

JOINT PLAN COMMITTEE

RAILROAD EMPLOYEES NATIONAL HEALTH AND WELFARE PLAN

A. KENNETH GRADIA
CHAIRMAN
NATIONAL CARRIERS' CONFERENCE COMMITTEE
1901 L STREET, N.W.
SUITE 500
WASHINGTON, D.C. 20036-3514

ROBERT A. SCARDELLETTI
CHAIRMAN
COOPERATING RAILWAY LABOR ORGANIZATIONS
HEALTH AND WELFARE COMMITTEE
3 RESEARCH PLACE
ROCKVILLE, MD 20850-3279

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

Dear Employee,

Pursuant to collective bargaining agreements between certain participating labor organizations represented by the Health and Welfare Committee of the Cooperating Railway Labor Organizations and railroads represented by the National Carriers' Conference Committee, changes are being made to the benefits provided by the Railroad Employees National Health and Welfare Plan (the "Plan"). Other changes are required as a result of the loss of grandfathered status under the Patient Protection and Affordable Care Act (the "Act") of 2010 (also referred to as Healthcare Reform) and for purposes of compliance with the Mental Health Parity and Addiction Equity Act ("MHPAEA").

Grandfathered Status Disclosure

Notwithstanding these changes, and at the present time, in the absence of contrary federal agency regulations or definitive guidance, the CHCB (Comprehensive Health Care Benefit) and the MHSA (Mental Health and Substance Abuse benefit) of the Plan continue to be grandfathered under the Patient Protection and Affordable Care Act (the "Act"). As permitted by the Act, a grandfathered benefit package can preserve certain basic health coverage that was already in effect when that law was enacted. A grandfathered benefit package may not include certain consumer protections of the Act that would otherwise apply; for example, the requirement to provide preventive health services without any cost-sharing. However, a grandfathered benefit package must comply with certain other consumer protections in the Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered benefit package and what might cause a benefit package to change from grandfathered status can be directed to your benefits administrator by calling the Member Services phone number located on the back of your Member Identification Card or:

For Aetna	1-800-842-4044
For Highmark BCBS	1-866-267-3320
For UnitedHealthcare	1-888-445-4379

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has access to a table summarizing which protections do and do not apply to grandfathered health plans which can be found at <http://www.dol.gov/ebsa/pdf/grandfatherregtable.pdf>.

Effective July 1, 2012, the following changes will be made to the Plan:

In-Network Deductibles

Under the Managed Medical Care Program (MMCP), for in-network services there will be a separate, stand-alone, individual annual deductible per year and a separate, stand-alone, family annual deductible per family per year. The individual and family annual deductible amounts will be phased in over a period of two years. For the six-month period from July 1 through December 31, 2012, inclusive, the annual deductible shall be \$100 per individual and \$200 per family. For calendar year 2013, the annual deductible shall be \$150 per individual and \$300 per family. Beginning January 1, 2014 the annual deductible shall be \$200 per individual and \$400 per family. The individual deductible applies separately to each family member; the family deductible is the most that you and your eligible dependents will have to pay in deductibles in any year no matter how many family members you have. In no event will a family's annual deductible exceed the \$200 in 2012; \$300 in 2013 and \$400 in 2014. These new deductibles only apply to services for which no co-pay applies. Any fixed-dollar co-pays that may be required will **not** apply towards the satisfaction of either the individual or family deductible.

Note: These new MMCP in-network deductibles will not apply towards the satisfaction of the MMCP out-of-network deductibles or the Comprehensive Health Care Benefit (CHCB) deductibles. These deductibles will not count towards satisfaction of any individual out-of-pocket maximum or family out-of-pocket maximum. However, amounts paid toward satisfying any CHCB deductible will count towards satisfying the new MMCP in-network deductible for any employee who becomes enrolled in the MMCP by reason of having moved to a geographic area where MMCP participation is mandatory or who is currently enrolled in CHCB and lives/moves into a geographical location where the employee has the option to elect either MMCP or CHCB.

In-Network Benefits

Under the MMCP, for in-network services for which a fixed-dollar co-pay does **not** apply, the current percentage of eligible expenses paid by the Plan will decrease from 100% to 95% of those eligible expenses that exceed the annual MMCP in-network deductible.

