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. 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 deductible?	In-Network and Out-of-Network: **$2,000** Individual/ **$3,500** Family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services and specific preventive medications targeting certain risk factors are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the 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.
What is the out-of-pocket limit for this plan?	For network providers $4,000 individual / $7,500 family; for out-of-network providers $6,000 individual / $11,500 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, the overall family out-of-pocket limit must be met. The individual in-network out-of-pocket limit for an individual in family coverage is $7,500.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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 (balance billing). 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 a referral.

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 (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	Preauthorization is required. Failure to obtain preauthorization may result in a reduction in benefits.
	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 (For specialty drugs, call 1-888-601-0967)	Generic drugs	Retail – $7.50 copay (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 copay (or actual cost, if less) after annual deductible Mail order – Not covered	Deductible does not apply to specific preventive medications targeting certain risk factors; you pay only the copay or coinsurance percentage. 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	Preauthorization may be required for specific specialty medications.

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 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.
	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	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
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Admission to inpatient skilled nursing facility is limited to 60 days per calendar year. Preauthorization required. Outpatient private duty nursing care is limited to 70 shifts/visits per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	----------None----------
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required.
If your child needs	Children's eye exam	Not covered	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)	
dental or eye care	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.)

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

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

- Infertility treatment: $20,000 lifetime max. (separate $5,000 lifetime max. for oral prescription drugs)
- Non-emergency care when traveling outside the U.S.
- Chiropractic Care
- Hearing aids for children
- Private-duty nursing, with the exception of inpatient private duty nursing (limited to 70 shifts/visits per year)
- Bariatric surgery (as approved by the claims administrator) at BCBS Blue Distinction Center, Blue Distinction Center+, or SurgeryPlus only
- 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: 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 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 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

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:

[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:

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	$2,000
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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is*	**$4,060**

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

The plan's overall deductible	$2,000
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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$100
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is*	**$2,820**

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

The plan's overall deductible	$2,000
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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is*	**$2,170**

* 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.