

AN AFFORDABLE ERISA COMPLIANT EMPLOYER SPONSORED HEALTH PLAN

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





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		
ACA Preventive & Wellness	Covered 100%		
Telemedicine	\$0 Co-Pay		
PROFESSIONAL SE	RVICES 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 T	HERAPY 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 SERV	VICES 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) procedure per plan year		
Inpatient 12/12 Pre-ex Applies	\$1,500 Co-Pay, then 100% Limited to two (2) procuedures per plan year		
HOSPITAL	BENEFITS		
Emergency Room 12/12 Pre-ex Applies	\$2,500 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%		



continued Summary Plan of Benefits			
MENTAL HEALTH & SUB	STANCE 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 SERVIO	CES & 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 Be	nefit 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	

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 None None Annual Mustimum of Covered Maximum None 100% of ACA mandated prescription, i.e. Birth Control Annual Maximum of Covered Services No Annual Maximum of Covered Services No Annual Maximum of Covered Services No Annual Maximum Routine Well Care. Are Provided under the Attoriable Care Act (ACA) Adult Preventative Services. Screenings and Services as Provided in the Attoriable Care Act MEC 1. Adult Annual Maximum Routine Well Care. Are Provided under the Attoriable Care Act (ACA) Adult Preventative Services. Screenings and Services as Provided in the Attoriable Care Act MEC 1. Adult Preventative Services. Screenings and Services as Provided in the Attoriable Care Act MEC 1. Adult Preventative Services. Screenings and Services as Provided in the Attoriable Care Act MEC 1. Adult Preventative Services. Screenings and Services as Provided in the Attoriable Care Act MEC 1. Adult Preventative Services. Screenings and Services as Provided in the Attoriable Care Act MEC 1. Advanced at 100% Covered at 100% Covered at 100% Screening Services. Screenings and Services as Screenings and Services as Screenings and Services as Screenings and Services. Screenings and Services are Screenings and Services. Screenings and Services are Screenings. Screenings and Services are Screenings and Services as Screenings and Services are Screenings. Screenings and Services are Screenings and Services. Screenings and Services are Screenings. Screenings and Services are Screenings and Services. Screenings and Services are Screenings and Services. Screenings and Services Screenings and Services. Screenings and Services Screenings and Services. Screenings and Service					
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12. Hearing 25. Tuberculin Testing Covered at 100%	12. Hearing	25. Tuberculin Testing	Covered at 100%		
13. Height, Weight and Body Mass Index 26. Vision 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:
 - o 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
 - o 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



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