AN AFFORDABLE ERISA COMPLIANT EMPLOYER SPONSORED HEALTH PLAN

USA HEALTH PLANS

VALUE BRONZE INDIVIDUAL PLAN

Includes Minimum Essential Coverage
Plus HI Extension Program

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

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

SERVE YOU Rx

USA HEALTH PLANS

SERVE YOU Rx

Value Bronze Individual Plan

Summary Plan of Benefits

PPO Network	First Health
Deductible	None (*Deductible may apple to Brand Rx)
Out-of-pocket Maximum	Individual $6,000 / Family $12,000
PROFESSIONAL SERVICES BENEFITS	
Physician's Office Visits Includes family and general physician, internist and OB/GYN physician Pre-Ex Covered Day 1	$75 Co-Pay, then 100% Limited to three (3) visits per plan year
Specialist's Office Visits Pre-Ex Covered Day 1	$150 Co-Pay, then 100% Limited to three (3) visits per plan year combined with mental health and substance abuse office visits.
Urgent Care Pre-Ex Covered Day 1	$150 Co-Pay, then 100% Limited to two (2) visits per plan year
Diagnostic X-ray & Laboratory Expenses *Non-hospital based* Pre-Ex Covered Day 1	$150 Co-Pay, then 100% Limited to three (3) tests/procedures per plan year
Advanced Imaging *12/12 Pre-ex Applies*	$1,000 Co-Pay, then 100% Limited to one (1) visit per plan year
REHABILITATION THERAPY BENEFITS	
Physical Therapy *12/12 Pre-ex Applies*	$100 Co-Pay, then 100% Limited to a combined four (4) visits per plan year
Occupational Therapy *12/12 Pre-ex Applies*	$100 Co-Pay, then 100% Limited to a combined four (4) visits per plan year
SURGICAL SERVICES BENEFITS	
Office	$75 Co-Pay, then 100% Limited to one (1) procedure per plan year
Outpatient Facility and Professional Fees *12/12 Pre-ex Applies*	$1,500 Co-Pay, then 100% Limited to one (1) procedures per plan year
Inpatient *12/12 Pre-ex Applies*	$1,500 Co-Pay, then 100% Limited to two (2) procedure per plan year
HOSPITAL BENEFITS	
Emergency Room *12/12 Pre-ex Applies*	$2500 Co-Pay Limited to one (1) visit per plan year Co-Pay waived if admitted
Inpatient Hospitalization & ICU *12/12 Pre-ex Applies*	$1,500 Co-Pay per day 5 Days Maximum per Year Plan plays 100% after Co-Pay during first 5 days
Inpatient Hospitalization & ICU *Additional Benefit - See HI Extension Program on page 4 *12/12 Pre-ex Applies*	Plan pays $2,000 per day, up to 365 days Day 6 through Discharge Date
Maternity Global Services *12/12 Pre-ex Applies* *Includes, but is not limited to facility, professional and physician fees for uncomplicated maternity related care.*	$3,500 Co-Pay, then 100%

USA HEALTH PLANS

SERVE YOU Rx

continued ...
Summary Plan of Benefits

MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS		
Inpatient Mental Health Treatment *12/12 Pre-ex Applies*	$1,500 Co-Pay per Day, then 100% Limited to five (5) days per plan year combined with inpatient hospital due to medical and surgical services, inpatient mental health hospitalization and inpatient substance abuse.	
Mental Health Treatment (Office Setting) Pre-Ex Covered Day 1	$100 Co-Pay, then 100% Limited to four (4) visits per plan year combined with mental health and substance abuse and specialist office visits.	
Inpatient Substance Abuse Treatment *12/12 Pre-ex Applies*	$1,500 Co-Pay per Day, then 100% Limited to five (5) days per plan year combined with inpatient hospital due to medical and surgical services, inpatient mental health hospitalization and inpatient substance abuse	
Substance Abuse Treatment (Office Setting) Pre-Ex Covered Day 1	$100 Co-Pay, then 100% Limited to four (4) visits per plan year combined with mental health and substance abuse and specialist office visits.	
MISCELLANEOUS SERVICES & SUPPLIES BENEFITS		
Home Health Care *12/12 Pre-ex Applies*	$100 Co-Pay, then 100% Limited to six (6) visits per plan year	
Ambulance Service *12/12 Pre-ex Applies*	$750 Co-Pay, then 100% Limited to one (1) ambulance trip per plan year Air Ambulance is Excluded	
Clinical Trials	Paid as any other benefit	
PRESCRIPTION DRUG BENEFITS *(available through a separate Pharmacy Benefit Manager)*		
Plan Year Deductible: Per Covered Person	$500	$500
	Retail Covered Person Pays 30-day supply (After Deductible)	**Mail-Order Covered Person Pays Up to 90-day supply (After Deductible)**
Generic* (tier-1) Pre-Ex Covered Day 1	50% (Deductible Waived)	50% (Deductible Waived)
Preferred Brand (tier-2) *12/12 Pre-ex Applies*	50%	50%
Non-Preferred (tier-3) *12/12 Pre-ex Applies*	50%	50%
Specialty Medications (tier-4)**	Not Covered	Not Covered

