AN AFFORDABLE ACA QUALIFIED AND ERISA COMPLIANT HEALTH PLAN SOLUTION

sb/afreedomplans
for SB/A CoOp Members
An ERISA Health Plan Solution

Introducing ...

SB/A CORE HEALTH PLAN

Plans A, B, C, D, and E – With ACA Minimum Essential Coverage

FREEDOM ICON I PLAN

$1,000 and $2,000 Inpatient Hospital Admission Option

PLANS INCLUDE:

PHCS PPO Network

Everyone qualifies - no medical underwriting

No deductible plus first dollar coverage

Minimum Essential Coverage (MEC) Annual Benefit

50-80% coinsurance, pharmacy,
full inpatient/outpatient hospitalization,
medical and surgical professional services,
emergency room, urgent care, labs and x-rays,
ambulance, maternity, mental health and
substance abuse

No waiting periods for base plans

EMPLOYERS:

- Your staff can purchase the amount of coverage they believe best fits their needs and lifestyle.
- Attract and retain valuable employees with a comprehensive medical benefits program.
- Employer sponsored Freedom Plans are exempt from regulations on offering benefits to part-time or 1099 employees.
- If annual coverage needs are expected to exceed the SB/A Core Health Plans' annual limitations, employees may consider additional industry available options.
- Potential return of unused claim funds.
- SB/A Core Health Plans utilize the PHCS Network, one of the largest nationwide preferred provider networks.

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LEAD TOGETHER

Administered by: Breckpoint, Inc.

THE SIGNATURE B&B COMPANIES
ACRISURE | AGENCY PARTNER

Facilitated by: SB/A Cooperative

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SB/A Core Health
Plans A, B, C, D, and E

Base Plan Coverage on all SB/A Core Health plans include the following:

PPO Network	PHCS
Deductible - Individual / Family	None
Telemedicine - Online and Telephonic Physician Calls 24/7/365	$0 Copay
Primary Care Physician (PCP) Office Visits Providers limited to Family Practice, Internal Medicine, Pediatrics, – office and other outpatient services.	3 PCP Visits at $20 Copay* per person per year. All other visits Subject to Coinsurance.
Specialist Care	Subject to Coinsurance
Prescription Drugs Generic / Brand	Subject to Coinsurance $500 Plan Benefit Maximum per Prescription per 30 Day Supply
Inpatient & Outpatient Hospital	Subject to Coinsurance
Mental / Behavioral Health Inpatient / Outpatient Limited to 30 Days or Visits	Subject to Coinsurance
Chiropractic Care (Limited to Spinal Adjustments)	Subject to Coinsurance
Medical Imaging, X-Ray, and Labs	Subject to Coinsurance
Emergency Room & Ambulance	Subject to Coinsurance
Urgent Care Facility	Subject to Coinsurance
Durable Medical Equipment	Subject to Coinsurance
ACA Preventive Care Services - Minimum Essential Coverage (MEC) **Adult, Women, Child - Immunization, Screenings, & Services** MEC not subject to Annual Maximum or Coinsurance Percentages (*Please see Minimum Essential Coverage in full brochure)*	MEC coverage paid at 100%

SB/A Core Health PLAN A

Annual Maximum Benefit
Individual $10,000 Family $20,000

BENEFIT SUMMARY

Coinsurance (Percentage of Covered Benefits by Plan)	50% of $10,000
Annual Out-of-Pocket Maximum	$5,000 Individual $10,000 Family
Annual Maximum Benefit Covered	$10,000 Individual $20,000 Family
Out of Network Coverage	See Provisions and Exclusions in Brochure

SB/A Core Health PLAN B

Annual Maximum Benefit
Individual $20,000 Family $40,000

BENEFIT SUMMARY

Coinsurance (Patient Pay)	50% of First $10,000 20% of Next $10,000
Annual Out-of-Pocket Maximum	$7,000 Individual $14,000 Family
Annual Maximum Benefit Covered	$20,000 Individual $40,000 Family
Out of Network Coverage	See Provisions and Exclusions in Brochure

SB/A Core Health PLAN C

Annual Maximum Benefit
Individual $20,000 / Family $40,000
Extra Enhanced Ind. $25,000 / Fam. $50,000 (2 or more enrolled)

