
 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, see the Plan Details (Summary Plan Descriptions) located at [bnsf.com/retirees](https://bnsf.com/retirees). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary>.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| What is the overall <a href="#">deductible</a> ?                                | In-Network and Out-of-Network: <b>\$3,000</b> Individual/ <b>\$6,000</b> Family  | Generally, you must pay all the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family deductible must be met before the <a href="#">plan</a> begins to pay.   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> services and specific preventive medications targeting certain risk factors are covered before you meet your <a href="#">deductible</a> . | This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| Are there other <a href="#">deductibles</a> for specific services?              | No.  | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a> \$5,000 individual / \$10,000 family; for <a href="#">out-of-network providers</a> \$7,000 individual / \$14,000 family                  | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met. The individual in-network out-of-pocket limit for an individual in family coverage is \$8,700.  |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> does not cover.  | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.bcbsil.com/bnsf">www.bcbsil.com/bnsf</a> or call 1-888-399-5945 for a list of <a href="#">network providers</a> .                                 | This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.  | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .  |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event  | Services You May Need                                  | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information  |
|---|--|---|---|---|
|   |  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)  |   |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>   | Primary care visit to treat an injury or illness       | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | Out-of-network charges are limited to the <a href="#">allowed amount</a> .  |
|   | <a href="#">Specialist</a> visit                       | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | Out-of-network charges are limited to the <a href="#">allowed amount</a> .  |
|   | <a href="#">Preventive care/screening/immunization</a> | No charge   | No charge   | Age and frequency schedules may apply.  |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | <a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> may result in a reduction in benefits.   |
|   | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   |   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> or call 1-800-378-7559. For specialty drugs, call 1-888-601-0967) | Generic drugs  | Retail – \$7.50 <a href="#">copay</a> (or actual cost, if less) after annual deductible<br>Mail order or 90 day at CVS pharmacy – \$15 (or actual cost if less) after annual deductible | Retail – \$7.50 <a href="#">copay</a> (or actual cost, if less) after annual deductible<br><br>Mail order – Not covered | <a href="#">Deductible</a> does not apply to specific preventive medications targeting certain risk factors; you pay only the copay or coinsurance percentage.<br><br>Retail is up to 34-day supply.<br>Mail order or CVS pharmacy is up to 90-day supply.<br>Out-of-network: In addition to the <a href="#">copayment</a> or <a href="#">coinsurance</a> , you also pay the difference between the actual out-of-network charge and the amount that would have been charged by the in-network pharmacy.<br>If you choose to use a brand-name drug when a generic is available, you will pay the cost difference (unless the brand name is required by your doctor). The difference will not apply to your <a href="#">deductible</a> or out-of-pocket maximum. |
|   | Preferred brand drugs                                  | Retail – 25% (min. \$30, max. \$120) after annual deductible<br>Mail order or 90 day at CVS pharmacy– 25% (min. \$60, max. \$240) after annual deductible                               | Retail – 25% (min. \$30, max. \$120) after annual deductible<br><br>Mail order – Not covered                            |   |
|   | Non-preferred brand drugs                              | Retail – 40% (min. \$50, max. \$150) after annual deductible<br>Mail order or 90 day at CVS pharmacy– 40% (min. \$100, max. \$300) after annual deductible                              | Retail – 40% (min. \$50, max. \$150) after annual deductible<br><br>Mail order – Not covered                            |   |
|   | <a href="#">Specialty drugs</a>                        | 30 day supply– 25% with a \$175 max. after annual deductible  | Not Covered   |   |

