AN AFFORDABLE ACA QUALIFIED AND ERISA COMPLIANT HEALTH PLAN SOLUTION

SB/A CORE HEALTH PLAN

With ACA Minimum Essential Coverage

PLANS A, B, and C

Maximizing savings and providing cutting-edge solutions to help you effectively manage your health care costs

Call David at 516-240-8877 and/or
Lenny at 516-240-8864
craftbrewinsurance@sbbinsure.com
https://nysba.linked.exchange

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THE SIGNATURE B&B COMPANIES
ACRISURE | AGENCY PARTNER

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SERVICE
FLEXIBILITY
INTEGRITY

Facilitated by: **SB/A Cooperative**

Administered by: **Breckpoint**

Partners of SB/A Core Health Plan

Breckpoint

Breckpoint is headquartered in Las Vegas, Nevada and has managed and operated self-funded risk pools across multiple industries since 2003 and has positioned itself as a leader for alternative risk options for employers of all sizes across the most needed lines of insurance. Within the employee benefit space specifically, Breckpoint administers limited benefit plan designs through its full service Third Party Administrator specializing in MEC enhanced products. Breckpoint specializes and supports traditional and level funded programs for employer sponsored limited benefit plans and also provides advisors and employers stop loss options for traditional major medical offerings. Whether captives, limited benefits plans or medical stop loss, Breckpoint champions the transparency, control and long-term savings that comes with self-funding, partially self-funding, and alternative risk solutions.

SB/A CoOp

The SB/A CoOp is a Non-Profit "Agency" Cooperative Corporation that does not buy or sell products or services but acts as the "Legal Collective Agent" of all the Cooperative Members to facilitate advantageous contractual relationships for and between the members. The SB/A CoOp may legally "aggregate" small employers together without becoming a Multiple Employer Welfare Association (MEWA) or acting as a Multiple Employer Trust (MET). The SBA CoOp sponsors the unique ERISA Employer Healthcare Benefits Plans that are ACA qualified when attached to ACA Minimum Essential Coverage.

Serve You Rx

Since 1987, Serve You Rx has been the pharmacy benefit manager (PBM) of choice for employee benefit brokers and consultants, their clients, including employers, unions, coalitions, and governmental entities, as well as third party administrators who are looking for a valuable partner to effectively manage prescription drug costs. **Serve You Rx** offers:

- Stability
- Consistency
- Flexibility
- Customized plan designs
- Consultative clinical support
- Robust trend management programs and strategies
- Exceptionally focused member and client service
- Quality-driven, **Serve You Rx** owned and operated mail service and specialty pharmacies
- Over 66,000 pharmacies nationwide
- Privately owned and headquartered in Milwaukee, Wisconsin
- Wholly-owned mail order pharmacy

The SB/A Cooperative

Efficiency | Savings | Simplicity | Freedom

The SB/A CoOp was formed in 2017 as a Non-Profit "Agency" Cooperative Corporation to provide for employer/employee health care benefits in the small and large group employer marketplace. Each group employer CoOp Member can sponsor a Partially Self-Funded ERISA Employer Welfare Benefit Plan for the benefit of its employees and their dependents. Called the "SB/A Cooperative Sponsored Freedom Plan," it is an ERISA health plan for sponsoring employers offered in conjunction with Preventive Care Benefits. The employer's claim exposure is protected via an "Aggregate Stop Loss Fund (ASLF)" owned by the SB/A CoOp Employer Members.

Each SB/A CoOp Employer Member has its own SB/A Cooperative Sponsored Freedom Plan funded claim account administered by Breckpoint, Inc, the Plan Administrator. The employer's maximum claim liability is limited to the 12-month level funding of its claim account. The Member Employers own the funds and will receive the defined surplus on a calendar year basis following a (12/18) accounting period.