In-Network Out-of-Pocket Maximum

Under the MMCP, for in-network services, there is an annual maximum out-of-pocket amount of coinsurance that must be paid by an individual and/or family. The individual and family annual out-of-pocket maximum amounts will be phased in over a period of two years. The amount payable by the employee as a result of this coinsurance shall be capped at \$500 per individual and \$1,000 per family for the six-month period from July 1 through December 31, 2012, inclusive. For calendar year 2013, the annual out-of-pocket maximum amount shall be \$750 per individual and \$1,500 per family. Beginning January 1, 2014 the annual out-of-pocket maximum amount shall be \$1,000 per individual and \$2,000 per family. Only the in-network 5% coinsurance will count towards satisfying these out-of-pocket maximums. Fixed-dollar co-pays will not count towards satisfaction of the MMCP in-network out-of-pocket maximums.

Note: Amounts paid towards reaching these in-network out-of-pocket maximums will not count towards satisfaction of the MMCP out-of-network out-of-pocket maximums or the CHCB out-of-pocket maximums. The in-network deductibles for MMCP discussed above will not count towards satisfaction

of the MMCP in-network or out-of-network out-of-pocket maximums, nor will they count towards satisfaction of the CHCB out-of-pocket maximum. However, amounts paid toward reaching any CHCB out-of-pocket maximum will count toward reaching the new MMCP in-network out-of-pocket maximum for any employee who becomes enrolled in the MMCP by reason of having moved to a geographic area where MMCP participation is mandatory or who is currently enrolled in CHCB and lives/moves into a geographical location where the employee has the option to elect either MMCP or CHCB.

Emergency Room Co-pay

Under the MMCP, the Emergency Room co-pay will change from \$25 to \$75 for each visit that is deemed an Emergency as defined by the Plan, regardless of the network status of the provider. If the service is not deemed to be an Emergency, the benefit is paid at the out-of-network level regardless of the network status of the provider. If the Emergency Room visit results in an admission to the hospital, the co-pay does **not** apply.

Note: Current MMCP ID cards display an Emergency Room co-pay of \$25. In the future, MMCP ID cards will show the new co-pay as \$75. Even if your MMCP ID card shows the old \$25 Emergency Room co-pay, you must pay the new \$75 Emergency Room co-pay effective July 1, 2012.

Urgent Care Center Co-pay

The Urgent Care Center co-pay for MMCP in-network services will decrease from \$25 to \$20.

Convenient Care Clinic / Retail Clinic Co-pay

Under the MMCP, for in-network services where a fixed-dollar co-pay of \$20 currently applies to an office visit, the co-pay will be reduced to \$10 if the office visit occurs at an in-network "Convenient Care/Retail Clinic." The Plan will **not** cover any radiological services performed at a Convenient Care/Retail Clinic.

An in-network "Convenient Care/Retail Clinic" is a health care facility typically located in a high-traffic retail store, supermarket, or pharmacy that is part of your benefits administrator's network of providers. Such clinics provide affordable treatment for uncomplicated minor illnesses and/or preventive care. Please contact the Member Services phone number located on the back of your Member Identification Card to locate an in-network Convenient Care Clinic/Retail Clinic near you.

Specialty Resource Services

Consulting Services & Information

Your benefits administrator (Aetna, Highmark BCBS, or UnitedHealthcare, each through its care coordination/medical management operation) will make available to you, if you wish to use them, consulting and similar services, along with relevant information you might find helpful, regarding treatment at certain hospitals and other facilities designated by your benefits administrator in connection with bariatric surgery, cancer and kidney disease. The Plan will offer these resource services under both the MMCP and the CHCB at no cost to you.

Surgeries & Associated Hospital Stays

Under the in-network portion of the MMCP only, for conditions to which the consulting services described above pertain, surgeries and the immediate hospital stay occasioned by the surgery (an "associated hospital stay") will be covered by the Plan without the application of any deductible or co-insurance as follows:

- Bariatric Surgery -- One surgery and associated hospital stay at a surgery center or hospital that is part of your benefits administrator's designated network of specialty bariatric surgery centers and hospitals.
- Complex Cancers -- Under certain limited circumstances described in the program made available by your benefits administrator, designated surgeries and associated hospital stays at hospitals and surgery

centers that are part of your benefits administrator's designated network of hospitals and centers for complex cancer surgery. Surgeries covered by this enhanced benefit are those performed in cases of certain complex cancers that satisfy specific clinical criteria established by each benefits administrator. This enhanced benefit is limited to surgeries; it does not apply, for example, to chemotherapy and/or radiation.

- Kidney Disease -- Surgeries and associated hospital stays at particular hospitals and surgery centers that are part of your benefits administrator's designated network of hospitals and centers for kidney transplants. This enhanced benefit does not cover renal dialysis.
- The "designated networks" of hospitals and centers referred to above are generally called "Institutes of Excellence" or "Institutes of Quality" by Aetna, "Centers for Blue Distinction" by Highmark BCBS, and "Centers of Excellence" by UnitedHealthcare.