| Common Medical Event  | Services You May Need                            | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information  |
|---|--|--|--|---|
|   |  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> may result in a reduction in benefits.   |
|   | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | -----None-----  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 20% <a href="#">coinsurance</a>              | 20% <a href="#">coinsurance</a>                    | -----None-----  |
|   | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a>              | 20% <a href="#">coinsurance</a>                    |   |
|   | <a href="#">Urgent care</a>                      | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    |   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required.   |
|   | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required.   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | -----None-----  |
|   | Inpatient services                               | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required.   |
| If you are pregnant   | Office visits                                    | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | -----None-----  |
|   | Childbirth/delivery professional services        | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    |   |
|   | Childbirth/delivery facility services            | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    |   |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | Limited to 40 visits/calendar year. <a href="#">Preauthorization</a> required.  |
|   | <a href="#">Rehabilitation services</a>          | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | Limited to 60 visits/calendar year. Includes physical, speech and/or occupational therapy. Habilitative care is limited to certain congenital, genetic or early acquired disorders. The maximums may not apply to such conditions as determined by the claims administrator |
|   | <a href="#">Habilitation services</a>            | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    |   |
|   | <a href="#">Skilled nursing care</a>             | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | Admission to inpatient skilled nursing facility is limited to 60 days per calendar year. <a href="#">Preauthorization</a> required. Outpatient private duty nursing care is limited to 70 shifts/visits per calendar year.  |
|   | <a href="#">Durable medical equipment</a>        | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | -----None-----  |
|   | <a href="#">Hospice services</a>                 | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required.   |

| Common Medical Event                   | Services You May Need      | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information |
|--|----------------------------|--|--|--|
|  |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
| If your child needs dental or eye care | Children's eye exam        | Not covered                                  | Not covered  | -----None-----   |
|  | Children's glasses         | Not covered                                  | Not covered  | -----None-----   |
|  | Children's dental check-up | Not covered                                  | Not covered  | -----None-----   |

### Excluded Services & Other Covered Services:

#### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>Acupuncture, except as anesthesia for covered surgery</li> <li>Cosmetic Surgery (except with specific medical conditions)</li> </ul> | <ul style="list-style-type: none"> <li>Dental Care</li> <li>Hearing aids</li> <li>Long Term Care</li> </ul> | <ul style="list-style-type: none"> <li>Routine eye care</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul> |
|---|---|---|

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>Infertility treatment: \$20,000 lifetime max. (separate \$5,000 lifetime max. for oral prescription drugs)</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Chiropractic Care</li> <li>Private-duty nursing, with the exception of inpatient private duty nursing (limited to 70 shifts/visits per year)</li> </ul> | <ul style="list-style-type: none"> <li>Bariatric surgery (as approved by the claims administrator) at BCBS Blue Distinction Center, Blue Distinction Center+, or SurgeryPlus only</li> <li>When you use services provided by SurgeryPlus-plan pays 100% of cost for certain surgeries (after deductible has been met)</li> </ul> |
|--|--|--|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: BCBS at 1-888-399-5945, the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

#### Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

#### Does this plan meet the Minimum Value Standards? Yes

If your previous [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

#### Language Access Services:

**Questions:** BCBS – Call 1-888-399-5945 or visit [www.bcbsil.com/bnsf](http://www.bcbsil.com/bnsf). Caremark – Call 1-800-378-7559 or visit [www.caremark.com](http://www.caremark.com).

[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-399-5945.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-399-5945.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-399-5945.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-399-5945.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist](#) coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**  
 Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>                |                |
|------------------------------------|----------------|
| Deductibles                        | \$3,000        |
| Copayments                         | \$10           |
| Coinsurance                        | \$1,900        |
| <i>What isn't covered</i>          |                |
| Limits or exclusions               | \$60           |
| <b>The total Peg would pay is*</b> | <b>\$4,970</b> |

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist](#) coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**  
 Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i>                |                |
|------------------------------------|----------------|
| Deductibles                        | \$3,000        |
| Copayments                         | \$60           |
| Coinsurance                        | \$500          |
| <i>What isn't covered</i>          |                |
| Limits or exclusions               | \$20           |
| <b>The total Joe would pay is*</b> | <b>\$3,580</b> |

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist](#) coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**  
 Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i>                |                |
|------------------------------------|----------------|
| Deductibles                        | \$2,800        |
| Copayments                         | \$0            |
| Coinsurance                        | \$0            |
| <i>What isn't covered</i>          |                |
| Limits or exclusions               | \$0            |
| <b>The total Mia would pay is*</b> | <b>\$2,800</b> |

\* Note that "Deductibles" assume employee-only coverage. The Total line does not consider any amount you may use from your health savings account (HSA) or health reimbursement account (HRA) to pay your share of expenses.