INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS®

900 Seventh Street, NW
Washington, DC 20001
202.833.7000
www.ibew.org

LONNIE R. STEPHENSON
International President

KENNETH W. COOPER
International
Secretary-Treasurer

January 5, 2018

To: All Railroad Members Working for Railroads Covered Under National Bargaining

Dear Sisters and Brothers:

On December 8, 2017, the IBEW reached a tentative agreement with the National Carriers Conference Committee (NCCC), the bargaining group of the nation's freight railroads. This agreement, covering all IBEW members working on railroads involved in national bargaining (see Exhibit "A" of the agreement for a list of the railroads), is retroactive effective January 1, 2015, through December 31, 2019, with general wage increases through 2019.

It was reached in a cooperative effort with our bargaining coalition, the Coalition of Rail Unions (CRU), which included the Brotherhood of Railway Carmen Division of the Transportation Communication Union (BRC/TCU), the International Association of Machinists (IAM), the Transportation Communication Union/IAM, (TCU) and the Transport Workers Union (TWU). With the exception of agreement language specific to other individual Rail Labor Unions, this agreement contains the same percentage wage increases and health care changes as the agreements reached earlier this fall and ratified by the unions in the Coordinated Bargaining Group (CBG), including the American Train Dispatchers Association (ATDA), the Brotherhood of Locomotive Engineers – Teamsters (BLE-T), the Brotherhood of Railroad Signalmen (BRS), the International Association of Sheet Metal, Air, Rail and Transportation Workers Transportation Division – SMART – UTU, and the National Conference of Firemen and Oilers of the Service Employees International Union – NCF&O/SEIU. These unions overwhelmingly ratified their agreements by margins as large as 88 percent.

Providing for 12.5 percent in general wage increases over its five-year term (three percent of which you already received on January 1, 2015), the average basic rate of pay for an IBEW member will go from $29.26 per hour to $33.09 per hour. The average member will realize a cumulative income gain over the life of the contract of approximately $20,124. Additionally, retroactive pay from July 1, 2016, through January 31, 2018, will average approximately $2,716.09. These figures are based on straight time hours only.

Please be advised there are no work rule changes.

As to the Health and Welfare (H&W) plan, it has been our position all along to remain steadfast in our conviction not to give in to the unreasonable demands of the railroads. I am pleased to advise that we were able to maintain your employee monthly cost share at $228.89 per month through the term of this agreement until it is renegotiated with the next contract. It is estimated that with the 15 percent cost share rate now in place in the current contract, the monthly employee cost could rise to anywhere between $250.00 to $355.00 per month, depending on plan experience and inflation (presently the 15 percent rate would equal approximately $250 p/e p/m). The benefit design changes negotiated will be effective February 1, 2018. And while we did agree to some changes in the benefit plan, the changes we did agree to fall far short of what the Carriers initially proposed, and even that much shorter of their last draconian demands made this past July.

The plan design changes that have been made, including some plan improvements, are outlined and explained in the H&W summary which is enclosed.

This agreement was difficult to reach and took quite a bit of time and effort to attain. After almost a year of getting nowhere in bargaining in October 2015 we were finally placed into mediation. Initially, the Carriers refused to discuss wage increases, and only wanted to talk about dramatic cost shifting in the health benefit costs from them to you. This past July the railroads modified their bargaining position, proposing various additional work rule changes, increasing their demands for further health care cost shifting onto your backs, and also taking retroactive pay off the table. It is important to note that their emboldened bargaining stance came following the election of President Donald Trump and the solidification of a republican controlled House and Senate. However, once they reached their agreements with the Rail Labor Unions in the CBG and those agreements were ratified, they made similar offers to the unions in our coalition, and that brings us to where we are today.

At this point the options are limited, and I believe you should know what the options are and what the potential consequences could be. If the agreement is rejected, that would at some time in the future (but no one can speculate as to how long), lead to a release from mediation followed by a 30-day cooling off period, and then the appointment of a Presidential Emergency Board (PEB) appointed by President Trump. President Trump has the right to pick anyone to serve on a PEB, and I doubt that his appointments would be labor friendly. In most cases where a majority of railroad workers have already ratified agreements, PEB's usually rule that a "pattern" has been established and that the organizations in front of the PEB should get agreements identical to what the other unions got. However, in this case with a Trump PEB, the recommendations could be for less than what the other organizations received.

Following the report of the PEB, which is usually made within 30 – 45 days of its appointment, another 30-day cooling off period would ensue, which most likely would lead to a strike vote. If you vote to strike, the president and Congress, especially considering today's economy, would most likely intervene to prevent it, and final resolution of the dispute would then rest in the hands of Congress. In view of the anti-labor sentiment in Congress today, an agreement could be imposed upon you with terms less favorable than those offered in the tentative agreement in front of you for your consideration.

Enclosed for your review and action you will find a copy of the tentative agreement, wage increase summary and H&W change summary, voting instructions, voting ballot, ballot envelope, and postage-paid return envelope. Please follow the instructions carefully so that your vote will count. Also enclosed in the ratification packet is an article by contributing editor of Railway Age Magazine Frank J. Wilner. Mr. Wilner has been involved with both labor and management in the rail industry for many years, and his opinions are well respected by representatives on both sides. His article analyzes the situation from "outside the box" and is an article worthwhile reading before

you cast your vote. A more detailed analysis of the agreement, along with related information can be found at the following link www.ibew.org/railroad. I urge you to visit the website to review the information. Please remember that this agreement runs through December 31, 2019, in less than two years the negotiating process will start all over again.

