AGREEMENT BETWEEN THE AMERICAN RAILWAY AND AIRWAY SUPERVISORS ASSOCIATION AND UNION PACIFIC RAILROAD

THIS AGREEMENT, made this 23th day of January, 2018, by and between Union Pacific Railroad Company (hereinafter referred to as the Carrier) and its employees represented by the American Railway and Airway Supervisors Association – Division of Transportation Communications Union/IAM (ARASA) (hereinafter referred to as the Organization):

IT IS HEREBY AGREED:

ARTICLE I – WAGES

Section 1 – First General Wage Increase

Effective January 1, 2015, all standard rates of pay in effect on December 31, 2014 for employees represented by the ARASA were increased by three (3) percent pursuant to Article I, Section 6 of the February 15, 2012 ARASA 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

On July 1, 2016, all hourly, daily, weekly, and monthly rates of pay in effect on the preceding day 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, 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 in the amount of two (2) percent applied so as to give effect to this increase irrespective of the method of payment. The increase provided for in this Section 3 shall be applied in the same manner as provided for in Section 2 hereof.

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 so as to give effect to this increase irrespective of the method of payment. The increase provided for in this Section 4 shall be applied in the same manner as provided for in Section 2 hereof.

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 so as to give effect to this increase irrespective of the method of payment. The increase provided for in this Section 5 shall be applied in the same manner as provided for in Section 2 hereof.

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, 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 Plans' 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 Plans or if the company administering the member's benefits determines that the service or supply is not Medically Appropriate.

(b) The Plans' 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 Plans 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 sentence, without any co-payment or co-insurance, the Telemedicine, Expert Second Opinion, Health Advocacy and End-of-Life Counseling benefits described in Exhibit A hereto. There shall be a co-payment of $10 for each Telemedicine visit under the In-Network segment of the MMCP.

(2) To improve the effectivenees 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 administer of such activities, regardless of what company administers the covered employees's or covered dependent's benefits. The process and timetable for implementation of this initiative is set forth in Side Letter # 4 to the 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 Management Channel Program described in Exhibit B hereto.

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

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

(3) They shall include the Fraud, Waste and Abuse Program described in Exhibit B 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 Railroad Employees National 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

Article III, Part C of the ARASA Agreement of February 15, 2012 is amended as follows effective for Plan Years beginning 2019, except as otherwise provided.

(a) The annual grace period shall be 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 ARASA from the Carrier.

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 B 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 carrier 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 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 from agreeing upon any subject of mutual interest.

SIGNED AT OMAHA NEBRASKA, THIS 23rd DAY OF JANUARY, 2017.

FOR THE EMPLOYEES REPRESENTING BY THE AMERICAN RAILWAY AND AIRWAY SUPERVISORS ASSOCIATION

FOR THE CARRIER:

B. W. Hargrett

January 23, 2018
#1

Mr. Mark Sellers
General Chairman ARASA
1104 Arbor Dawn Lane
Schertz, TX. 78154

Dear Mr. Sellers:

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 March 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, I 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,

B. W. Hanquist

B. W. Hanquist
Senior Director Labor Relations

January 23, 2018
#2

Mr. Mark Sellers
General Chairman ARASA
1104 Arbor Dawn Lane
Schertz, TX. 78154

Dear Mr. Sellers:

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,

B. W. Hanquist

B. W. Hanquist
Senior Director Labor Relations

I agree:

_____
Mark Sellers

January 23, 2018
#3

Mr. Mark Sellers
General Chairman ARASA
1104 Arbor Dawn Lane
Schertz, TX. 78154

Dear Mr. Sellers:

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 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 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) 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,

B. W. Hanquist

B. W. Hanquist
Sr. Director Labor Relations

I agree:

_____
Mark Sellers

January 23, 2018
#4

Mr. Mark Sellers
General Chairman ARASA
1104 Arbor Dawn Lane
Schertz, TX. 78154

Dear Mr. Sellers:

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 TCU/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,

B. W. Hanquist
Senior Director Labor Relations

I agree:

_____
Mark Sellers

Exhibit A--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, solely as an in-network 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 B – 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.