

Vermeer Corp Iowa Nationwide HDHP Blue POS



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, visit <https://vermeerbenefits.com> or call 1-641-621-8767. 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.healthcare.gov/sbc-glossary or call 1-641-621-8767 to request a copy.

Important Questions	Answers	Why this Matters:
<u>What is the overall deductible?</u>	In-Network (IN) Provider: \$3,750 person/ \$7,500 family per calendar year. Out-of-Network (OON) Provider: \$4,000 person/ \$8,000 family per calendar year.	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Preventive care</u> from in-network providers and routine vision exams are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits .
<u>Are there other <u>deductibles</u> for specific services?</u>	No. There are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	In-Network (IN) Provider: \$3,750 person/ \$7,500 family per calendar year. Out-of-Network (OON) Provider: \$4,000 person/ \$8,000 family per calendar year. The In-Network health and drug card <u>out-of-pocket</u> maximum amounts accumulate together.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	Premiums, <u>balance-billed charges</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an out-of-network provider, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an out-of-network provider for some services (such as lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a <u>referral</u> to see a specialist?</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 Your Designated Primary Care Provider (PCP) (You will pay the least)	What You Will Pay In-Network (IN) Provider (You will pay more)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Specialist visit	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	One routine hearing exam per calendar year.
	Preventive care/screening/immunization	No charge	No charge	0% <u>coinsurance</u>	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Preventive medical examinations performed for administrative purposes are covered in addition to a preventive exam..
If you have a test	Diagnostic test (x-ray, blood work)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call Vermeer at 1-641-621-8767.

Common Medical Event	Services You May Need	What You Will Pay Your Designated Primary Care Provider (PCP) (You will pay the least)	What You Will Pay In-Network (IN) Provider (You will pay more)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at availableatexpress-scripts.com/prescriptions</p>	<p>Retail & Vermeer Family Pharmacy Generic Drugs: Tier 1</p>		<p>0% coinsurance (must meet deductible first)</p>	<p>Not Covered</p>	<p>Deductible: The Deductible must be satisfied before 0% coinsurance.</p> <p>Generic Policy: Dispense as Written (DAW) If a Brand name drug is filled when a Generic equivalent is available, you will be required to pay the Generic cost share plus the difference in cost between the Generic and Brand name drug.</p>
	<p>Retail & Vermeer Family Pharmacy Preferred Brand Drugs: Tier 2</p>		<p>0% coinsurance (must meet deductible first)</p>	<p>Not Covered</p>	<p>Deductible: The Deductible must be satisfied before 0% coinsurance.</p> <p>Generic Policy: Dispense as Written (DAW) If a Brand name drug is filled when a Generic equivalent is available, you will be required to pay the Generic cost share plus the difference in cost between the Generic and Brand name drug.</p>

	Retail & Vermeer Family Pharmacy Non-Preferred Brand: Drugs: Tier 3		0% coinsurance (must meet deductible first)	Not Covered	Deductible: The Deductible must be satisfied before 0% coinsurance. Generic Policy: Dispense as Written (DAW) If a Brand name drug is filled when a Generic equivalent is available, you will be required to pay the Generic cost share plus the difference in cost between the Generic and Brand name drug.
	Specialty Drugs: Tier 4		0% coinsurance (must meet deductible first)	Not Covered	Specialty Medications: Specialty Medications are high-cost drugs that are often injected or infused and require special storage and monitoring. These medications must be obtained through Accredo specialty pharmacy by calling Accredo at 1.800.803.2523. Some exceptions apply. These medications are limited to a 30-day supply. Variable Copay Program available for select specialty drugs filled through Vermeer Family Pharmacy. Participation in Variable Copay Program may reduce your specialty drug cost. Your out-of-pocket expenses that are covered by the Variable Copay Program will not count toward the deductible and/or out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	<u>Physician/surgeon fees</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
If you need immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	For <u>emergency medical conditions</u> treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the <u>in-network</u> level. You may be balance billed for any <u>out-of-network</u> service as established under the rules developed for implementation of the No Surprises Act.
	<u>Urgent care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call Vermeer at 1-641-621-8767.

Common Medical Event	Services You May Need	What You Will Pay Your Designated Primary Care Provider (PCP) (You will pay the least)	What You Will Pay In-Network (IN) Provider (You will pay more)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Bariatric surgery is limited to Blue Distinction Centers.
	Physician/surgeon fees	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Inpatient services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
If you are pregnant	Office visits	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
If you need help recovering or have other special health needs	Home health care	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Rehabilitation services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Habilitation services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Skilled nursing care	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Durable medical equipment	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Wigs are covered up to \$500 per calendar year when hair loss results from alopecia or cancer diagnosis.
	Hospice services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.

For more information about limitations and exceptions, see your plan document or call Vermeer at 1-641-621-8767.

Common Medical Event	Services You May Need	What You Will Pay Your Designated Primary Care Provider (PCP) (You will pay the least)	What You Will Pay In-Network (IN) Provider (You will pay more)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	One routine vision exam per calendar year.
	Children's glasses	Not covered	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	Not covered	-----None-----

For more information about limitations and exceptions, see your plan document or call Vermeer at 1-641-621-8767.

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
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term 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.)

- Applied Behavior Analysis therapy
- Bariatric surgery (one per lifetime)
- Chiropractic care
- Infertility treatment (\$15,000 LTM)
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (one vision exam per calendar year)

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-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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, you can contact: Vermeer at 1-641-621-8767 or Employee Benefits Security Administration at 1-866-444-EBSA (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 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.

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

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 <u>deductible</u>	\$3,750
■ PCP <u>coinsurance</u>	0%
■ Hospital(facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,750
<u>Copayments</u>	\$0
<u>Coinurance</u>	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,810

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

■ The plan's overall <u>deductible</u>	\$3,750
■ <u>Specialist</u> <u>coinsurance</u>	0%
■ Hospital(facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,750
<u>Copayments</u>	\$0
<u>Coinurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$3,770

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

■ The plan's overall <u>deductible</u>	\$3,750
■ <u>Specialist</u> <u>coinsurance</u>	0%
■ Hospital(facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

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