EXTRA ENHANCED BENEFITS

Extra Inpatient Hospital & Outpatient Surgery and Professional Services Excludes Outpatient Drugs, Kidney Dialysis, Chemo Therapy, & All Other Infusion Therapy	Covered at 100% If Admitted
Annual Maximum Benefit Covered	$25,000 Individual $50,000 Family (2 or more enrolled)
Limitations	See Provisions and Exclusions

BASIC & EXTRA ENHANCED BENEFIT SUMMARY

Coinsurance on Base Plan (Patient Pay)	50% of First $10,000 20% of Next $10,000
Annual Out-of-Pocket Maximum	$7,000 Individual $14,000 Family (2 or more enrolled)
Annual Maximum Benefit Covered	Basic $20,000 Individual Basic $40,000 Family Enhanced $25,000 Individual Enhanced $50,000 Family
Out of Network Coverage	See Provisions and Exclusions in Brochure

SB/A Core Health PLAN D

Annual Maximum Benefit
Individual $20,000 / Family $40,000
Extra Enhanced Ind. $130,000 / Fam. $260,000 (Min. 5 enrolled)

BENEFIT SUMMARY

Extra Inpatient Hospital & Outpatient Surgery and Professional Services Excludes Outpatient Drugs, Kidney Dialysis, Chemo Therapy, & All Other Infusion Therapy *(see Provisions and Exclusions)*	Covered at 100% If Admitted
Annual Maximum Benefit Covered	$20,000 Individual + $130,000 Extra Enhanced $40,000 Family + $260,000 Extra Enhanced (Minimum 5 Enrolled)
Limitations	See Provisions and Exclusions

BASIC & ENHANCED BENEFITS

Coinsurance on Base Plan (Patient Pay)	50% of First $10,000 20% of Next $10,000 0% of Next $130,000
Annual Out-of-Pocket Maximum	$7,000 Individual $14,000 Family (Minimum 5 Enrolled)
Annual Maximum Benefit Covered	Basic $20,000 Individual Basic $40,000 Family Enhanced $130,000 Individual Enhanced $260,000 Family
Out of Network Coverage	See Provisions and Exclusions in Brochure

SB/A Core Health PLAN E

Annual Maximum Benefit
Individual $20,000 / Family $40,000
Extra Enhanced Ind. $230,000 / Fam. $460,000 (Min. 5 enrolled)

BENEFIT SUMMARY

Extra Inpatient Hospital & Outpatient Surgery and Professional Services Excludes Outpatient Drugs, Kidney Dialysis, Chemo Therapy, & All Other Infusion Therapy *(see Provisions and Exclusions)*	Covered at 100% If Admitted
Annual Maximum Benefit Covered	$20,000 Individual + $230,000 Extra Enhanced $40,000 Family + $460,000 Extra Enhanced (Minimum 5 Enrolled)
Limitations	See Provisions and Exclusions

BASIC & ENHANCED BENEFITS

Coinsurance on Base Plan (Patient Pay)	50% of First $10,000 20% of Next $10,000 0% of Next $230,000
Annual Out-of-Pocket Maximum	$7,000 Individual $14,000 Family (Minimum 5 Enrolled)
Annual Maximum Benefit Covered	Basic $20,000 Individual Basic $40,000 Family Enhanced $230,000 Individual Enhanced $460,000 Family
Out of Network Coverage	See Provisions and Exclusions in Brochure