While we strived for something better, in today's economy and in view of our options, I and your negotiating committee recommend ratification of the tentative agreement now before you. I would like to thank the negotiating committee for attaining this agreement for our members. The committee, led by Railroad Department Director Bill Bohné, consisted of your System Council General Chairmen: System Council 2 Jim Wisniski, System Council 6 Tom Owens, System Council 7 Arthur J. Davidson, System Council 9 J.J. Giuliano, and System Council 16 Dale Doyle.

Thank you for your patience, cooperation, and solidarity during these trying times. If you have any questions pertaining to the agreement, please feel free to contact your general chairman or Railroad Department Director Bill Bohné by email to Bill_Bohne@IBEW.org.

With best wishes, I am

Fraternally yours,

Lonnie R. Stephenson

Lonnie R. Stephenson
International President

LRS:rmd
Enclosures
Copy to All International Vice Presidents
All Railroad General Chairmen

MEDIATION AGREEMENT

THIS AGREEMENT, made this ___ day of _____, 2018, by and between the participating carriers listed in Exhibit A attached hereto and made a part hereof, and represented by the National Carriers' Conference Committee, and the employees of such carriers shown thereon and represented by the International Brotherhood of Electrical Workers, witnesseth:

IT IS HEREBY AGREED:

ARTICLE I - WAGES

Section 1 - First General Wage Increase

Effective January 1, 2015, all hourly, daily, weekly, and monthly rates of pay in effect on December 31, 2014 for employees represented by the IBEW were increased by three (3) percent pursuant to Article I, Section 6 of the January 5, 2012 National IBEW Agreement. This 3% general wage increase was mutually negotiated to apply as the first-year increase of this five-year Agreement, the term of which runs from January 1, 2015 through December 31, 2019.

Section 2 - Second General Wage Increase

Effective July 1, 2016, all hourly, daily, weekly, and monthly rates of pay in effect on June 30, 2016 for employees covered by this Agreement shall be increased in the amount of two (2) percent applied so as to give effect to this increase in pay irrespective of the method of payment. The increase provided for in this Section 2 shall be applied as follows:

(a) **Hourly Rates** -

Add 2 percent to the existing hourly rates of pay.

(b) **Daily Rates** -

Add 2 percent to the existing daily rates of pay.

(c) **Weekly Rates** –

Add 2 percent to the existing weekly rates of pay.

(d) **Monthly Rates** -

Add 2 percent to the existing monthly rates of pay.

(e) **Disposition of Fractions** -

Rates of pay resulting from application of paragraphs (a) to (d), inclusive, above which end in fractions of a cent shall be rounded to the nearest whole cent, fractions less than one-half cent shall be dropped, and fractions of one-half cent or more shall be increased to the nearest full cent.

(f) **Application of Wage Increase** -

The increase in wages provided for in this Section 2 shall be applied in accordance with the wage or working conditions agreement in effect between each carrier and the labor organization party hereto. Special allowances not included in fixed hourly, daily, weekly, or monthly rates of pay for all services rendered, and arbitraries representing duplicate time payments, will not be increased. Overtime hours will be computed in accordance with individual schedules for all overtime hours paid for.

Section 3 – Third General Wage Increase

Effective July 1, 2017, all hourly, daily, weekly and monthly rates of pay in effect on June 30, 2017 for employees covered by this Agreement shall be increased by two (2) percent applied in the same manner as provided for in Section 2 hereof and applied so as to give effect to this increase irrespective of the method of payment.

Section 4 - Fourth General Wage Increase

Effective July 1, 2018, all hourly, daily, weekly, and monthly rates of pay in effect on June 30, 2018 for employees covered by this Agreement shall be increased in the amount of two-and-one-half (2.5) percent applied in the same manner as provided for in Section 2 hereof and applied so as to give effect to this increase irrespective of the method of payment.

Section 5 – Fifth General Wage Increase

Effective July 1, 2019, all hourly, daily, weekly, and monthly rates of pay in effect on June 30, 2019 for employees covered by this Agreement shall be increased in the amount of three (3) percent applied in the same manner as provided for in Section 2 hereof and applied so as to give effect to this increase irrespective of the method of payment.

ARTICLE II - HEALTH AND WELFARE

Part A – Employee Sharing of Plan Costs

Section 1 – Monthly Employee Cost-Sharing Contributions

The employee monthly cost-sharing contribution amount shall be $228.89 until such time as otherwise mutually agreed by the parties during negotiations commencing when this Agreement becomes amendable pursuant to Article III.

Section 2 – Other Terms

Existing arrangements regarding the method of making employee cost-sharing contributions on a pre-tax basis shall be continued subject to the provisions of the Railway Labor Act.

Part B – Plan Changes

Section 1 – Continuation of Plans

The Railroad Employees National Health and Welfare Plan ("the Plan"), the

Railroad Employees National Dental Plan, the Railroad Employees National Early Retirement Major Medical Benefit Plan, the Railroad Employees National Vision Plan ("the Vision Plan"), and the Railroad Employees National Health Flexible Spending Account Plan ("FSA"), modified as provided in this Article with respect to employees represented by the organization and their eligible dependents, shall be continued subject to the provisions of the Railway Labor Act.

Section 2 – Plan Design Changes

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

(1) The Annual Deductible for In-Network Services for which a fixed-dollar co-payment does not apply shall be $325 per individual and $650 per family, respectively, in 2018 and $350 and $700, respectively, in 2019 and thereafter.

(2) The Individual and Family In-Network Out-of-Pocket Maximums shall be $1,800 and $3,600, respectively, in 2018 and $2,000 and $4,000, respectively, in 2019 and thereafter.

(3) The Emergency Room fixed-dollar co-payment for In-Network and Out-of-Network Services shall be $100, for each visit, but shall not apply if the visit results in admission to the hospital.

