INTERNATIONAL ASSOCIATION OF MACHINISTS
AND AEROSPACE WORKERS
DISTRICT LODGE 19

PRESIDENT DIRECTING GENERAL CHAIRMAN: JOHN LACEY

December 27, 2017

TO: ALL IAMAW MEMBERS SUBJECT TO THE NATIONAL FREIGHT AGREEMENT

Dear Sisters and Brothers:

Please be advised the IAMAW District Lodge 19 has reached a Tentative Agreement with the National Carriers Conference Committee (NCCC) on December 7th, 2017 after several rounds of negotiating over a period of almost three (3) years.

We strongly believe that it is in the best interest of our membership to **"Ratify"** this Tentative Agreement due to good increases in compensation and the current monthly employee contribution to remain frozen at $228.89 per month for health care until the next agreement is negotiated.

We have prepared Agreement Summaries which are attached, for your review.

Your General Chairman will be working with this office and the Local Lodges to schedule meetings to explain the Tentative Agreement and answer questions. Feel free to contact your servicing General Chairman if you have any questions or need clarification concerning the Tentative Agreement. We want you to be fully informed and understand the Agreement before casting your vote.

The Local Lodges must notify the members with the time, date and place for your ratification vote, which should be held any day in the month of January, 2018 and returned to the District no later than February 5th, 2018.Tellers must be appointed to count the votes which are cast by secret ballot. All ballots and stubs along with a tally sheet must be postmarked by February 5th and mailed to:

District 19
Cheryl Lane
221 Cheryl Ln.
Clinton, TN 37716

After you have reviewed the Tentative Agreement, you are encouraged to vote **"YES",** as I strongly believe this is in the best interest of our membership.

Sincerely and fraternally yours,

John Lacey

John Lacey
President Directing General Chairman

5 KNOLLWOOD DRIVE • BRANFORD, CT 06405 • PHONE: 203-483-4241 • FAX 203-483-4258

Examples of Retroactive Pay and Hourly Rate Increases

ASSUMPTIONS:

a. Rates of pay may vary by Railroad
b. Effective date of new agreement is January 1, 2015
c. Employees rate of pay on 12/31/2014 was $29.29
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	$29.29	3 %	$30.17
July 1, 2016	$30.17	2 %	$30.77
July 1, 2017	$30.77	2 %	$31.39
July 1, 2018	$31.39	2.5 %	$32.17
July 1, 2019	$32.17	3 %	$33.14

2. Retroactive Pay

	Hourly Rate	Previous Hrly Rate	Difference of Rates	Straight Time Hours	Retroactive Pay
July 1, 2016 –June 30, 2017	$30.77 -	$30.17 =	$.60 x	2080 =	$1248.00
July 1, 2017-Jan. 31, 2018	$31.39 -	$30.77 =	$.62 x	1213.3 =	$ 752.25
					$2000.25

Retroactive Pay Totals: $1248.00 + $ 752.25 = $2000.25

3. Wage Increase Totals over Agreement Lifetime

Effective Date	Previous Rate of Pay	New Rate of Pay	Increase of Pay	x Hours = ST	Yearly Total of Increase
1/1/2015	$29.29	$30.17	$.88	3120	$2745.60
7/1/2016	$30.17	$30.77	$.60	2080	$1248.00
7/1/2017	$30.77	$31.39	$.62	2080	$1289.60
7/1/2018	$31.39	$32.17	$.78	2080	$1622.40
7/1/2019	$32.17	$33.14	$.97	2080	$2017.60
					$8893.20

Wage Increase for 5 Year Agreement Totals: $8893.20

- **The above figures are based solely on straight time hours, actual figures will vary depending on overtime hours worked for each individual**

December 5, 2017

Health and Welfare Contract Summary

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

Cost Sharing

FROZEN AT $228.89

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

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

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

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

Annual Deductible

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

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

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

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

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

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

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

What is the annual individual deductible?

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

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

What is the annual family deductible?

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

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

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

Coinsurance – Out-of-Pocket Maximums

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

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

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

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

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

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

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

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

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

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

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

What are the annual out-of-pocket maximums?

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

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

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

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

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

Telemedicine (new program)

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

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

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

Mental Health and Substance Abuse Benefits (MHSA)

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

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

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

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

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

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

Flexible Spending Accounts

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

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

Care Coordination/Medical Management Programs

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

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

Pharmacy Benefit Manager

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

New Voluntary Programs

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

Centers of Excellence (COE) Resource Services

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

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

Two new options under the COE will include:

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

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

Expert Second Opinions

This voluntary program is at no cost to the member.

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

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

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

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

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

Health Advocacy

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

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

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

End-of-Life Counseling

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

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

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

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

Prescription Drug Plan Changes

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

Screen Rx

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

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

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

Medical Channel Management Program

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

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

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

Fraud, Waste and Abuse

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

Case No. A-13802

MEDIATION AGREEMENT

THIS AGREEMENT, made this ____ day of _____, 2018, by and between the participating carriers listed in Exhibit A attached hereto and represented by the National Carriers' Conference Committee, and the employees shown thereon and represented by the International Association of Machinists and Aerospace 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 IAM were increased by three (3) percent pursuant to Article I, Section 6 of the January 11, 2012 National IAM 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 4 - 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.

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 IAM pursuant to the Letter of Understanding between the parties dated August 31, 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/ Directing General Chairman of the IAM 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	**FOR THE EMPLOYEES REPRESENTED BY THE**

EXHIBIT A REPRESENTED BY THE NATIONAL CARRIERS' CONFERENCE COMMITTEE:

AKG

12/7/17

INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS:

JEL

12/7/17

_____, 2018
#1

Mr. John Lacey
President/ Directing General Chairman
International Association of Machinists &
Aerospace Workers
7010 Broadway, Suite 203
Denver, CO 80221

Dear Mr. Lacey:

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. John Lacey
President/ Directing General Chairman
International Association of Machinists &
Aerospace Workers
7010 Broadway, Suite 203
Denver, CO 80221

Dear Mr. Lacey:

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:

JEL

John Lacey

_____, 2018
#3

Mr. John Lacey
President/ Directing General Chairman
International Association of Machinists &
Aerospace Workers
7010 Broadway, Suite 203
Denver, CO 80221

Dear Mr. Lacey:

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:

JEL

John Lacey

_____, 2018
#4

Mr. John Lacey
President/ Directing General Chairman
International Association of Machinists &
Aerospace Workers
7010 Broadway, Suite 203
Denver, CO 80221

Dear Mr. Lacey:

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 IAM, 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:

JEL

John Lacey

EXHIBIT A
(IAM)

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 ASSOCIATION OF MACHINISTS & AEROSPACE WORKERS AND NOTICES SERVED ON OR SUBSEQUENT TO NOVEMBER 1, 2014 BY THE GENERAL CHAIRMEN, OR OTHER RECOGNIZED REPRESENTATIVES, OF THE INTERNATIONAL ASSOCIATION OF MACHINISTS & AEROSPACE 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 Association of Machinists & Aerospace Workers.

Alton & Southern Railway Company
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
New Orleans Public Belt Railroad
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
Port Terminal Railroad Association
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.

* * * * * *

Notes:

1 - Health & Welfare only

2 - Health & Welfare and Supplemental Sickness only

FOR THE CARRIERS:

AKG

FOR THE IAM:

JEL

_____, **2018**
Arlington, VA

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.