IMPORTANT! The enhanced benefit under the in-network portion of the MMCP for any surgery described above requires that the surgery be pre-approved by your benefits administrator and that you work with an assigned case manager/care coordinator both before and after your surgery because of the complexity of the health care issues associated with these procedures. The requisite pre-approval may require satisfaction of criteria specified by your benefits administrator.

Note: In order to determine if a specific disease or condition qualifies under any of the above Specialty Resource Services programs for enhanced coverage, your benefits administrator **must be notified prior** to any services being provided. ***If prior notification is not received, the benefits will be subject to standard benefit provisions.*** Your benefits administrator can be reached by calling the number on the back of your medical ID card. The programs and services offered will vary by each benefits administrator.

Treatment Decision Support Program – Consultative Services

Your benefits administrator will manage access to enhanced one-on-one coaching for services for potential procedures that target conditions such as back pain, knee/hip replacement, benign prostate disease, prostate cancer, benign uterine conditions, hysterectomy, breast cancer, coronary disease and bariatric surgery for covered employees and their covered dependents at no cost to the member. This program is wholly voluntary and will be available under both the MMCP and the CHCB.

Note: To learn which specific conditions are supported by this program and to access the associated services, contact your benefits administrator by calling the number on the back of your medical ID card.

Radiology Notification Program

Under this program, a radiology notification process is required for participating (network) physicians, health care professionals, facilities and ancillary providers for certain advanced outpatient imaging procedures. This is a prior notification requirement only, not a precertification, preauthorization, or medical necessity determination program. This program is invisible to the covered member and there is no balance billing to the patient if the provider fails to follow the prior notification requirements.

Preventive Care Benefits

Under the MMCP, certain preventive care in-network services will be covered for such duration as required by applicable law at 100%, with no co-pay, deductible or coinsurance as a result in the change in grandfathered status. Some examples are:

- Routine immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Director of the Centers for Disease Control and Prevention
- Certain screenings supported by the Health Resources and Services Administration

- Certain additional cancer screenings
- Regular well-baby and well-child visits from birth to age 21
- Obesity screening and counseling
- Tobacco use screening and cessation programs for adults

Please call the number on the back of your ID card to obtain more information about which preventive services are payable at 100%; not all preventive care services are included in these government-required benefits.

Note: No changes related to preventive care benefits are being made under the out-of-network portion of the MMCP or under the CHCB for the reasons referenced in the Grandfathered Status Disclosure section.

Dependent Child Coverage to Age 26

Eligibility under the Plan will no longer be denied because a dependent child is eligible for coverage through another employer. Your children do not need to be living with you to be eligible for coverage. This change effective July 1, 2012 applies only to:

Your married or unmarried

- natural children,
- stepchildren,
- adopted children (including children placed with you for adoption).

Managed Pharmacy (Rx) Services Benefit Changes

Rx Co-pays

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

Retail Prescription Drugs: (Prescriptions up to 21 days Supply)	Generic co-pays will decrease from \$10 to \$5 Formulary brand co-pays will increase from \$20 to \$25 Non-formulary brand co-pays will increase from \$30 to \$45
Mail Order Prescription Drugs: (Prescriptions from 22-90 days Supply)	Generic co-pays will decrease from \$20 to \$5 Formulary brand co-pays will increase from \$30 to \$50 Non-formulary brand co-pays will increase from \$60 to \$90

Rx Clinical Management Rules/Programs

Coverage Approval (also known as Prior Authorization)

For certain medications, Medco must review the prescription with your doctor to determine whether the medication meets the requirements for coverage. For example, *Retin-A*[®] may be covered for acne, but not for cosmetic purposes.

- The coverage review uses Plan rules based on U.S. Food and Drug Administration-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective. If coverage is approved, the member will pay the appropriate co-payment.
- The coverage review for certain medications helps assure that coverage is provided to those members for whom the medication is safe, effective and appropriate.

Quantity/Dose Duration

Certain medications will now be authorized for coverage in a limited quantity within a specified time period. This program evaluates the quantity and dosing of a medication over a specific timeframe and alerts the pharmacist to the need for a coverage review when the quantity or dose exceeds the covered amount.

Step Therapy

For certain medications, this program requires that a member first try one or more specified drugs to treat a particular condition before the Plan will cover another (usually more expensive) drug that his or her doctor may have prescribed. Step therapy is intended to reduce costs for members and the Plan by encouraging the use of alternative medications that are equally effective when compared to the usually more expensive prescribed medications.