(4) The fixed-dollar co-payment for each visit to an In-Network Provider that is an Urgent Care Center, or 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, shall be $25. The fixed-dollar co-payment for each visit to any other In-Network Provider that is not a Convenient Care Clinic shall be $40. The fixed-dollar co-payment for each visit to a Convenient Care Clinic shall be $10.

(5) Eligible Expenses for In-Network Services, other than ACA Preventive Health Services, shall be paid at 90% after any applicable deductible is satisfied and at 100% following

payment of an applicable fixed-dollar co-payment or after the In-Network Out-of-Pocket Maximum is met.

(6) The Annual Deductible for Out-of-Network Services shall be $650 per individual and $1,300 per family, respectively, in 2018, and $700 per individual and $1,400 per family, respectively, in 2019 and thereafter.

(7) The Individual and Family Out-of-Network Out-of-Pocket Maximums shall be $3,600 and $7,200, respectively, in 2018 and $4,000 and $8,000, respectively, in 2019 and thereafter.

(8) Eligible Expenses for Out-of-Network Services shall be paid at 70% after any applicable deductible is satisfied and at 100% after the Out-of-Pocket Maximum is met, in each case subject to a 20% reduction in benefits for failure to give any notice required by the Plan or if the company administering the member's benefits determines that the service or supply is not Medically Appropriate.

(b) The Plan's Comprehensive Health Care Benefit ("CHCB") shall be modified as follows:

(1) The Annual Deductible shall be $325 per individual and $650 per family, respectively, in 2018 and $350 and $700, respectively, in 2019 and thereafter.

(2) The Individual and Family Out-of-Pocket Maximums shall be $2,800 and $5,600, respectively, in 2018 and $3,000 and $6,000, respectively, in 2019 and thereafter.

(3) Eligible Expenses, other than those for ACA Preventive Health Services, shall be paid at 80% after any applicable deductible is satisfied and at 100% after the Out-of-Pocket Maximum is met, in each case subject to a 20% reduction in benefits for failure to give any notice required by the Plan or if the company administering the member's benefits determines that the service or supply is not Medically Appropriate.

(c) The Plan's Managed Medical Care Program ("MMCP") and its Comprehensive Health Care Benefit ("CHCB") shall both be modified as follows:

(1) They shall include arrangements for covered employees and their covered dependents to receive, on a wholly voluntary basis and, except as noted in the immediately succeeding sentences, without any co-payment or co-insurance, the Telemedicine, Expert Second Opinion, Health Advocacy and End-of-Life Counseling benefits described in Exhibit B hereto. There shall be a co-payment of $10 for each Telemedicine visit under the In-Network segment of the MMCP. Co-insurance shall be applied as applicable to each Telemedicine visit under CHCB.

(2) To improve the effectiveness of the Plan's Care Coordination/ Medical Management activities, the parties shall select one of the three current medical vendors to serve as the sole provider and administrator of such activities, regardless of what company administers the covered employee's or covered dependent's benefits. The process and timetable for implementation of this initiative is set forth in Side Letter #4 to this Agreement.

(3) Benefits for Eligible Expenses for Covered Health Services that consist of Mental Health Care or Substance Abuse Care shall be provided under the MMCP and CHCB and shall continue to be administered by the current provider of Mental Health Care and Substance Abuse Care benefits. Such Expenses shall be subject to all of the terms and conditions of the MMCP and CHCB as are applicable to the programs' coverage of medical and surgical services in accordance with mental health parity laws.

(4) The MMCP and CHCB will not cover the cost of those Specialty Drugs that are covered under the Medical Channel Management Program described in Exhibit C hereto.

(5) The Centers of Excellence (COE) Resource Services shall be expanded as described in Exhibit B hereto.

(d) The Plan's Prescription Drug Card and Mail Order Prescription Drug Programs shall both be modified as follows:

(1) They shall include the Medical Channel Management Program described in Exhibit C hereto, or its equivalent.

(2) They shall include the Screen Rx Program described in Exhibit C hereto, or its equivalent.

(3) They shall include the Fraud, Waste and Abuse Program described in Exhibit C hereto, or its equivalent.

(e) The Plan's Prescription Drug Card program shall be modified as follows:

(1) The co-payment per fill for a Generic Drug at an In-Network Pharmacy shall be $10.

(2) The co-payment per fill for a Brand Name Drug that is a Formulary Drug dispensed at an In-Network Pharmacy shall be $30 if the drug is ordered by a Physician to be "Dispensed As Written" or if there is no equivalent Generic Drug. Otherwise, the co-payment shall be $30 plus the difference in cost between the equivalent Generic Drug and the prescribed Brand Name Drug.

(3) The co-payment per fill for a Brand Name Drug that is a Non-Formulary Drug dispensed at an In-Network Pharmacy shall be $60 if the drug is ordered by a Physician to be "Dispensed As Written" or if there is no equivalent Generic Drug. Otherwise, the co-payment shall be $60 plus the difference in cost between the equivalent Generic Drug and the prescribed Brand Name Drug.

(f) The Plan's Mail Order Prescription Drug Program shall be modified as follows:

(1) The co-payment per fill for a Generic Drug shall be $10.

(2) The co-payment per fill for a Brand Name Drug that is a Formulary Drug shall be $60.

(3) The co-payment per fill for a Brand Name Drug that is a Non-Formulary Drug shall be $120.

(g) The Plan's Mental Health and Substance Abuse program ("MHSA") shall be fully integrated into the Plan's MMCP and CHCB as called for under Section (c)(3) above and shall not be a separate Plan program.

(h) The Vision Plan shall be modified as follows:

(1) One eye exam per calendar year.

(2) One Prescription pair of eyeglass Lenses (or two Prescription separate eyeglass Lenses) every two calendar years.

