Health Services will continue to be paid at 100% with no deductible or coinsurance applied.

Changes to the Mental Health and Substance Abuse Care Benefit (MHSA)

Integration of MHSA into the MMCP and CHCB

The Plan's Mental Health and Substance Abuse program ("MHSA") will be fully integrated into the Plan's MMCP and CHCB and will not be a separate Plan program. Benefits for mental health and substance abuse care will still be administered by United Behavioral Health (UBH), but the fixed-dollar copayments (if you are enrolled in MMCP), deductibles, coinsurance, and Out-of-Pocket Maximums generally applied under MMCP and CHCB will now apply to mental health and substance abuse care, subject to mental health parity laws.

New Benefit Enhancements Added to the Plan

Added Value Programs

Effective on January 1, 2018, or as soon as administratively practicable thereafter, the Plan will make available to you new voluntary programs to enhance the benefits you already receive under the Plan. These programs are Telemedicine, Expert Second Opinion, Health Advocate, End-of-Life Counseling, and new Cleveland Clinic Centers of Excellence and they are summarized below. These services are wholly voluntary and your use of these services is not required to receive benefits otherwise available under the Plan. You will receive additional information providing the details of each of these programs.

- **Telemedicine**: Telemedicine is a service providing access to virtual physician visits via online video or phone consultations with 24 hours per day and 365 days per year availability. During a virtual visit, you can obtain a diagnosis and possibly a prescription (restrictions apply). This benefit is designed to broaden your access to care and will be administered by Teladoc, a leading national telemedicine provider. If you are enrolled in MMCP, a fixed-dollar co-pay of $10 will be charged to you for each telemedicine visit. If you are enrolled in CHCB, a telemedicine visit will be paid at 80% (i.e., the coinsurance otherwise applied to Eligible Expenses under CHCB), whether or not your deductible is satisfied.

- **Expert Second Opinion**: Expert Second Opinion is a service providing you the opportunity to request second opinions from experts in a particular field or condition. These second opinions will generally include a clinical evaluation of your medical situation, a thorough review and analysis of your medical records, and answers to complex medical questions. These services will be performed by experts affiliated with Best Doctors, a leading national provider of these services. There will be no member cost associated with this program.

- **Health Advocate**: You will be able to reach experienced registered nurses or benefits specialists by phone or online 24/7 to assist with resolving a number of issues that may include but are not limited to:

    - 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

- Finding treatment for complex and serious diagnoses
- Explaining insurance plan options and enrollment
- Transferring medical records, x-rays and lab results
- Researching the latest approaches to care
- Coordinating services during and after a hospital stay

These services are administered by Health Advocate, a leading nationwide company specializing in member advocacy. There will be no member cost associated with this program.

- **End-of-Life Counseling**: You will be able to receive end-of-life counseling under the Plan. These programs are designed to improve the quality of the communication and shared decision-making processes between you, your family, and your physicians in connection with advanced illnesses (life expectancy of one year or less). This program is administered by Vital Decisions. Utilization of this program is on a voluntary and member-initiated basis and there is no member cost associated with this program.

- **Centers of Excellence (COE) Resource Services –Cleveland Clinic**: Beginning in 2018, the Plan will expand its COE Resource Services Program to provide access to Cleveland Clinic's Heart Program. If you are diagnosed with a severe cardiac condition, you can request Cleveland Clinic to conduct a clinical assessment of your condition and determine whether surgical intervention is appropriate. If surgery is appropriate, Cleveland Clinic's world-renowned cardiac surgery team is available to you. This program is wholly voluntary and available at no cost to qualifying members. Benefits currently available to you under the existing COE Resource Services Program, such as the travel benefit will also apply to the Cleveland Clinic's Heart Benefit.

Changes to the Managed Pharmacy Services Benefit (MPSB)

MPSB Co-pays

Co-pays for Prescription Drugs under the Managed Pharmacy Services Benefit (administered by **Express Scripts**) will change as follows:

Retail Prescription Drugs: Co-pays for Generic Drugs at an In-Network Pharmacy will change from $5 to $10 per fill.

Co-Pays for Brand Name Drugs that are Formulary Drugs that are dispensed at an In-Network Pharmacy will change from $25 to $30 per fill if the drug is ordered to be "Dispensed as Written" or if there is no equivalent Generic Drug. Otherwise, the co-pay will be $30 per fill plus the difference in cost between the equivalent Generic Drug and the prescribed Brand Name Drug.

Co-Pays for Brand Name Drugs that are Non-Formulary Drugs that are dispensed at an In-Network Pharmacy will change from $45 to $60 if the drug is ordered to be "Dispensed as Written" or if there is no equivalent Generic Drug. Otherwise, the co-pay will be $60 plus the difference in cost between the equivalent Generic Drug and the prescribed Brand Name Drug.

Mail Order Prescription Drugs: Co-pays for Generic Drugs will change from $5 to $10 per fill.

	Co-Pays for Brand Name Drugs that are Formulary Drugs will change from $50 to $60 per fill.
	Co-Pays for Brand Name Drugs that are Formulary Drugs will change from $90 to $120 per fill.

New MPSB Clinical Management Rules/Programs

Effective January 1, 2018, or as soon as administratively practicable thereafter (as noted below), the Plan will make the following programs applicable:

Screen RX: (effective January 1, 2018)	This program is designed to encourage you to take your prescribed medications. If you are determined to be at risk of becoming non-adherent, i.e., not taking medicine as prescribed by your doctor, you will receive up to three automated calls from Express Scripts. The calls will specifically refer to your medications and you will be offered multiple opportunities to speak with a live pharmacist during the telephone call. If you are not reached by phone, you will receive a letter explaining how you can adhere to taking your prescriptions and a toll-free number you can call for support. This service is provided at no cost to you.
Medical Channel Management: (effective as soon as administratively practical after January 1, 2018)	For certain specified Specialty Drugs (as determined by Express Scripts), you will be required to receive administration of the drug through the Plan's MPSB rather than through its Medical Programs.
Fraud, Waste, and Abuse: (effective January 1, 2018)	This program involves proactive utilization of advanced analytics to identify potential abuse of prescription medications, in particular controlled substances. If Express Scripts determines that you may be at risk of abusing prescription medication, Express Scripts, with cooperation from your medical benefit administrator, will place restrictions on your ability to obtain certain prescription medication.

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This document is intended to serve as a summary of material modifications to the summary plan description and as a summary of material reductions in covered services for the Plan. Unless specifically addressed in this summary of material modifications, the information contained in the summary plan description remains in effect unchanged. Please contact your benefits administrator (Aetna, Highmark BCBS, or UnitedHealthcare), UBH, or Express Scripts with any questions related to the information provided above.