L2225

HI Extension Program

for Value Bronze Individual Plan

Guaranteed Acceptance

Hospital Indemnity Benefit

The following benefits are payable when a Participant has a qualified Hospital confinement. To receive benefits, each Participant must be enrolled in this program and complete the applicable Elimination / Waiting Period. Unless otherwise indicated below, any benefit amount, limitation, or benefit maximum applies to each Participant.

MVP Programs are affordable and comprehensive for both employers and employees. However, recognizing these programs have some limitations, the HI Extension Program (elected at the employer level) was created with SB/A to provide a vital tax-free benefit to help offset potential out-of-pocket costs. Benefits are designed to provide protection when an MVP plan's hospital benefits are exhausted.

HI Extension	Benefit / Reimbursement Amount	Elimination / Waiting Period	Limitation
Value Bronze HI Extension	**$2,000 per day** (Day 6 through discharge date)	**5 Days** $0 Benefit for days 1-5	up to **365 Days** per condition (diagnosis)

Plans shown have an initial benefit waiting period of 299 days for pregnancy. Benefits are available for most medically necessary treatment of an illness or injury that occur in a hospital facility. Benefits are not available for hospital confinement initiated during the Elimination Period. Please refer to the full Summary of Benefits for full plan Definition, Limitations, & Exclusions.

Please note: This is a generic representation of benefits and is only intended to serve as an initial proposal of benefits potentially available. Refer to the Schedule of Benefits for the official list of Benefits Coverage, Limitations, & Exclusions. If benefits outlined on this page differ from the Schedule of Benefits on Official Plan Documents, the Schedule of Benefits or Official Plan Documents will govern.

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 as Provided in the Affordable Care Act MEC		
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 Eligible		
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

Plan Provisions:

- Value Bronze Individual Plans have provisions and exclusions that may impact eligibility for enrollee benefits.
- Employees must sign the appropriate employee application.
- Does not qualify as insurance
- Plan covers services provided by First Health PPO network providers – non-First Health PPO providers are not covered by the plan
- Conditions that existed or have been treated within 12 months prior to the members' coverage effective date are excluded for 12 months from the members' coverage effective date – the exclusion applies to:
  - Inpatient and outpatient facilities for medical, surgical, substance abuse and mental health services, Maternity Services and Birthing, Home Health Care, Emergency Room Services, Advanced Imaging, Physical and Occupational Therapy, Preferred Brand (Tier 2) and Non-Preferred Brand (Tier 3) prescriptions
  - Physician and Specialist Office Visit Services and Generic Drugs are not subject to the 12 /12 Pre-Existing Condition Limitation
- Intensive Care Unit, Cardiac Care Unit, and Neonatal Intensive Care Unit (ICU, CCU, and NICU) charges are covered at standard semi-private room rates
- Maternity Genetic Testing is subject to the 12 /12 Pre-Existing Condition Limitation and is limited to a $500 allowable amount upon being eligible
- Emergency Room Co-Pay is waived if admitted, however the Inpatient Services are subject to $1500 Co-Pay per Day
- All Rehabilitation Therapy Benefits, Surgical Services, Hospital Benefits, and Mental Health & Substance Abuse Benefits are subject to Medical Necessity and Prior Authorization approval by the claim's administrator.
- All Inpatient and Outpatient Facility services are subject to pre-notification and prior authorization approval by plan administrator
- Visit limitations apply – consult benefit summary
- Eligible prescription drugs are subject to $500 allowable amount per 30-day retail prescription per month ($1500 allowable amount per 90-day prescription) – The $500 30-day and $1500 90-day allowable amount is subject to member 50% coinsurance.Amounts more than the allowable amount are member responsibility.

Benefit Exclusions:

- Outpatient Drugs, Kidney Dialysis, Chemotherapy, and all other Infusion Therapy is excluded from coverage under Outpatient Benefit Provisions;
- 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
- 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 except if deployed on active duty;
- Services, treatment or loss rendered in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay.

VALUE BRONZE INDIVIDUAL PLAN COST

VALUE BRONZE INDIVIDUAL PLAN with HI EXTENSION INCLUDED

	Individual	Individual + Spouse	Individual + Child(ren)	Individual + Family
Value Bronze Individual Plan	$470.67	$791.15	$746.94	$991.18
HI Extension Benefit	$28.33	$53.85	$52.06	$83.82
Total Monthly Cost	**$499.00**	**$845.00**	**$799.00**	**$1,075.00**

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