(3) One pair of eyeglass frames for Prescription Lenses every two calendar years.

Part C – Flexible Spending Accounts

The FSA, established on behalf of the railroads represented by the National Carriers' Conference Committee in the 2010 national bargaining round and made available to the employees represented by the IBEW pursuant to the Letter of Understanding between the parties dated February 20, 2012, is amended as follows effective for Plan Years beginning 2019, except as otherwise provided.

(a) The annual grace period shall end on March 15 of the calendar year immediately following the end of each Plan Year.

(b) Annual contributions through pre-tax wage deductions may be made up to the maximum amount permitted by law, provided, however, that such

contribution amount shall be capped at $3000 for Plan Year 2019 and shall increase by not more than $500 annually for each Plan Year thereafter.

(c) The Carriers' right to terminate participation in the FSA of employees covered by this Agreement for failure to meet any level or percentage of enrollment in the FSA of such employees eligible to enroll is suspended beginning Plan Year 2018, provided, however, that such suspension may be revoked for any Plan Year, commencing 2020, upon ninety (90) days written notice to the President of the IBEW from the Chairman of the National Carriers' Conference Committee.

Part D – Solicitation of Bids from Pharmacy Benefit Managers

The Plan shall promptly solicit bids from suitable companies to provide pharmacy benefit management services to the Plan and shall offer to negotiate a contract with such bidder as may be selected, as provided in Side Letter #3 to this Agreement.

Part E – Effective Date and Definitions

(a) The modifications provided for in this Article shall be effective February 1, 2018.

(b) Any terms used in this Article that are defined in the Plan shall be given the same meaning, unless otherwise provided. A "Specialty Drug", for purposes of the Medical Channel Management Program described in Exhibit C hereto, or its equivalent, shall include any Prescription Drug classified by the Plan's Pharmacy Benefit Manager for its general book of business as a specialty drug.

ARTICLE III - GENERAL PROVISIONS

Section 1 - Court Approval

This Agreement is subject to approval of the courts with respect to participating carriers in the hands of receivers or trustees.

Section 2 - Effect of this Agreement

(a) The purpose of this Agreement is to settle the disputes growing out of the notices served upon the organization by the carriers listed in Exhibit A on or subsequent to November 1, 2014 (including any notices outstanding as of that date), and the notices served by the organization signatory hereto upon such carriers on or subsequent to November 1, 2014 (including any notices outstanding as of that date).

(b) This Agreement shall be construed as a separate agreement by and on behalf of each of said carriers and their employees represented by the organization signatory hereto, and shall remain in effect through December 31, 2019 and thereafter until changed or modified in accordance with the provisions of the Railway Labor Act, as amended.

(c) No party to this Agreement shall serve or progress, prior to November 1, 2019 (not to become effective before January 1, 2020), any notice or proposal.

(d) This Article will not bar management and the organization on individual railroads from agreeing upon any subject of mutual interest.

SIGNED AT ARLINGTON, VA., THIS _____ DAY OF _____, 2018.

FOR THE PARTICIPATING CARRIERS LISTED IN EXHIBIT A REPRESENTED BY THE NATIONAL CARRIERS' CONFERENCE COMMITTEE:

AKG

Chairman

12/8/17

FOR THE EMPLOYEES REPRESENTED BY THE INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS:

LRS

President

12/8/17

_____, 2018
#1

Mr. Lonnie R. Stephenson
International President
International Brotherhood of
Electrical Workers
900 Seventh Street, N.W.
Washington, D.C. 20001

Dear Mr. Stephenson:

This confirms our understanding with respect to the general wage increases provided for in Article I, Sections 2 and 3 of the Agreement of this date.

The carriers will make all reasonable efforts to pay the retroactive portion of such general wage increases as soon as possible and no later than sixty (60) days after the date of this Agreement. The carriers will also implement the general wage increases referenced above on February 1, 2018, or as soon thereafter as practicable.

If a carrier finds it impossible to make such retroactive payments and/or implement the referenced general wage increases by the dates specified above, such carrier shall notify you in writing explaining why such payments and/or implementation have not been made and indicating when such action(s) will occur.

Very truly yours,

AKG

A. Kenneth Gradia

_____, 2018
#2

Mr. Lonnie R. Stephenson
International President
International Brotherhood of
Electrical Workers
900 Seventh Street, N.W.
Washington, D.C. 20001

Dear Mr. Stephenson:

This refers to the increase in wages provided for in Sections 2 and 3 of Article I of the Agreement of this date.

It is understood that the retroactive portion of those wage increases shall be applied only to employees who have an employment relationship with a carrier on the date of this Agreement or who retired or died subsequent to June 30, 2016.

Please acknowledge your agreement by signing your name in the space provided below.

Very truly yours,

AKG

A. Kenneth Gradia

I agree:

LRS

Lonnie R. Stephenson

_____, 2018
#3

Mr. Lonnie R. Stephenson
International President
International Brotherhood of
Electrical Workers
900 Seventh Street, N.W.
Washington, D.C. 20001

Dear Mr. Stephenson:

This confirms our understanding with respect to Article II, Part D of the Agreement of this date.

During our discussions in connection with the Agreement of this date, the parties recognized that it would be in the best interests of all stakeholders to conduct a request for information or request for proposals (in either case, an "RFI") from certain national pharmacy benefit managers ("PBMs") in connection with the possible selection of a new PBM to administer pharmacy benefits under The Railroad Employees National Health and Welfare Plan (the "Plan"). We agreed that it would be best to establish a formalized process to solicit information from potential PBMs, review that information, and ultimately select a new PBM or continue with the existing PBM. That process is described below.

The PBM review and selection process will be conducted in four phases – RFI submission, RFI response review, PBM selection, and PBM implementation.

