

ARTICLE II - COST-OF-LIVING PAYMENTS

Cost-of-Living Payments Under July 1, 2008 Agreement

Section 1

Article III, Part B, of the July 1, 2008 National UTU Agreement, shall be eliminated effective June 30, 2011.

Section 2

Any local counterpart to the above-referenced Article III, Part B that is in effect on a carrier party to this Agreement shall be amended in the same manner as provided in Section 1.

ARTICLE III - HEALTH AND WELFARE

Part A - Plan Changes

Section 1 - Continuation of Plans

The National Railway Carriers and United Transportation Union Health and Welfare Plan ("NRC/UTU H&W Plan") and the Railroad Employees National Health and Welfare Plan (individually and collectively referred to in this Agreement, depending on the context, as "the Plan"), the Railroad Employees National Dental Plan ("the Dental Plan"), the Railroad Employees National Early Retirement Major Medical Benefit Plan ("ERMA"), and the Railroad Employees National Vision Plan ("the Vision Plan"), modified as provided in this Article with respect to employees represented by the organization and their eligible dependents, will be continued subject to the provisions of the Railway Labor Act.

Section 2 - Plan Design Changes -- NRC/UTU H&W Plan

(a) The Plan's Managed Medical Care Program ("MMCP") shall be revised as follows:

- (1) There shall be a separate, stand-alone, Annual Deductible of \$200 per individual and \$400 per family for In-Network Services for which a fixed-dollar copayment does not apply.
- (2) The percentage of Eligible Expenses paid by the Plan for any In-Network Services for which a fixed-dollar copayment does not apply (as defined by procedure code) shall be 95% of the Eligible Expenses that exceed the applicable Annual Deductible provided for in clause (1) above; the amount payable by the employee as a result of this "coinsurance" shall be capped at \$1,000 per individual per year and \$2,000 per family per year.
- (3) The Emergency Room Co-Payment for In-Network Services shall be increased to \$75.00 for each visit, but shall not apply if the visit results in admission to the hospital.
- (4) The Urgent Care Center Co-Payment for In-Network Services shall be decreased to \$20.00 for each visit.
- (5) In cases where a fixed-dollar copayment of \$20 currently applies to an office visit, the copayment shall be reduced to \$10 if the office is in a "convenient care clinic." A "convenient care clinic" means, for purposes of this Section, a health care facility typically located in a high-traffic retail store, supermarket or pharmacy that provides

affordable treatment for uncomplicated minor illness and/or preventative care to consumers.

- (6) The Plan shall not cover radiological services performed at a convenient care clinic.

(b) The Plan's Managed Medical Care Program ("MMCP") and its Comprehensive Health Care Benefit ("CHCB") shall both be revised to include:

- (1) Participation in a "Radiology Notification Program" (as described in Exhibit B hereto);
- (2) Arrangements for covered employees and their covered dependents to receive, on a wholly voluntary basis and without any copayment or coinsurance, the following additional "Centers of Excellence Resource Services" (as described in Exhibit B hereto): Bariatric Resource Services, Cancer Resource Services, and Kidney Resource Services;
- (3) Arrangements for covered employees and their covered dependents to receive, on a wholly voluntary basis and without any copayment or coinsurance, the resource services made available under a "Treatment Decision Support Program" (as described in Exhibit B hereto).

(c) The Plan's Prescription Drug Card and Mail Order Prescription Drug Programs shall be revised as follows:

- (1) Prior Authorization by the Plan's current pharmacy benefit manager (or any successor pharmacy benefit manager) ("PBM") shall be required, in accordance with such PBM's Prior Authorization Program then in effect, before any prescription drugs in the therapeutic drug categories shown on Exhibit C hereto as subject to such Program shall be dispensed; provided, however, that no more than a three to five-day supply of such a drug may be dispensed at retail in accordance with the PBM's Temporary Override Program without Prior Authorization.
 - (2) Employees and their covered dependents shall be required to adhere to Step Therapy and Quantity/Duration Limits Programs then in effect of the Plan's PBM with respect to the prescription drugs in the therapeutic drug categories shown on Exhibit C hereto as subject to such Step Therapy Program and/or Quantity/Duration Limits Program, as the case may be.
 - (3) Employees and their covered dependents may, on a wholly voluntary basis and in accordance with program criteria, participate in the PBM's Personalized Medicine and/or Generic Rx Advantage Program then in effect.
- (d) The Plan's Prescription Drug Card Program Co-Payments to In-Network Retail Pharmacies per prescription are revised as follows:
- (1) Generic Drug - decrease to \$5.00;
 - (2) Brand Name (Non-Generic) Drug On Program Administrator's Formulary - increase to \$25.00;
 - (3) Brand Name (Non-Generic) Drug Not On Program Administrator's Formulary ~ increase to \$45.00;

(e) The Plan's Mail Order Prescription Drug Program Co-Payments per prescription are revised as follows:

- (1) Generic Drug - decrease to \$5.00
- (2) Brand Name (Non-Generic) Drug on Program Administrator's Formulary – increase to \$50.00;
- (3) Brand Name (Non-Generic) Drug not on Program Administrator's Formulary – increase to \$90.00.

