SBMA
BENEFIT GUIDE

ENROLL NOW!

You are eligible for benefits under your employer's open enrollment effective January 1st or the first day of the month following your date of hire.

GET YOUR ID CARD IN DAYS

COVERAGE YOU NEED AT A PRICE YOU CAN AFFORD

MEDICAL COVERAGE

WellCare: Covers all preventive services 100% and includes telehealth and prescription discounts.

OptimaCare: Covers all preventive services 100%, primary care visits at a $15 copay, urgent care at a $50 copay and discounts on additional services such as specialist visits, labs and x-rays. This plan also includes virtual health and prescription drug benefits.

EliteCare: Covers all preventive services 100% and office visits, urgent care, labs and x-rays offered at various copays. This plan also includes virtual health and prescription drug benefits.

ANCILLARY COVERAGE

Delta Preventive Dental: Coverage includes diagnostic and preventive services covered 100%.

Delta Dental 1000: Coverage includes diagnostic and preventive services at 100%, basic and restorative services at 80% and major services at 50%. Out-of-network services are offered at 80%/50%/50% respectively. There is no coverage for orthodontia.

VSP Vision: Coverage includes comprehensive eye exams at a $10 copay, frame allowances, lenses at a $25 copay or contact lenses at an allowance or covered in full after copay depending on medical necessity.

ENROLLMENT APPLICATION

SBMA

EMPLOYEE INFORMATION

Name_____ Social Security Number_____

Employer_____ Hire Date_____

Birth Date_____ Sex ❑ Male ❑ Female

Address_____ Phone Number_____

City/State/Zip_____ Email_____

DEPENDENT INFORMATION

Name_____ Name_____

Social Security Number_____ Social Security Number_____

Birth Date_____ Birth Date_____

❑ Male ❑ Female ❑ Spouse ❑ Child ❑ Male ❑ Female ❑ Spouse ❑ Child

Name_____ Name_____

Social Security Number_____ Social Security Number_____

Birth Date_____ Birth Date_____

❑ Male ❑ Female ❑ Spouse ❑ Child ❑ Male ❑ Female ❑ Spouse ❑ Child

COVERAGE ELECTIONS

Medical Election (choose 1)				
Monthly Rates	Employee Only	Employee/Spouse	Employee/Child(ren)	Family
WellCare	❑ $60.00	❑ $105.00	❑ $105.00	❑ $165.00
OptimaCare	❑ $120.00	❑ $225.00	❑ $225.00	❑ $330.00
EliteCare	❑ $140.00	❑ $265.00	❑ $265.00	❑ $385.00

Ancillary Elections (choose only 1 dental plan)				
Monthly Rates	Employee Only	Employee/Spouse	Employee/Child(ren)	Family
Delta Preventive Dental	❑ $19.80	❑ $37.53	❑ $35.28	❑ $58.86
Delta Dental 1000	❑ $38.97	❑ $78.24	❑ $73.50	❑ $118.53
VSP Vision	❑ $9.95	❑ $19.90	❑ $20.90	❑ $34.85

❑ waive coverage

EMPLOYEE ACKNOWLEDGMENT

I hereby acknowledge the offer of health insurance coverage, providing Minimum Essential Coverage (MEC), for myself, and my eligible dependents. If electing coverage, I authorize my employer to make salary reductions for my portion of the insurance premiums. I understand that I may not make changes to my coverage elections until my employer's next open enrollment period or due to a qualifying event.

Signature_____ Date_____

WELLCARE

SBMA

Medical Benefits	WellCare
Preventive / Wellness	Covered 100%
Prescription Discount Program by PureRx	Included
Virtual Health Benefits	**freshbenies**
24/7/365 Telehealth	Included
benieWALLET	Included

[1]The WellCare plan excludes out-of-network services and covers only the services listed above and on the Preventive Care Benefits page.

[2]The PureRx prescription discount program offers discounts up to 80% on most FDA-approved prescription medications.

[3]freshbenies members have access to physicians via phone or video, with prescriptions sent directly to the member's pharmacy, when medically necessary.

Locating a participating provider in the PHCS network all begins with the specific network logo on the front of your medical ID card. Please locate the PHCS logo on your card and follow the instructions below.

PHCS Preventive Services Only

By phone: call **1.800.371.2507**
Online: visit **www.multiplan.com/sbmapreventiveservices** and follow the steps below

1. Read the acknowledgment on the bottom of the screen and click OK
2. Enter a provider name, specialty, or facility type in the search box or choose one from the drop down
3. Enter your city/county and click on the magnifying glass icon to search
4. Read the statement at the bottom of the screen and click OK to view the results

freshbenies® A FRESH APPROACH TO BENEFITS

freshbenies gives convenient access to virtual doctor visits and more!

Telehealth: Call anytime, visit with a US-based, licensed doctor and get a prescription written, if medically necessary – at NO COST.
benieWALLET: Store and access all your health-related cards in one, easy place so they're ready anytime, anywhere.
To access your services, log in at **freshbenies.com**, download the freshbenies app or call **1.855.373.7450**

PureRx

Present your medical card with your prescription to any of our 60,000+ retail pharmacies to fill your prescription. Additional information will be provided on your medical ID card.