1. RFI Submission. The Chairman of the National Carriers' Conference Committee and the designated representatives from the Unions signatory to this Letter Agreement or a counterpart Letter Agreement shall designate carrier and union representatives to prepare the RFI with support from advisors and counsel. The RFI shall be submitted to Express Scripts, Inc., Optum Rx, and CVS/Caremark (collectively, the "PBM Candidates") no later than January 31, 2018.

2. RFI Response Review. The PBM Candidates shall be instructed to provide responses to the RFI no later than March 20, 2018. The designated carrier and union representatives shall schedule a meeting to occur no later than April 20, 2018. The purpose of this meeting shall be to review summaries of the RFI responses, and to determine which PBM Candidates should be invited to provide in-person presentations. Such determination shall be made by unanimous vote of the designated representatives, with each side having one vote. In the event that the designated representatives are not unanimous, the determination will be made by the Joint Plan Committee ("JPC"). In-person presentations shall be conducted by PBM Candidates no later than May 30, 2018. The designated carrier and labor representatives, and their advisors and counsel, shall be invited to attend.

3. PBM Selection. No later than June 30, 2018, management (through the Chairman of the National Carriers' Conference Committee) and labor (through the designated representatives from the Unions signatory to this Letter Agreement or a counterpart Letter Agreement) shall inform one another of their respective preferred PBM Candidate. The JPC shall vote on which PBM Candidate to select no later than July 13, 2018. The selected PBM Candidate shall be notified no later than August 1, 2018.

4. PBM Implementation. During the period beginning August 1, 2018 and ending November 30, 2018, the designated carrier and union representatives, with support from advisors and counsel, shall negotiate a services agreement with the selected PBM Candidate that shall be conditioned upon approval by the JPC. The JPC shall vote on whether to approve the negotiated agreement, and if approval is given, shall execute it, no later than December 31, 2018. The designated carrier and labor representatives will work together to prepare and distribute member communications related to the new PBM.

Key dates described above are summarized in the following table:

Task to be Completed	**No Later Than**
RFI formally submitted to PBM Candidates.	January 31, 2018
Deadline for PBM Candidate response to RFI.	March 20, 2018
Meeting to discuss RFI responses.	April 20, 2018
In-person presentations by PBM Candidates.	May 30, 2018

Meeting to select PBM.	June 30, 2018
Joint Plan Committee formally approves PBM.	July 13, 2018
Selected PBM Candidate Notified.	August 1, 2018
Implementation Period	August 1 – December 31, 2018
Effective date of new PBM.	January 1, 2019

Please acknowledge your agreement by signing your name in the space provided below.

Very truly yours,

AKG

A. Kenneth Gradia

I agree:

LRS

Lonnie R. Stephenson

_____, 2018

#4

Mr. Lonnie R. Stephenson
International President
International Brotherhood of
Electrical Workers
900 Seventh Street, N.W.
Washington, D.C. 20001

Dear Mr. Stephenson:

This will confirm our understanding concerning the implementation of Article II – Health and Welfare, Part B, Section 2(c)(2) of the Agreement of this date.

The following process and timetable for implementation of this initiative by the Joint Plan Committee (JPC) shall occur:

- The three current medical vendors will be invited to make proposals to the representatives of the National Carriers' Conference Committee ("NCCC") and the IBEW, along with the other Unions who may be party to the same provisions, as designated by the Chairman of the NCCC and the participating Unions, respectively, to serve as the sole provider and administrator of the Plan's Care Coordination/Medical Management ("CC/MM") activities, regardless of what company administers a covered employee's or covered dependent's medical benefits.

- The designated representatives shall mutually establish metrics and criteria, with assistance of the Willis Towers Watson care management group, to evaluate each vendor's proposal as well as the selected vendor's performance through 2019. The JPC shall have the right to rebid the Plan's CC/MM activities for CY 2020 and beyond.

- Meetings with the finalists will be held on or about January 26, 2018.

- The vendors will submit their Best and Final Offers by February 2, 2018.

- The successful bidder will be chosen by February 9, 2018, and notified by February 12, 2018.

- The Implementation Period, including development of guidelines, negotiation and execution of agreements, and transition plan to transition to new arrangements that assures continuity of care for affected individuals will occur from February 12, 2018 to May 4, 2018.

- Appropriate member communications shall be developed and disseminated between April 1, 2018 and May 31, 2018.

- The new CC/MM arrangements go live on June 1, 2018 (though certain elements may be phased in earlier).

I trust this accurately describes the understanding we have reached. Please confirm your agreement by signing your name below.

Very truly yours,

AKG

A. Kenneth Gradia

I agree:

LRS

Lonnie R. Stephenson

_____, 2018
#5

Mr. Lonnie R. Stephenson
International President
International Brotherhood of
Electrical Workers
900 Seventh Street, N.W.
Washington, D.C. 20001

Dear Mr. Stephenson:

This will confirm our understanding regarding the Agreement of this date ("2018 National IBEW Agreement") with respect to local discussions between the Organization and certain carriers concerning matters described in Attachment D of the Organization's December 12, 2014 Section 6 Notice.

Upon written request by the Organization's designated representative to the applicable carrier's designated representative, the parties shall commence local discussions on a voluntary and informal basis (i.e., not under Section 6 of the Railway Labor Act). Any proposals in the aforementioned Attachment D that involve changing terms of national benefit, vacation, or holiday plans, and/or address matters contained in the 2018 National IBEW Agreement, will not be part of such voluntary local discussions. Any voluntary local discussions on an applicable carrier shall conclude by the earlier of the date on which a voluntary agreement is reached or December 31, 2018, unless extended by mutual agreement.

