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 SB/A MEC

FREEDOM ICON I, II, AND V PLAN

$1,000, $2,000, $5,000 Inpatient Hospital Admission Options with SB/A MEC

SB/A MEC PLAN

ACA Minimum Essential Coverage

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.
- Standard 3 EE Group Enrollment. Special EE requirements for Plans D & E

To learn more about the
SB/A Core Health Plans, Freedom ICON Plans,
and SB/A MEC Plans, visit:
sbaenrollments.com

Facilitated by:
SB/A Cooperative

Administered by:
The Loomis Company

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for SB/A CoOp Members
An ERISA Health Plan Solution

Partners of SBA Core Health and Freedom ICON Plans

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. $24 annual fee.
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.

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 (Patient Responsibility)	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 Responsibility)	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

BENEFIT SUMMARY

Coinsurance on Base Plan (Patient Responsibility)	50% of First $10,000 20% of Next $10,000 0% of Next $25,000
Annual Out-of-Pocket Maximum	$7,000 Individual $14,000 Family
Annual Maximum Benefit Covered	Basic $20,000 Individual Basic $40,000 Family Extra Enhanced $25,000 Individual Extra Enhanced $50,000 Family
Out of Network Coverage	See Provisions and Exclusions in Brochure

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 $25,000 Individiual / $50,000 Family
Annual Maximum Benefit Covered	$25,000 Individual $50,000 Family
Limitations	See Provisions and Exclusions

SB/A Core Health PLAN D

Plans D + E Combined Require 10+ EE

Annual Maximum Benefit
Individual $20,000 / Family $40,000
Extra Enhanced Ind. $130,000 / Fam. $260,000

BENEFIT SUMMARY

Coinsurance on Base Plan (Patient Responsibility)	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
Annual Maximum Benefit Covered	Basic $20,000 Individual Basic $40,000 Family Extra Enhanced $130,000 Individual Extra Enhanced $260,000 Family

EXTRA ENHANCED BENEFITS

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 $130,000 Individual / $260,000 Family
Annual Maximum Benefit Covered	$20,000 Individual + $130,000 Extra Enhanced $40,000 Family + $260,000 Extra Enhanced
Limitations	See Provisions and Exclusions
Out of Network Coverage	See Provisions and Exclusions in Brochure

SB/A Core Health PLAN E

Plans D + E Combined Require 10+ EE

Annual Maximum Benefit
Individual $20,000 / Family $40,000
Extra Enhanced Ind. $230,000 / Fam. $460,000

BENEFIT SUMMARY

Coinsurance on Base Plan (Patient Responsibility)	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
Annual Maximum Benefit Covered	Basic $20,000 Individual Basic $40,000 Family Enhanced $230,000 Individual Enhanced $460,000 Family

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 $230,000 Individual / $460,000 Family
Annual Maximum Benefit Covered	$20,000 Individual + $230,000 Extra Enhanced $40,000 Family + $460,000 Extra Enhanced
Limitations	See Provisions and Exclusions
Out of Network Coverage	See Provisions and Exclusions in Brochure

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 10+ Enrolled in Plans D & E Combined.
- 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 12/12 pre-existing condition provision. Conditions which exist 12 months before the effective date will be excluded from coverage for the first 12 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 and ICON II Plans

Summary Plan of Benefits

	Freedom ICON I Inpatient Hospital $1,000 /Admission Plan	Freedom ICON II 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 Up to $500 if medically necessary Maximum of 2 Admissions per Plan Year Out-of-Network: Not Covered	In-Network Provider Coverage Up to $1,000 if medically necessary Maximum of 2 Admissions per Plan Year Out-of-Network: Not Covered
Inpatient Medical & Surgical Hospitalization; Surgical and Professional Services	In-Network Provider Coverage if Admitted up to $1,000 per Admission if medically Necessary Maximum of 2 Admissions per Plan Year Out-of-Network: Not Covered	In-Network Provider Coverage if Admitted up to $2,000 per Admission if Medically Necessary Maximum of 2 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 [1] (MEC) (Please see Minimum Essential Coverage in full brochure)	Covered at 100%	Covered at 100%

[1] *Employer groups with 50 or more employees will have unlimited annual ACA MEC Benefits versus $1,000 Annual Maximum for Groups less than 50.*

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Freedom ICON V Plan
Summary Plan of Benefits