The purpose for which the SB/A CoOp is organized is to foster the development of Partially Self-Funded healthcare benefit arrangements which include the use of Level Funded ERISA compliant "Limited Benefit Plans," the use of Employer funded "Aggregate Stop Loss" coverage and reinsurance consistent with applicable state and federal laws, including ERISA. To act primarily as the legal agent for all the Cooperative Members in arranging for and facilitating ERISA compliant and ACA qualified employer/employee health benefit plans that are administered by a legal Third Party Administrator (TPA). Brokers/Agents that are members of SBA CoOp and who are compenstated by SB/A CoOp, market the SB/A CoOp and "The SB/A Freedom Plans."

To participate and take advantage of the SB/A Freedom Plans options, the following is required:

1. Broker and Employers must join the SB/A CoOp – complete the SB/A CoOp Membership Agreement and pay the annual $24 membership fee.
2. Broker completes the SB/A CoOp Compensation form, Broker W-9, and Broker Information Form – this is a one-time requirement.
3. Employer completes the Group Information Form.
4. Employees complete the SB/A Sponsored Freedom Plan Employee Enrollment Form. For larger employer groups, Employers can submit an electronic eligibility spreadsheet.

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Annual Maximum Benefit Individual $10,000 Family $20,000	SB/A Core Health PLAN A Summary Plan of Coverage
PPO Network	**PHCS**
BASIC BENEFITS SUMMARY	
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	MEC coverage paid at 100%
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

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Annual Maximum Benefit Individual $20,000 Family $40,000	SB/A Core Health PLAN B Summary Plan of Coverage
PPO Network	**PHCS**
BASIC BENEFITS SUMMARY	
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	MEC coverage paid at 100%
BENEFIT SUMMARY	
Coinsurance (Percentage of Covered Benefits by Plan)	50% of First $10,000 80% 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

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Annual Maximum Benefit Individual $20,000 / Family $40,000 Extra Enhanced Ind. $25,000 / Fam. $50,000 (2 or more enrolled)	SB/A Core Health PLAN C Summary Plan of Coverage
PPO Network	**PHCS**
BASIC BENEFITS SUMMARY	
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	MEC coverage paid at 100%
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 (Percentage of Covered Benefits by Plan)	50% of First $10,000 80% 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

Minimum Essential Coverage ACA Annual Benefits

All Employer Plans – MEC Covered Services		Minimum Essential Coverage (MEC Plan) In-Network Provider (PPO) Only
Annual Deductible		None
Member Annual Out-of-Pocket Maximum		None
Co-Insurance Percentage covered (Plan Pays Based on Contracted Amounts)		100%
Pharmacy Benefit		100% of ACA mandated prescription, i.e. Birth Control
Annual Maximum of Covered Services		No Annual Maximum
Routine Well Care – As Provided Under the Affordable Care Act (ACA)		
Adult Preventative Services - Screenings and Services Listed Below are Eligible		
1. Abdominal Aortic Aneurysm	9. Diet Counseling	Covered at 100%
2. Alcohol Misuse	10. Obesity	Covered at 100%
3. Aspirin	11. Sexually Transmitted Infection (STI)	Covered at 100%
4. Blood Pressure	12. Syphilis	Covered at 100%
5. Cholesterol	13. HIV	Covered at 100%
6. Colorectal Cancer	14. Tobacco Use	Covered at 100%
7. Depression	15. Immunization Vaccines	Covered at 100%
8. Type 2 Diabetes		Covered at 100%
Women Preventative Services – Screenings and Services Listed Below are Eligible		
1. Anemia	12. Gestational Diabetes	Covered at 100%
2. Bacteriuria Urinary Tract	13. Gonorrhea	Covered at 100%
3. BRCA	14. Hepatitis B	Covered at 100%
4, Breast Cancer Mammography	15. Human Immunodeficiency Virus (HIV)	Covered at 100%
5. Breast Cancer Chemoprevention	16. Human Papillomavirus (HPV) DNA Test	Covered at 100%
6. Breastfeeding	17. Osteoporosis	Covered at 100%
7. Cervical Cancer	18. Rh Incompatibility	Covered at 100%
8. Chlamydia Infection	19. Tobacco Use	Covered at 100%
9. Contraception	20. Sexually Transmitted Infections (STI)	Covered at 100%
10. Domestic and Interpersonal Violence	21. Syphilis	Covered at 100%
11. Folic Acid Supplements	22. Well Woman Visits	Covered at 100%
Child Preventative Services – Screenings and Services Listed Below are Eligibile		
1. Alcohol and Drug Use	14. Hematocrit or Hemoglobin	Covered at 100%
2. Autism	15. Hemoglobinopathies or Sickle Cell	Covered at 100%
3. Behavioral	16. HIV	Covered at 100%
4. Blood Pressure	17. Immunization Vaccines	Covered at 100%
5. Cervical Dysplasia	18. Iron Supplements	Covered at 100%
6. Congenital Hypothyroidism	19. Lead Exposure	Covered at 100%
7. Depression	20. Medical History	Covered at 100%
8. Developmental	21. Obesity	Covered at 100%
9. Dyslipidemia	22. Oral Health	Covered at 100%
10. Fluoride Supplements	23. Phenylketonuria (PKU)	Covered at 100%
11. Gonorrhea	24. Sexually Transmitted Infection	Covered at 100%
12. Hearing	25. Tuberculin Testing	Covered at 100%
13. Height, Weight and Body Mass Index	26. Vision	Covered at 100%