Please acknowledge your agreement by signing your name in the space provided below.

Very truly yours,

AKG

A. Kenneth Gradia

I agree:

LRS

Lonnie R. Stephenson

EXHIBIT A
(IBEW)

RAILROADS REPRESENTED BY THE NATIONAL CARRIERS' CONFERENCE COMMITTEE IN CONNECTION WITH NOTICES SERVED ON OR SUBSEQUENT TO NOVEMBER 1, 2014 BY AND ON BEHALF OF SUCH CARRIERS UPON THE INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS, AND NOTICES SERVED ON OR SUBSEQUENT TO NOVEMBER 1, 2014 BY THE GENERAL CHAIRMEN, OR OTHER RECOGNIZED REPRESENTATIVES, OF THE INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS UPON SUCH CARRIERS.

Subject to indicated footnotes, this authorization is co-extensive with notices filed and with provisions of current schedule agreements applicable to employees represented by the International Brotherhood of Electrical Workers.

The Belt Railway Company of Chicago
Bessemer and Lake Erie Railroad Company d.b.a. C.N.
BNSF Railway Company
Consolidated Rail Corporation
CSX Transportation, Inc.
Delaware & Hudson Railroad Company d.b.a. C.P. - 2
Gary Railway Company – 1
Grand Trunk Western Railroad Company d.b.a. C.N.
Illinois Central Railroad Company and Chicago, Central & Pacific Railroad Company d.b.a. C.N.
Indiana Harbor Belt Railroad Company
The Kansas City Southern Railway Company
Kansas City Southern Railway
Louisiana and Arkansas Railway
MidSouth Rail Corporation
Gateway Western Railway
SouthRail Corporation
The Texas Mexican Railway Company
Joint Agency
Norfolk Southern Railway Company

The Alabama Great Southern Railroad Company
Central of Georgia Railroad Company
The Cincinnati, New Orleans & Texas Pacific Railway Company
Georgia Southern and Florida Railway Company
Interstate Railroad Company
Tennessee, Alabama and Georgia Railway Company
Tennessee Railway Company
Northeast Illinois Regional Commuter Railroad Corporation (METRA) - 2
Northern Indiana Commuter Transportation District – 2
Soo Line Railroad Company d.b.a. C.P. - 2
Terminal Railroad Association of St. Louis
Union Pacific Railroad Company
Wisconsin Central Ltd. d.b.a. C.N.
Wisconsin Central Ltd. as successor to Duluth, Missabe & Iron Range Railway d.b.a. C.N.

* * * * * *

Notes:

1 - Health & Welfare only

2 - Health & Welfare and Supplemental Sickness only

FOR THE CARRIERS:

AKG

FOR THE INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS:

LRS

_____, 2018
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Exhibit B--Added Value 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, members can obtain a diagnosis and possibly a prescription. It is not intended as a replacement for the standard PCP relationship, but as an enhancement to broaden member access.

Telemedicine will be offered uniformly, as an in-network MMCP and CHCB benefit, across each of the Plan's benefit administrators making use of a single telemedicine organization, namely, Teladoc, a leading national telemedicine provider that has real-time eligibility (RTE) bridges built with all three of the Plan's benefit administrators.

Expert Second Opinion

This program will offer voluntary, member-initiated expert second opinions that will generally include clinical evaluation of the member's medical situation, a thorough review of the member's medical records, and answers to complex member medical questions. The services provided by this program will be performed by experts affiliated with Best Doctors, a leading provider of these services in the country.

Members will initiate the service by calling a dedicated 800-number or online, and then proceed to provide detailed data on their medical situation to a physician with a specialty matched to their condition. Best Doctors collects all the records-the member just needs to sign a release form. The member's case is then reviewed by one or more world renowned Experts who provide their opinions and recommendations via a detailed written report that is thoroughly reviewed with the member. There will be no member cost associated with this program.

Health Advocate

Health Advocate, a leading provider of the kind of services provided by this program, will make available by phone or online 24/7 individuals who are typically seasoned registered nurses or experienced benefits specialists, on a voluntary and member initiated basis, to help resolve a number of issues, including, but 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

End-of-Life Counseling

Vital Decisions' end-of-life counseling programs will be made available to Plan members on a voluntary and member-initiated basis. These programs utilize both telephonic and technology-enabled solutions that provide a compassionate, patient centered experience that readies a patient for relevant end-of-life decision-making.

The programs are designed to improve the quality of the communication and shared decision-making processes for Plan members with advanced illness (life expectancy of one year or less), their family and their physicians. The improvement of these processes is achieved by assisting the individuals to overcome the inherent barriers and obstacles that normally prevent them from effectively communicating their quality of life priorities to their family and physicians and participating in making significant end-of-life decisions.

Core principles of Vital Decisions' program strategy and methods are:

- Care decisions should reflect the personal quality of life priorities and values of the individual especially during the time of complex or serious illness.
- Behavioral Economics and Behavior Change Science should be selectively and effectively utilized to achieve high quality values communications and a shared decision-making process that integrate a patient's values.
- The member should understand that he/she is the key to success and focus of improving the processes.

Centers of Excellence (COE) Resource Services – Cleveland Clinic

The Plan's current Centers of Excellence (COE) Resource Services will be expanded through the Plans' entering into a contract with the Cleveland Clinic to provide enhanced specialty services to members. During the first year of the contract, only the Cleveland Clinic's Heart Benefit will be available to members. During the second year, the Cleveland Clinic's Orthopedic and Spine Benefit, in addition to the Heart Benefit, will be available to members. Specific services covered under the Cleveland Clinic COE Resource Services program will be set forth in the contract entered into between the Plans and the Cleveland Clinic.