Requires 3 or more enrolled

Freedom ICON I Plan

Summary Plan of Benefits

	Freedom ICON I Inpatient Hospital $1,000 /Admission Plan	Freedom ICON I Inpatient Hospital $2,000 /Admission Plan
Telemedicine - Online and Telephonic Physician Calls 24/7/365	$0 Copay Unlimited Calls	$0 Copay Unlimited Calls
Network	PHCS Specific Services Network	PHCS Specific Services Network
Plan Deductible	None	None
Member Annual Out-of-Pocket Maximum	None	None
Primary Care Physician Office Visits General Practice, Pediatric, Internal Medicine	In-Network Provider: $35 Copay Out-of-Network: Not Covered	In-Network Provider: $35 Copay Out-of-Network: Not Covered
Specialist Office Visits	In-Network Provider: $75 Copay Out-of-Network: Not Covered	In Network Provider: $75 Copay Out-of-Network: Not Covered
Urgent Care Visits	In-Network Provider: $125 Copay Out-of-Network: Not Covered	In Network Provider: $125 Copay Out-of-Network: Not Covered
Emergency Room Visits	$250 Copay In-Network Provider Coverage up to $1,000 per Incident Out-of-network Not Covered	$250 Copay In-Network Provider Coverage up to $1,000 per Incident Out-of-network Not Covered
Outpatient Surgery	In-Network Provider Coverage If Admitted Maximum Benefit $1,000 Out-of-Network: Not Covered	In-Network Provider Coverage If Admitted Maximum Benefit $1,000 Out-of-Network: Not Covered
Inpatient Medical & Surgical Hospitalization; Surgical and Professional Services	In-Network Provider Coverage up to $1,000 per Admission Maximum of 10 Admissions per Plan Year Out-of-Network: Not Covered	In-Network Provider Coverage up to $2,000 per Admission Maximum of 10 Admissions per Plan Year Out-of-Network: Not Covered
Mental Health	In-Network Coverage up to $250/day If Medically Necessary Maximum of 7 Days per Plan Year Out-of-Network: Not Covered	In-Network Coverage up to $250/day If Medically Necessary Maximum of 7 Days per Plan Year Out-of-Network: Not Covered
Prescription Medications	In-Network Provider: 50% Coinsurance For 30 Day Supply - Generic Only Brand Rx - 100% Patient Pay Responsibility	In-Network Provider: 50% Coinsurance For 30 Day Supply - Generic Only Brand Rx - 100% Patient Pay Responsibility
ACA Minimum Essential Coverage (MEC) (*Please see Minimum Essential Coverage in full brochure)*	Covered at 100%	Covered at 100%

Core Health Plans A B C D E - Provisions and Exclusions

Preventative Care, Wellness Visits, Pap Smears, Flu Shots, Immunizations, and more.

Primary Care, Specialist, and Urgent Care Visits Plus X-rays, CT and MRI Scans, Lab and Diagnostic Services. Prescription Drugs – ACA at 100% (includes Birth Control), plus all others at indicated co-insurance up to threshold limit using the Serve You Rx pharmacy card at your favorite pharmacy.

- Inpatient / Outpatient Mental / Behavioral Health benefits limited to 30 days or visits.
- Pharmacy benefits are eligible for Rx discounts above base plan threshold.
- $500 Plan Benefit Maximum per Brand Prescription per 30 Day Supply.
- Employees must sign the appropriate employee application.
- No Medical Underwriting.
- No Pre-Existing Condition Exclusions.
- No Waiting Periods (includes Prenatal checks).
- Plans A, B, and C are available to employer groups with 3 or more enrolled.
- Plans D and E are available to employer groups with 5 or more enrolled.
- Patient is eligible for “Contractual Discounts” in excess of Annual Maximum benefits as “Patient Pay Responsibility.”
- Notice: All Non-Network Providers involved in the emergency services or the legally required Continuum of Care will be accepted, and Providers will be paid at Network contractual rates.

Extra Enhanced Benefits – Inpatient/Outpatient Benefit Provisions & Exclusions (Plan C, D, E)

- Extra Enhanced Inpatient Hospital & Outpatient Hospital Surgery Benefit Services are in addition to base benefits.
- Annual Maximum benefit is limited to stated annual amounts – Plan C $25,000 Individual / $50,000 Family; Plan D $130,000 Individual / $260,000; Plan E $230,000 Individual / $460,000 Family
- Extra Enhanced Inpatient/Outpatient Benefit provision Plan C, D, E, is effective 60 days after the effective date of the member.
- Extra Enhanced Inpatient Hospital & Outpatient Surgery Benefit Plan C – $25,000 Individual / $50,000 Family, Plan D - $130,000 Individual / $260,000 Family, Plan E $230,000 Individual / $460,000 Family
- Extra Enhanced provision Plan C is subject to a 12/6 pre-existing condition provision. Conditions which exist 12 months before the effective date will be excluded from coverage for the first 6 months of coverage.
- Extra Enhanced provision Plan D & E are subject to a 24/24 pre-existing condition provision. Conditions which exist 24 months before the effective date will be excluded from coverage for the first 24 months of coverage. Pre-Existing Condition Requirement is applied to Extended Coverage Amounts above $20,000 on Plans C, D & E.
- Mental/Behavioral Inpatient/Outpatient Healthcare benefits limited to 30 days or visits.
- Emergency Room, Lab, X-ray, Imaging are covered if admitted to an Inpatient Hospital stay.
- Maternity inpatient hospital and outpatient services are effective 10 months after the effective date.
- Outpatient Drugs, Kidney Dialysis, Chemo Therapy, and all other Infusion Therapy is excluded from coverage under Extra Enhanced Inpatient Hospital & Outpatient Surgery Benefit provision.
- Observation stays are excluded from coverage

Exclusions from coverage:

- Any hospital confinement that began on or before the effective date is excluded from plan coverage.
- Workers Compensation injuries and illness.
- Cosmetic surgery procedures – exceptions to some reconstructive surgeries.
- Bariatric/Gastric Sleeve surgery.
- Sex transformation / change surgery.

