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

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

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%

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	=	_____

Walmart Business

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	=	_____