Member participation in the Cleveland Clinic COE Resource Services program shall be entirely voluntary. Benefits currently available to members under the existing COE Resource Services program, such as the travel benefit and cost-sharing waiver, shall also apply to the Cleveland Clinic COE Resource Services program.

An additional hospital(s) may be added to this enhanced COE network after successful completion of the first year for services specific to cardiac care as defined in the first year of implementation or specific to orthopedic services as defined in the second year.

Exhibit C – New Pharmacy Programs

Screen Rx

The program will work as follows:

- Members predicted to become non-adherent, i.e., not taking medicine as prescribed by their doctor, will receive up to three automated outbound calls showing Express Scripts' name on the caller ID. The calls will specifically refer to the member's medications.

- Members will be asked to answer questions determined by branching logic about adherence barriers. Calls are expected to last 5 minutes on average and will afford the member multiple opportunities to speak with a live pharmacist.

- Members not reached by phone will receive a letter with adherence tips and an 800 number for 24/7 support.

Medical Channel Management

Under this program, members will obtain specified Specialty Drugs through the Plan's Pharmacy Programs rather than through its Medical Programs.

Fraud, Waste and Abuse

This program involves proactive utilization of advanced analytics to identify potential abuse of prescription medications, in particular controlled substances. Where abuse is confirmed through investigation and objective evidence, appropriate restrictions are implemented by Express Scripts (pharmacy lock limiting member to one pharmacy or one prescriber) in collaboration with medical vendor.

December 8, 2017 IBEW Tentative National Agreement

Examples of Hourly Rate Increases and Retroactive Pay

ASSUMPTIONS:

a. Rates of pay may vary slightly by Railroad
b. Effective date of new agreement is January 1, 2015
c. Journeyman IBEW rate of pay on 12/31/2014 was $29.26
d. Employee is paid at straight time for 2080 hours annually (52 weeks X 40 hours = 2080 hours)

1. General Wage Increases

Effective Date	Previous Rate X	GWI Increase =	New Pay Rate
January 1, 2015	$29.26	3%	$30.14
July 1, 2016	$30.14	2%	$30.74
July 1, 2017	$30.74	2%	$31.35
July 1, 2018	$31.35	2.5%	$32.13
July 1, 2019	$32.13	3%	$33.09

2. Retroactive Pay

Date	Pay Increase X	Straight Time Hours =	Retroactive Pay
7/1/2016 – 6/30/2017	$.60 ($30.74-$30.14)	2080	$1,248.00
7/1/2017 – 1/31/2018	$1.21 ($31.35-$30.14)	1213.3	$1,468.09
		Retroactive Pay Total =	**$2,716.09**

3. Cumulative Realized Income Gain Over Term of Agreement

Effective Date	New Rate -	Previous Rate =	Pay Increase X	ST Hours =	CRIG*
1/1/2015	$30.14	$29.26	$.88	3120	$2,745.60
7/1/2016	+$.60 = $30.74	$29.26	$1.48	2080	$3,078.40
7/1/2017	+$.61 = $31.35	$29.26	$2.09	2080	$4,347.20
7/1/2018	+$.78 = $32.13	$29.26	$2.87	2080	$5,969.60
7/1/2019	+$.96 = $33.09	$29.26	$3.83	1040	$3,983.20
				Total =	**$20,124.00**

Wage Increase for 5 Year Agreement Totals: $20,124.00

- **The above figures are estimates based solely on the Journeyman straight time rate of pay and hours, actual figures will vary depending on individual rates and overtime hours worked.**

***CRIG = Cumulative Realized Income Gain Over Term of Agreement**

OVER

December 8, 2017 IBEW Tentative National Agreement

Health and Welfare Changes

Employee Monthly Cost Sharing – Will remain frozen at $228.89 until a new contract is negotiated.

Benefit Changes – Changes below apply to In-Network "MMCP – Managed Medical Care Plan." *

	Proposed	**Current**
ER Co-pay	$100 (if not admitted)	$75
Primary Care Co-pay	$25	$20
Urgent Care Co-pay	$25	$20
Convenient Clinic Co-pay	$10	$10
Telemedicine Co-pay	$10	N/A
Annual Deductible *Individual / Family	*$325 / $650 (1/1/2018)	*$200 / $400
	*$350 / $700 (1/1/2019)	
Co-Insurance after Ded.	10% of charge	5% of charge
Out-of-Pocket Max. *Individual / Family	*$1,800 / $3,600 (1/1/2018)	*$1,000 / $2,000
	*$2,000 / $4,000 (1/1/2019)	

Prescriptions

	Generic / Formulary / Non-Formulary	
Retail	$10 / $30/ $60	$5 / $25/ $45
Mail Order	$10 / $60 / $120	$5 / $50 / $90

New Added Value Programs – Telemedicine, Expert Second Opinion, Health Advocate, End-of-Life Counseling, and Centers of Excellence (COE) Resource Services – Cleveland Clinics.

NOTE: *The specific Health & Welfare changes can be found in the enclosed agreement, including changes to the Comprehensive Health Care Benefits (CHCB) and all "Out-of-Network" services. Additionally, a more in-depth analysis of the Health and Welfare Benefit changes can be found at "2017 National Agreement Health & Welfare Detailed Summary" on the IBEW website, Railroad Department section.

OVER

Ratifications make rail strike unlikely

Friday, December 01, 2017
Written by Frank N. Wilner, Contributing Editor
RAILWAY AGE MAGAZINE

The probability of a national railroad strike has likely been reduced to single digits with ratification of a new national wage, benefits and work rules agreement by four rail unions comprising more than half of unionized rail workers.