Freedom ICON I - Plan Provisions and Exclusions

- ICON I and ICON II has provisions and exclusions that may impact eligibility for enrollee benefits.
- Employees must sign the appropriate employee application.
- Does not qualify as insurance
- Notice: All Non-Network Providers involved in the emergency services or the legally required Continuum of Care will be accepted, and Providers will be paid at Network contractual rates.

Benefit Exclusions:

- Treatment relating to a covered person: taking part in any war or act of war (including service in the armed forces), commission of or attempt to commit a felony, an act of terrorism, or participating in an illegal occupation, riot or insurrection;
- Sickness or Injury sustained while on active duty in the armed forces of any country. This does not include Reserve or National Guard duty for training;
- Services, treatment or loss rendered in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;
- Surgery and treatment, procedures, products, or services that are experimental or investigative;
- Suicide;
- Surgery to correct vision or hearing, unless a result of a covered Injury, medically necessary surgery for glaucoma, cataracts or other sickness or injury;
- Dental care, dental x-rays, or dental treatment;
- Gastric or intestinal bypass services including lap banding, gastric stapling, and other similar procedures to facilitate weight loss; the reversal, or revision of such procedures; or services required for the treatment of complications from such procedures. This exclusion does not apply to completion of a weight reduction program that may be payable under the Health Screening benefit;
- Rest cures or custodial care, or treatment of sleep disorders;
- Cosmetic surgery (exceptions for some reconstructive or illness procedures):
- Workman's Compensation injuries and illnesses
- Sex transformation/surgery

SB/A Core Health Plans
Costs

SB/A CORE HEALTH PLAN A: Minimum 3 EE

Individual $10,000 / Family $20,000

Employee Only	$285.50
Employee + Spouse	$476.50
Employee + Child(ren)	$458.00
Employee + Family	$600.50

SB/A CORE HEALTH PLAN B: Minimum 3 EE

Individual $20,000 / Family $40,000

Employee Only	$357.00
Employee + Spouse	$616.80
Employee + Child(ren)	$586.00
Employee + Family	$790.00

SB/A CORE HEALTH PLAN C: Minimum 3 EE

Individual $20,000 / Family $40,000
with Extra Enhanced Benefit
Individual $25,000 / Family $50,000

Employee Only	$418.50
Employee + Spouse	$752.10
Employee + Child(ren)	$709.00
Employee + Family	$974.50

SB/A CORE HEALTH PLAN D: Minimum 5 EE

Individual $20,000 / Family $40,000
with Extra Enhanced Benefit
Individual $130,000 / Family $260,000

Employee Only	$550.00
Employee + Spouse	$879.50
Employee + Child(ren)	$833.75
Employee + Family	$1,065.00

SB/A CORE HEALTH PLAN E: Minimum 5 EE

Individual $20,000 / Family $40,000
with Extra Enhanced Benefit
Individual $230,000 / Family $460,000

Employee Only	$655.00
Employee + Spouse	$1,055.50
Employee + Child(ren)	$996.25
Employee + Family	$1,295.00

Freedom ICON I Plan
Costs

FREEDOM ICON I PLAN Minimum 3 EE

Option 1

Inpatient Hospital $1,000/Admission Plan

Employee Only	$220.00
Employee + Spouse	$319.20
Employee + Child(ren)	$304.80
Employee + Family	$368.00

FREEDOM ICON I PLAN Minimum 3 EE

Option 2

Inpatient Hospital $2,000/Admission Plan

Employee Only	$233.00
Employee + Spouse	$346.50
Employee + Child(ren)	$329.50
Employee + Family	$401.00

For complete brochures

and to learn more about the

SB/A Core Health Plans

and Freedom ICON I Plans

visit:

https://nysba.linked.exchange

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