Freedom ICON V
Inpatient Hospital $5,000 /Admission Plan

Telemedicine - Online and Telephonic Physician Calls 24/7/365	$0 Copay Unlimited Calls
Network	PHCS Specific Services Network
Plan Deductible	None
Member Annual Out-of-Pocket Maximum	None
Primary Care Physician Office Visits General Practice, Pediatric, Internal Medicine	In-Network Provider: $35 Copay Out-of-Network: Not Covered
Specialist Office Visits	In-Network Provider: $75 Copay Out-of-Network: Not Covered
Urgent Care Visits	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
Outpatient Surgery	In-Network Provider Coverage if Admitted Up to $2,000 if medically necessary Maximum of 2 Admissions per Plan Year Out-of-Network: Not Covered
Inpatient Medical & Surgical Hospitalization; Surgical and Professional Services	In-Network Provider Coverage if Admitted up to $5,000 per Admission if medically Necessary Maximum of 2 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
Prescription Medications	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%

[1] *Employer groups with 50 or more employees will have unlimited Annual Maximum versus $1,000 Annual Maximum*

Freedom ICON I, II, and V - Plan Provisions and Exclusions

- ICON I, ICON II, and ICON V 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.
- Freedom ICON I, II, and V are available to employer groups of 3 or more enrolled.

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 MEC Plan (STAND ALONE)

SB/A MEC Plan is included with Freedom ICON Plans & SBA Core Health Plans

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%

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

SB/A CORE HEALTH PLAN A:

✦ Individual $10,000 / Family $20,000

	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

	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
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	=	_____

Plans D & E Require 10+ EE Combined Enrollment

SB/A CORE HEALTH PLAN D:

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

	Estimated Enrollment		Fixed + Claim Funding = Total		Cost Per Selection
Employee Only	_____	X	($245.00 + $305.00) = $550.00	=	_____
Employee + Spouse	_____	X	($300.00 + $579.50) = $879.50	=	_____
Employee + Child(ren)	_____	X	($300.00 + $533.75) = $833.75	=	_____
Employee + Family	_____	X	($300.00 + $765.00) = $1,065.00	=	_____

SB/A CORE HEALTH PLAN E:

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

	Estimated Enrollment		Fixed + Claim Funding = Total		Cost Per Selection
Employee Only	_____	X	($260.00 + $395.00) = $655.00	=	_____
Employee + Spouse	_____	X	($305.00 + $750.50) = $1,055.50	=	_____
Employee + Child(ren)	_____	X	($305.00 + $691.25) = $996.25	=	_____
Employee + Family	_____	X	($305.00 + $990.00) = $1,295.00	=	_____

RATES: Freedom ICON I, II, V Plans

Freedom ICON Plan Require 3 or more enrolled

FREEDOM ICON I PLAN

✦ **Inpatient Hospital $1,000/Admission Plan**

	Estimated Enrollment		Fixed + Claim Funding = Total		Cost Per Selection
Employee Only	_____	X	($148.00 + $72.00) = $220.00	=	_____
Employee + Spouse	_____	X	($168.00 + $151.20) = $319.20	=	_____
Employee + Child(ren)	_____	X	($168.00 + $136.80) = $304.80	=	_____
Employee + Family	_____	X	($188.00 + $180.00) = $368.00	=	_____

FREEDOM ICON II PLAN

✦ **Inpatient Hospital $2,000/Admission Plan**

	Estimated Enrollment		Fixed + Claim Funding = Total		Cost Per Selection
Employee Only	_____	X	($148.00 + $85.00) = $233.00	=	_____
Employee + Spouse	_____	X	($168.00 + $178.50) = $346.50	=	_____
Employee + Child(ren)	_____	X	($168.00 + $161.50) = $329.50	=	_____
Employee + Family	_____	X	($188.00 + $213.00) = $401.00	=	_____

FREEDOM ICON V PLAN

✦ **Inpatient Hospital $5,000/Admission Plan**

	Estimated Enrollment		Fixed + Claim Funding = Total		Cost Per Selection
Employee Only	_____	X	($158.00 + $101.00) = $259.00	=	_____
Employee + Spouse	_____	X	($178.00 + $213.00) = $391.00	=	_____
Employee + Child(ren)	_____	X	($178.00 + $192.00) = $370.00	=	_____
Employee + Family	_____	X	($198.00 + $252.00) = $450.00	=	_____

RATES: SB/A MEC Plans

SB/A MEC Plan is included in SBA Core Health and Freedom ICON Plans

SB/A MEC PLAN

	Estimated Enrollment		Fixed + Claim Funding = Total		Cost Per Selection
Employee Only	_____	X	($79.50 + $20.00) = $99.50	=	_____
Employee + Spouse	_____	X	($94.50 + $45.00) = $139.50	=	_____
Employee + Child(ren)	_____	X	($94.50 + $35.00) = $129.50	=	_____
Employee + Family	_____	X	($104.50 + $60.00) = $164.50	=	_____

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," SB/A Core Health and Freedom ICON Plans (as attached), and the SB/A MEC Plans 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: _____