The ratified agreements will now be considered by railroads as patterns to be accepted by the unions that have yet to reach and/or ratify a tentative agreement. Those unions remain at the bargaining table with the National Railway Labor Conference, which represents U.S. Class I railroads and many regionals and short lines. Class I carriers include BNSF, CSX, Kansas City Southern, Norfolk Southern and Union Pacific.

Under the Railway Labor Act, contracts never expire, but continue in force until periodically amended. The National Mediation Board (NMB) controls the process, providing skilled mediators who work to focus the parties on common interests and constructive dialogue.

The Railway Labor Act prohibits strikes or lockouts until the NMB releases the parties. Even then, there is a lengthy process leading to non-binding recommendations by a Presidential Emergency Board (PEB), followed by additional talks before a strike or lockout may occur.

This round of national bargaining over wages, benefits and work rules began almost three years ago. Railroads have been negotiating as a single coalition, while the 12 labor unions voluntarily separated into three separate coalitions.

The largest union coalition, which reached the tentative agreement in October, includes the American Train Dispatchers Association; Brotherhood of Locomotive Engineers and Trainmen; Brotherhood of Railroad Signalmen; International Brotherhood of Boilermakers, Iron Ship Builders, Forgers and Helpers; and Sheet Metal, Air, Rail and Transportation Workers (SMART) Transportation Division (including yardmasters).

Four of those six unions, representing conductors, dispatchers, engineers and signalmen, ratified. The boilermakers rejected the tentative agreement, while the firemen and oilers haven't completed the ratification vote.

Two other coalitions remain at the bargaining table. One, comprising 22% of unionized rail workers, includes the International Association of Machinists and Aerospace Workers; International Brotherhood of Electrical Workers; Transportation Communications International Union; and Brotherhood Railway Carmen. The third coalition, comprising 20% of unionized rail workers, includes the Brotherhood of Maintenance of Way Employes and the shopcraft side of SMART.

Provisions of the ratified agreement are retroactive to January 2015, and its terms are not subject to renegotiation before January 2020.

OVER

There now will be pressure on remaining unions to accept the pattern set. In fact, the NMB can keep those unions at the bargaining table indefinitely – especially if the NMB determines they are not engaged in good-faith bargaining.

If one or more do not reach a tentative agreement that is ratified by its members, the NMB eventually will release them from bargaining, which begins a series of three 30-day cooling-off periods punctuated by appointment of a PEB that will make non-binding settlement recommendations. Should those recommendations—typically mindful of the pattern already set—be rejected, a strike could then occur.

There has not been a national railroad strike since 1991. Historically, Congress steps in within hours with legislation ending a national railroad work stoppage, imposing a third-party settlement most often mirroring PEB recommendations. Railway Labor Act procedures would delay such an unlikely outcome at least until spring. Congress can and has imposed less generous terms on overly truculent unions, and there is practical reason to assume that this current conservative congressional majority would not look kindly on a holdout after most other unions have settled.

In fact, the ratified agreements reflect realization among workers of an economic environment characterized by wage stagnation and increasing healthcare cost burdens on most American workers, and a rail industry coping with a significant reduction in its bedrock coal traffic. Viewing the tentative agreement as equitable in this environment, BLET and SMART-TD members ratified it by overwhelming margins – 80% for SMART-TD and near 90% among BLET members.

The ratified contract, which is still on the table for the unions that have yet to settle, puts at least $33,000 more into the pockets of the highest paid rail workers within just two years and more than $16,000 by mid-2019 to those in the lower wage rungs. And there is not a single work rules change.

Although healthcare co-pays, deductibles and out-of-pocket maximums rise—but more slowly than medical cost inflation, and barely for those in good health—employee monthly insurance premiums are capped at the current level until at least mid-2020. By contract, other private sector and federal workers pay significantly more. In fact, railroads will be paying some 90% of all employee healthcare costs.

Both labor and carrier negotiators were complimentary of the guidance provided the Coordinated Bargaining Coalition by NMB mediator Eva Durham, and in the latter stages by NMB member Linda Puchala, who was a NMB mediator for many years prior to her 2009 elevation as a Senate-confirmed NMB seat.

December 8, 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.

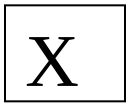
Out-of-pocket Maximum - The maximum dollar amount a member is required to pay out of pocket during a year. Until this maximum is met, the Plan and member shares in the cost of covered expenses which do not have a fixed copayment. After the maximum is reached, the Plan pays all covered expenses subject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

JANUARY 2018 IBEW National Railroad Agreement

OFFICIAL VOTING INSTRUCTIONS

Voting on this contract is by "Secret Ballot," with votes counted member by member. All "Ballot" envelopes will be removed from the return envelopes and placed in a separate container prior to opening the ballots. **No one will know how you voted!**

Place an "X" in the appropriate box on the "Official Ballot."

Example: 

Fold the ballot and place the ballot inside the "**Ballot**" envelope.

Place the ballot envelope inside the self-addressed stamped return envelope and mail it immediately.

You ***must*** place your full name, address, Local Union number, and System Council number in the space provided on the upper left-hand corner of the self-addressed stamped return envelope. Your Local Union and System Council numbers are located under your name on the envelope the ratification package was mailed in. ***Return envelopes missing this information will not be opened and, therefore, your vote will not count*****!** Also, please check the box under your return address if this address is different from the address your ratification package was mailed to. If we mailed the package to the correct address then no action is necessary.

All ballots **must** be postmarked no later than **January 31, 2018**. Any ballots postmarked after this date will not be counted.

You must use this official ballot. **Photo copies of this ballot will not be accepted!**

It is imperative that you follow these instructions in order for your vote to count.

Ballots will be counted on Wednesday, February 7, 2018 at the IBEW International Headquarters building.

Thank you for your participation and cooperation.