(f) The design changes contained in this Section shall become effective on January 1, 2012 or as soon thereafter as practicable.

Section 3 - Plan Design Changes - ERMA

(a) ERMA's Prescription Drug Card and Mail Order Prescription Drug Programs shall be revised as follows:

- (1) Prior Authorization by ERMA's current pharmacy benefit manager (or any successor pharmacy benefit manager) ("PBM") shall be required, in accordance with such PBM's Prior Authorization Program then in effect, before any prescription drugs in the therapeutic drug categories shown on Exhibit C hereto as subject to such Program shall be dispensed; provided, however, that no more than a three to five-day supply of such a drug may be dispensed at retail in accordance with the PEB's Temporary Override Program without Prior Authorization.
- (2) Retirees and their covered dependents shall be required to adhere to Step Therapy and Quantity/Duration Limits Programs then in effect of ERMA's PBM with respect to

the prescription drugs in the therapeutic drug categories shown on Exhibit C hereto as subject to such Step Therapy Program and/or Quantity/Duration Limits Program, as the case may be.

- (3) Retirees and their covered dependents may, on a wholly voluntary basis and in accordance with program criteria, participate in the PBM's Personalized Medicine and/or Generic Rx Advantage Program then in effect.

(b) The design changes contained in this Section shall become effective on January 1, 2012 or as soon thereafter as practicable, and shall apply only to individuals who become eligible for ERMA coverage on or after January 1, 2012.

Part B - Employee Sharing of Cost of H&W Plans

Section 1 - Monthly Employee Cost-Sharing Contributions

(a) Effective January 1, 2010, the employee monthly cost-sharing contribution amount shall be \$200.00.

(b) Effective January 1, 2011, the employee monthly cost-sharing contribution amount shall be \$202.90.

(c) Effective January 1, 2012, each employee covered by this Agreement shall contribute to the Plan, for each month that his employer is required to make a contribution to the Plan on his behalf for foreign-to-occupation health benefits coverage for himself and/or his dependents, a monthly cost-sharing contribution in an amount equal to the lesser of 15% of the Carriers' Monthly Payment Rate for 2012 or \$200.00.

(d) The employee monthly cost-sharing contributions amount shall be adjusted, effective July 1, 2016, so as to equal the lesser of 15% of the Carrier's Monthly Payment Rate for 2016 or \$230.00, unless otherwise mutually agreed by the parties during negotiations commencing when this Agreement becomes amendable pursuant to Article VIII.

(e) For purposes of subsections (c) and (d) above, the "Carriers' Monthly Payment Rate" for any year shall mean the sum of what the carriers' monthly payments to –

- (1) the Plan for foreign-to-occupation employee and dependent health benefits, employee life insurance benefits and employee accidental death and dismemberment insurance benefits,
- (2) the Dental Plan for employee and dependent dental benefits and
- (3) the Vision Plan for employee and dependent vision benefits,

would have been during that year, per non-hospital association road employee, in the absence of any employee contributions to such Plans.

Section 2 - Pre-Tax Contributions

Employee cost-sharing contributions made pursuant to this Part shall be made on a pre-tax basis pursuant to the existing Section 125 cafeteria plan to the extent applicable.

ARTICLE III – HEALTH AND WELFARE

Q1 – Will employees still be offered the opportunity to “opt-out” of the H&W Plan and be eligible for the \$100 monthly payment?

A1 - Yes.

Q2 - Will the annual deductible and co-insurance requirements apply during the extended coverage afforded employees who are off sick or injured?

A2 - Yes.

Q3 - When an individual/family satisfies the annual out-of-pocket maximum amounts, are the fixed dollar co-pay requirements of the plan still applicable, i.e. office visit, ER, etc.?

A3 - Yes. The employee is still required to satisfy the fixed dollar co-pay requirements, but all other covered expenses are paid at 100%.

Q4 - What types of service will be subject to the annual deductible?

A4 - Any charges for services for which a fixed dollar copayment does not apply. For example, any charges for services that are not covered by the office visit copayment, such as lab charges and x-rays, are subject to the annual deductible.

Q5 - Will the annual deductible (\$200/400) apply toward the annual out-of-pocket maximum?

A5 - No.

Q6 - What effect will these ERMA Plan changes have on an employee who retires and is eligible for ERMA in 2011?

A6 – None. The changes to ERMA apply only to individuals who become eligible for ERMA coverage on or after January 1, 2012.

Q7 - Address the issue of coverage for treatment of a condition that began prior to the medical benefit design change.

A7 – The design changes will not apply to hospital charges for a continuous stay that starts before and ends on or after the effective date of the changes. The design changes will apply to all other services rendered on or after the effective date of the changes, even if such services are for treatment of a condition that began prior to that date.