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) on myBNSF.com. 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 www.myBNSF.com.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network and Out-of-Network: **$3,000** Individual/ **$6,000** Family Does not apply to preventive care and specific preventive medications targeting certain risk factors.	You must pay all the costs up to the **deductible** amount before this **health insurance** plan begins to pay for covered services you use. The **deductible** starts over each January 1. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services. See the chart starting on page 2 for other costs that you may be required to pay for services this plan covers.
What is the out-of-pocket limit for this plan?	For network providers $5,000 individual / $10,000 family; for out-of-network providers $7,000 individual / $14,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. The individual out-of-pocket limit for an individual in family coverage is $7,150.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.bcbsil.com/bnsf** or call **1-888-399-5945** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Out-of-network charges are limited to the **allowed amount**.
	Specialist visit	20% coinsurance	40% coinsurance	Out-of-network charges are limited to the **allowed amount**.
	Preventive care/ screening/ immunization	No charge	No charge	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	----------None----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com or call 1-800-378-7559	Generic drugs	Retail – $7.50 co-payment (or actual cost, if less) after annual deductible Mail order or 90 day at CVS pharmacy – $15 (or actual cost if less) after annual deductible	Retail – $7.50 co-payment (or actual cost, if less) after annual deductible Mail order – Not covered	**Deductible** does not apply to specific preventive medications targeting certain risk factors. Retail is up to 34-day supply. Mail order or CVS pharmacy is up to 90-day supply. Out-of-network: In addition to the **copayment** or **coinsurance**, 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. 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 **deductible** or out-of-pocket maximum.
	Preferred brand drugs	Retail – 25% (min. $30, max. $120) after annual deductible 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 Mail order – Not covered	
	Non-preferred brand drugs	Retail – 40% (min. $50, max. $150) after annual deductible 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 Mail order – Not covered	
	Specialty drugs	30 day supply– 25% with a $175 max. after annual deductible	Not Covered	---------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition		90 day supply-25% with a $525 max. after annual deductible		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40%coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in a reduction in benefits. Out-of-Network bariatric services are not covered under the Plan.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	----------None----------
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	----------None----------
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	----------None----------
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	----------None----------
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 40 visits/calendar year. Preauthorization required.
	Rehabilitation services	20% coinsurance	40% coinsurance	60 visits/calendar year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 70 visits/calendar year; preauthorization required.
	Durable medical equipment	20% coinsurance	40% coinsurance	----------None----------
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (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 (This isn't a complete list. Check the Plan Details (Summary Plan Description) for more information and a list of any other excluded services.)

- Acupuncture, except as anesthesia for covered surgery
- Cosmetic Surgery (except with specific medical conditions)
- Dental Care
- Glasses
- Hearing aids
- Long Term Care
- Routine eye care

Other Covered Services (This isn't a complete list. Check the Plan Details (Summary Plan Description) for more information and a list of any other excluded services.)

- Chiropractic Care
- Infertility treatment: $2,500 lifetime max. (separate $2,500 lifetime max. for oral prescription drugs)
- Non-emergency services when traveling outside the U.S.
- Private-duty nursing (limited to 70 shifts/visits per year)
- Treatment for Autism Spectrum Disorder
- Weight Loss Programs, including in-network bariatric surgery (as approved by the claims administrator)
- When you use services provided by SurgeryPlus-plan pays 100% of cost for certain surgeries (after deductible has been met)

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact the BNSF Benefits Center at 1-877-451-2363.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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit 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.

Does this plan provide Minimum Essential Coverage? **Yes**.

Does this plan meet Minimum Value Standards? **Yes**.
The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:
[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, kwiijigo holne' 1-888-399-5945.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,640
- **Patient pays** $3,900

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:*

Deductibles*	$3,000
Copays	$0
Coinsurance	$900
Limits or exclusions	$0
Total*	**$3,900**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1,940
- **Patient pays** $3,460

Sample care costs:

Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office visits and procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:*

Deductibles*	$3,000
Copays	$0
Coinsurance	$460
Limits or exclusions	$0
Total*	**$3,460**

* Note that "Deductibles" assume employee-only coverage.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums** you pay for coverage.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan, and **deductibles** assume employee-only coverage.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments** and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles** and **coinsurance**.