Personalized Medicine

This voluntary program makes genetic testing available to members to optimize prescription drug therapies for certain conditions.

- The conditions, medications, and testing covered by the program will change periodically as new genetic tests become available and are included in the program. The initial medication will be Warfarin.
- The most up to date information on the conditions and drugs covered by the program can be accessed online or by calling Medco Member Services.
- For members who qualify based on Medco specific criteria, the Personalized Medicine Program will include access to certain specified genetic tests administered and analyzed by one of several designated clinical laboratories, and a clinical program that includes consultation with the prescribing doctor about the test results by a representative of Medco trained specifically in genetic testing.
- The results of the genetic tests are for informational purposes only. Any dosing or medication changes remain the sole discretion of the member's doctor.
- Member participation is voluntary and if a member decides to participate, Medco will manage the member's coverage under the program.
- Results are completely confidential and can only be shared with you and your doctor.

Generic Rx Advantage

This program allows members (and their eligible dependents) to sign up with Medco to receive their first fill of a new generic prescription through the **Medco Pharmacy**[®] mail-order service at no cost.

- A new generic prescription is one that has not been filled through the Medco Pharmacy mail order service within the past 12 months.
- If a medication qualifies for this program, the member or dependent will receive a letter with instructions for taking advantage of the savings opportunity.
- This program applies to different medications determined by Medco and allows for one fill per member/dependent per medication.

Mental Health and Substance Abuse Benefit (MHSA) – Changes

Your Plan's Mental Health and Substance Abuse benefit package (MHSA) will be modified effective July 1, 2012 to satisfy the requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and regulations thereunder. The major changes will include:

Benefit Amounts

The MHSA benefit for out-of-network services will be increased from 75% to 85% of eligible expenses after satisfaction of the applicable deductible (\$100 individual, \$300 family) and if applicable notification requirements are met. If those notification requirements are not met, the 85% benefit will be reduced to 68%. Also, once the applicable annual out-of-pocket maximum (\$1,500 individual, \$3,000 family) has been reached, the 85% benefit will be increased to 100% of eligible expenses if applicable notification requirements are met, while the current 68% benefit payable if those requirements are not met will be increased to 80%. The applicable notification requirements are described below.

Benefit Limitations

Out-of-network outpatient services that the MHSA covers if rendered by, among others, a medical doctor or psychologist will also be covered if rendered by a licensed or certified social worker or other mental health or substance abuse practitioner.

There will be no limitation on the amount of benefits paid if a member or eligible dependent voluntarily discontinues an approved treatment program before completing the program.

Out-of-network services provided at a Treatment Center or Outpatient Clinic will no longer be limited to 30 days/episodes of treatment per confinement/benefit period or to 2 confinement/benefit periods per the member's lifetime.

Notification Requirements

The certification procedures in effect under the MHSA will no longer apply. Instead, employees and eligible dependents will be required to comply with the notification requirements described below. ***Please bear in mind that, as noted above, the percentage of eligible expenses payable under the MHSA will be reduced if these notification requirements are not followed.***

Notification Requirements

In-Network Services	No Member Notification Required (provider does notification)
Out-of-Network Services	Member Notification Required for Certain MHSA Services (see below)

United Behavioral Health (UBH) must be notified of any out-of-network service listed below:

- Inpatient admission to a hospital or Treatment Center
- Intensive outpatient treatment program
- Outpatient electro-convulsive treatment
- Psychological testing
- Outpatient treatment of opioid dependence
- Extended outpatient treatment visits beyond 45 – 50 minutes in duration with or without medication management

In addition, a member must receive authorization from UBH to pay in-network benefits for services performed by out-of-network providers when in-network providers are not available.

Note: For an out-of-network inpatient confinement which is the result of an Emergency, a member (or the member's representative or physician) must call UBH within **48 hours** (excluding weekends and holidays) from the date the confinement begins. Members no longer need to notify UBH when Emergency services are rendered on an in-network basis or on an out-of-network outpatient basis.

Review Procedures

All services under the MHSA, whether inpatient or outpatient, and regardless of whether they are provided on an in-network or out-of-network basis, will be subject to concurrent review for appropriateness. Also, services for which a member does not notify UBH in accordance with the requirements explained above will be subject to retroactive review to determine the amount payable by the Plan for those services. The review standards UBH applies in making concurrent and retroactive review determinations will be similar to the standards the

relevant benefits administrator applies when making concurrent and retroactive review determinations under the MMCP and CHCB.

In Closing

Please contact your benefits administrator (Aetna, Highmark BCBS, or UnitedHealthcare), UBH, or Medco with any questions related to the information provided above.