



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*

**SERVICE
FLEXIBILITY
INTEGRITY**

Facilitated by:
SB/A Cooperative
Administered by:
The Loomis Company

SERVE YOU 

Partners of SB/A Core Health Plan

Third Party Administrator (TPA)

Third Party Administrator (TPA) is defined as an organization that handles the administrative duties of a self-funded health benefits plan. SB/A CoOp partners with top Third Party Administrators to function as contract administrator on behalf of an Employer's self-funded health plan program.

Organizations such as SB/A CoOp outsource TPAs to facilitate those administrative duties such as billing, claims processing, employee enrollment, and maintain compliance with state

and federal regulations. TPA functions and authorities are set by a fiduciary.

A TPA provides access to contracted Preferred Provider Organization healthcare networks, pharmacy PBMs and telemedicine. SB/A CoOp TPA partnership specializes in traditional and level funded programs. The TPA partnership integrates medical management data with the claims adjudication process to allow for seamless customer service and one point contact for service needs.

SB/A CoOp

The SB/A CoOp is a non-profit "Agency" Cooperative Corporation. The SB/A CoOp Inc., 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 sponsors unique ERISA Employer Healthcare Benefit 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 employer marketplace. Each group employer SB/A CoOp Member can sponsor a partially self-funded ERISA Employer Welfare Benefits Plan for the benefit of its employees and their dependents.

SB/A CoOp may legally “aggregate” small business employers and protect claim exposure 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 and funded claim account administered by a contracted Third Party Administrator.

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

1. Employers and Brokers must become Members of the SB/A CoOp. Complete the Membership Agreement.
2. Employers complete the Group Information form.
3. Employees complete the Group Health Application. No medical application.
4. Brokers and Agents of Record; contact SB/A CoOp for appointment.

The Employer’s maximum claim liability is limited to the 12-month level funding of its claim account. Member Employers own the fund and may receive a defined surplus on a calendar basis (12/18) in accordance with Fiduciary responsibility.

The Small Business Agency Cooperative

was organized 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.

SB/A CoOp acts primarily as the legal agent for all 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 the SB/A CoOp and who are compensated by the SB/A CoOp, may market the SB/A CoOp and its group health and welfare benefit plans.

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	Generic and Brand Drugs are Subject to Coinsurance <i>See Provisions</i>
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

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

Generic and Brand Drugs
are Subject to Coinsurance
See Provisions

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

<p>Annual Maximum Benefit Individual \$20,000 / Family \$40,000 Extra Enhanced Ind. \$25,000 / Fam. \$50,000 (3 or more enrolled)</p>	<p>SB/A Core Health PLAN C Summary Plan of Coverage</p>
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PPO Network	PHCS
<u>BASIC BENEFITS SUMMARY</u>	
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	Generic and Brand Drugs are Subject to Coinsurance <i>See Provisions</i>
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 (3 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																
Annual Maximum Benefit Covered	<table border="0" style="width: 100%;"> <tr> <td style="width: 15%;">Basic</td> <td style="width: 30%;">\$20,000</td> <td style="width: 15%;">Individual</td> <td style="width: 40%;"></td> </tr> <tr> <td>Basic</td> <td>\$40,000</td> <td>Family</td> <td></td> </tr> <tr> <td>Enhanced</td> <td>\$25,000</td> <td>Individual</td> <td></td> </tr> <tr> <td>Enhanced</td> <td>\$50,000</td> <td>Family</td> <td></td> </tr> </table>	Basic	\$20,000	Individual		Basic	\$40,000	Family		Enhanced	\$25,000	Individual		Enhanced	\$50,000	Family	
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	Covered at 100%
2. Alcohol Misuse	Covered at 100%
3. Aspirin	Covered at 100%
4. Blood Pressure	Covered at 100%
5. Cholesterol	Covered at 100%
6. Colorectal Cancer	Covered at 100%
7. Depression	Covered at 100%
8. Type 2 Diabetes	Covered at 100%
9. Diet Counseling	Covered at 100%
10. Obesity	Covered at 100%
11. Sexually Transmitted Infection (STI)	Covered at 100%
12. Syphilis	Covered at 100%
13. HIV	Covered at 100%
14. Tobacco Use	Covered at 100%
15. Immunization Vaccines	Covered at 100%
Women Preventative Services – Screenings and Services Listed Below are Eligible	
1. Anemia	Covered at 100%
2. Bacteriuria Urinary Tract	Covered at 100%
3. BRCA	Covered at 100%
4. Breast Cancer Mammography	Covered at 100%
5. Breast Cancer Chemoprevention	Covered at 100%
6. Breastfeeding	Covered at 100%
7. Cervical Cancer	Covered at 100%
8. Chlamydia Infection	Covered at 100%
9. Contraception	Covered at 100%
10. Domestic and Interpersonal Violence	Covered at 100%
11. Folic Acid Supplements	Covered at 100%
12. Gestational Diabetes	Covered at 100%
13. Gonorrhea	Covered at 100%
14. Hepatitis B	Covered at 100%
15. Human Immunodeficiency Virus (HIV)	Covered at 100%
16. Human Papillomavirus (HPV) DNA Test	Covered at 100%
17. Osteoporosis	Covered at 100%
18. Rh Incompatibility	Covered at 100%
19. Tobacco Use	Covered at 100%
20. Sexually Transmitted Infections (STI)	Covered at 100%
21. Syphilis	Covered at 100%
22. Well Woman Visits	Covered at 100%
Child Preventative Services – Screenings and Services Listed Below are Eligible	
1. Alcohol and Drug Use	Covered at 100%
2. Autism	Covered at 100%
3. Behavioral	Covered at 100%
4. Blood Pressure	Covered at 100%
5. Cervical Dysplasia	Covered at 100%
6. Congenital Hypothyroidism	Covered at 100%
7. Depression	Covered at 100%
8. Developmental	Covered at 100%
9. Dyslipidemia	Covered at 100%
10. Fluoride Supplements	Covered at 100%
11. Gonorrhea	Covered at 100%
12. Hearing	Covered at 100%
13. Height, Weight and Body Mass Index	Covered at 100%
14. Hematocrit or Hemoglobin	Covered at 100%
15. Hemoglobinopathies or Sickle Cell	Covered at 100%
16. HIV	Covered at 100%
17. Immunization Vaccines	Covered at 100%
18. Iron Supplements	Covered at 100%
19. Lead Exposure	Covered at 100%
20. Medical History	Covered at 100%
21. Obesity	Covered at 100%
22. Oral Health	Covered at 100%
23. Phenylketonuria (PKU)	Covered at 100%
24. Sexually Transmitted Infection	Covered at 100%
25. Tuberculin Testing	Covered at 100%
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.
- Generic and Brand Drugs are Subject to Coinsurance - \$500 per prescription per month per 30 day supply is the maximum eligible amount per prescription to be applied to the coinsurance percentage. Discounted prescription costs in excess of \$500 are 100% the member's responsibility
- Pharmacy benefits are eligible for Rx discounts above base plan threshold.
- 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.



SB/A Core Health Plans Application

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

SB/A CORE HEALTH PLAN A:

Annual Co-Insurance Limit ◆ **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:

Annual Co-Insurance Limit ◆ **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:

Annual Co-Insurance Limit ◆ **Individual \$20,000 / Family \$40,000**
◆ **with Extra Enhanced Benefit Individual \$25,000 / Family \$50,000**

Minimum 3 EE	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: _____