This is only a summary. If you want more detail about your coverage and costs, see the Plan Details (Summary Plan Descriptions) on myBNSF.com or call BlueCross BlueShield (BCBS) at 1-888-399-5945.

Important Questions	Answers	Why this Matters: PREMED
What is the overall deductible?	In-Network and Out-of-Network: **$1,500** Individual/ **$3,000** 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.** You may use funds**, if available,** from a health savings account (HSA) or health reimbursement account (HRA) toward paying the **deductible** and other out-of-pocket expenses.
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.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network: **$3,500** Individual/**$7,000** Family Out-of-Network: **$5,500** Individual/**$11,000** Family	The **out–of–pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balanced-billed charges and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers see: BCBS: **www.bcbsil.com/bnsf** or call **1-888-399-5945**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: BCBS – Call 1-888-399-5945 or visit www.bcbsil.com/bnsf. **Caremark** – Call 1-800-378-7559 or visit www.caremark.com. If you aren't clear about any of the underlined terms in this form, see the Glossary. You can view the Glossary on myBNSF.com or at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the numbers above to request a paper copy.

Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See the Plan Details (Summary Plan Descriptions) or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network (**non-preferred**) **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
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	
	Other practitioner office visit	20% coinsurance	40% coinsurance	Limited to 60 visits per calendar year for chiropractic and osteopathic manipulation.
	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	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
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. $25, max. $100) after annual deductible Mail order or 90 day at CVS pharmacy – 25% (min. $50, max. $200) after annual deductible	Retail – 25% (min. $25, max. $100) after annual deductible Mail order – Not covered	
	Non-preferred brand drugs	Retail – 40% (min. $40, max. $125) after annual deductible Mail order or 90 day at CVS pharmacy– 40% (min. $80, max. $250) after annual deductible	Retail – 40% (min. $40, max. $125) after annual deductible Mail order – Not covered	
	Specialty drugs	Covered the same as any other drug	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---none---
	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	---none---
	Urgent care	20% coinsurance	40% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Preauthorization required.
If you have mental health, behavioral health or substance abuse needs	Mental/behavioral health outpatient services	20% coinsurance	40% coinsurance	---none---
	Mental/behavioral health inpatient services	20% coinsurance	40% coinsurance	Preauthorization required.
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	---none---
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Preauthorization required.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	---none---
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	---none---
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 40 visits per calendar year; preauthorization required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Limited to a combined 60 visits per calendar year for each of: outpatient physical, occupational and speech therapies.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 70 shifts/visits per calendar year; preauthorization required.
	Durable medical equipment	20% coinsurance	40% coinsurance	---none---
	Hospice service	20% coinsurance	40% coinsurance	Preauthorization required.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	---none---
	Glasses	Not covered	Not covered	---none---
	Dental check-up	Not covered	Not covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check the Plan Details (Summary Plan Descriptions) or plan document for 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 Descriptions) or plan document for other covered services and your costs for these 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)
- Weight loss program, including 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:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the BNSF Benefits Center at 1-877-451-2363. You may also contact your state insurance department, 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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.

Questions: BCBS – Call 1-888-399-5945 or visit www.bcbsil.com/bnsf. **Caremark** – Call 1-800-378-7559 or visit www.caremark.com. If you aren't clear about any of the underlined terms in this form, see the Glossary. You can view the Glossary on myBNSF.com or at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the numbers above to request a paper copy.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. 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 page.

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** $4,690
- **Patient pays** $2,850

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*	$1,500
Copays	$0
Coinsurance	$1,200
Limits or exclusions	$150
Total*	**$2,850**

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

- **Amount owed to providers:** $4,100
- **Plan pays** $2,020
- **Patient pays**$2,080

Sample care costs:

Prescriptions	$1,500
Medical equipment and supplies	$1,300
Office visits and procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:*

Deductibles*	$1,500
Copays	$0
Coinsurance	$500
Limits or exclusions	$80
Total*	**$2,080**

* Note that "Deductibles" assume single (non-family) coverage. The Total line does not consider any amount you may use from a health savings account (HSA) or health reimbursement account (HRA), if available, to pay your share of expenses.

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 single (non-family) 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**. You should also consider contributions you make to accounts such as health savings account (HSA), that help you pay out-of-pocket expenses.

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