Plan 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.
- 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 and Outpatient Benefit Provisions & Exclusions (Plan C only):

- 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.
- Mental/Behavioral Inpatient/Outpatient Healthcare benefits limited to 30 days or visits.
- Emergency Room, Lab, X-ray, and Imaging are covered if admitted to an Inpatient Hospital stay.
- Extra Enhanced Inpatient/Outpatient Benefit provision 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) provision 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. 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.

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.

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SB/A Core Health Plans Application

The SB/A Core Health Plan Cost & SB/A CoOp Authorization

SB/A CORE HEALTH PLAN A:

✦ Individual $10,000 / Family $20,000

Minimum 3 EE

	Estimated Enrollment		Fixed + Claim Funding = Total		Cost Per Selection
Employee Only	_____	X	($193.00 + $92.50) = $285.50	=	_____
Employee + Spouse	_____	X	($273.00 + $203.50) = $476.50	=	_____
Employee + Child(ren)	_____	X	($273.00 + $185.00) = $458.00	=	_____
Employee + Family	_____	X	($323.00 + $277.50) = $600.50	=	_____

SB/A CORE HEALTH PLAN B:

✦ Individual $20,000 / Family $40,000

Minimum 3 EE

	Estimated Enrollment		Fixed + Claim Funding = Total		Cost Per Selection
Employee Only	_____	X	($203.00 + $154.00) = $357.00	=	_____
Employee + Spouse	_____	X	($278.00 + $338.80) = $616.80	=	_____
Employee + Child(ren)	_____	X	($278.00 + $308.00) = $586.00	=	_____
Employee + Family	_____	X	($328.00 + $462.00) = $790.00	=	_____

SB/A CORE HEALTH PLAN C:

✦ Individual $20,000 / Family $40,000

Minimum 3 EE

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

	Estimated Enrollment		Fixed + Claim Funding = Total		Cost Per Selection
Employee Only	_____	X	($203.00 + $215.50) = $418.50	=	_____
Employee + Spouse	_____	X	($278.00 + $474.10) = $752.10	=	_____
Employee + Child(ren)	_____	X	($278.00 + $431.00) = $709.00	=	_____
Employee + Family	_____	X	($328.00 + $646.50) = $974.50	=	_____

SB/A CoOp Employer Application

This SB/A CoOp Employer Application hereby authorizes SB/A CoOp as Legal Agent to facilitate the establishment of, and the Employees' enrollment in the Employer's "Self-Funded ERISA Compliant," "The SB/A Core Health Plans" (as attached) at and for the Employer as detailed herein:

Employer Name: (print) _____

Employer Address: (print) _____

Employer Signature: _____ Date: _____

Broker Name: _____ Effective Date Requested: _____

SB/A Cooperative Acceptance by: _____ Date: _____