OPTIMACARE

SBMA

Medical Benefits	OptimaCare
Preventive / Wellness	Covered 100%
Primary Care Visits	$15 Copay
Specialist Visits	Network Discount
Urgent Care	$50 Copay
Laboratory Services / X-Rays	Network Discount
Prescription Drugs	Tier 1: $15 Copay, Tier 2: $30 Copay Tier 3: $50 Copay, Tier 4: $75 Copay
Virtual Health Benefits	**freshbenies**
24/7/365 Telehealth	Included
Behavioral Health	$50 fee (first 3 visits then $85 fee after)
benieWALLET	Included

[1]The OptimaCare plan excludes out-of-network services and covers only the services listed above and on the Preventive Care Benefits page.
[2]Claims are repriced through the MultiPlan PHCS network. For services subject to the network discount, members will be responsible for paying the remaining balance after the network discount is applied. Discounts vary based on provider contracts.
[3]Prescription drug benefits are subject to the formulary drug list. To review the formulary please visit www.sbmabenefits.com/purerx-standard. Copay amounts listed are based on a unit quantity of 30 for a 30-day supply. Pricing may vary based on quantity and supply.
[4]Virtual Health Benefits are offered through freshbenies. Members have access to 1) physician visits via phone or video, with prescriptions sent directly to the member's pharmacy, when medically necessary and 2) therapist consultations via video at $50 each (first 3 visits - $85 after).

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PHCS Specific Services

By phone: call **1.800.457.1309**
Online: visit **www.multiplan.com/sbmaspecificservices** and follow the steps below

1. Read the acknowledgment on the bottom of the screen and click OK
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ELITECARE

SBMA

Medical Benefits	EliteCare
Preventive / Wellness	Covered 100%
Primary Care / Specialist Visits	$15 Copay
Urgent Care	$50 Copay
Laboratory Services / X-Rays	$50 Copay
Prescription Drugs	Tier 1: $15 Copay, Tier 2: $30 Copay Tier 3: $50 Copay, Tier 4: $75 Copay
Virtual Health Benefits	**freshbenies**
24/7/365 Telehealth	Included
Behavioral Health	$50 fee (first 3 visits then $85 fee after)
benieWALLET	Included

[1]The EliteCare plan excludes out-of-network services and covers only the services listed above and on the Preventive Care Benefits page.
[2]Prescription drug benefits are subject to the formulary drug list. To review the formulary please visit www.sbmabenefits.com/purerx-standard. Copay amounts listed are based on a unit quantity of 30 for a 30-day supply. Pricing may vary based on quantity and supply.
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PREVENTIVE CARE BENEFITS

SBMA

Preventive benefits for adults

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk
- Blood Pressure screening
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults 45 to 75
- Depression screening
- Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese
- Diet counseling for adults at higher risk for chronic disease
- Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over living in a community setting
- Hepatitis B screening for people at high risk
- Hepatitis C screening for adults age 18 to 79 years
- HIV screening for everyone age 15 to 65, and other ages at increased risk
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use
- Immunizations for adults — doses, recommended ages, and recommended populations vary: Chickenpox (Varicella), Diphtheria, Flu (influenza), Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Measles, Meningococcal, Mumps, Whooping Cough (Pertussis), Pneumococcal, Rubella, Shingles, and Tetanus
- Lung cancer screening for adults 50 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
- Obesity screening and counseling
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Statin preventive medication for adults 40 to 75 years at high risk
- Syphilis screening for all adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Tuberculosis screening for certain adults with symptoms at high risk

Preventive benefits for women

- Bone density screening for all women over age 65 or women age 64 and younger that have gone through menopause
- Breast cancer genetic test counseling (BRCA) for women at higher risk (counseling only; not testing)
- Breast cancer mammography screenings: every 2 years for women over 50 and older or as recommended by a provider for women 40 to 49 or women at higher risk for breast cancer
- Breast Cancer chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
- Birth control: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."
- Cervical Cancer screening: Pap test (also called a Pap smear) for women 21 to 65
- Chlamydia infection screening for younger women and other women at higher risk
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before
- Domestic and interpersonal violence screening and counseling for all women

Preventive benefits for women (continued)

- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Maternal depression screening for mothers at well-baby visits
- Preeclampsia prevention and screening for pregnant women with high blood pressure
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Sexually Transmitted Infections counseling for sexually active women
- Expanded tobacco intervention and counseling for all pregnant tobacco users
- Urinary incontinence screening for women yearly
- Urinary tract or other infection screening
- Well-woman visits to get recommended services for women

Preventive benefits for children

- Alcohol, tobacco, and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Bilirubin concentration screening for newborns
- Blood Pressure screening for children: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Blood screening for newborns
- Depression screening for adolescents beginning at age 12
- Developmental screening for children under age 3
- Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years for children at higher risk of lipid disorders
- Fluoride supplements for children without fluoride in their water source
- Fluoride varnish for all infants and children as soon as teeth are present
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns; and regular screenings for children and adolescents as recommended by their provider
- Height, weight and body mass index (BMI) measurements taken regularly for all children
- Hematocrit or hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns
- Hepatitis B screening for adolescents at higher risk
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use
- Immunizations for children from birth to age 18 — doses, recommended ages, and recommended populations vary: Chickenpox (Varicella); Diphtheria, Tetanus, and Pertussis (DTaP); Haemophilus influenza type B; Hepatitis A; Hepatitis B; Human Papillomavirus (HPV); Inactivated Poliovirus; Influenza (flu shot); Measles; Meningococcal; Mumps; Pneumococcal, Rubella; and Rotavirus
- Lead screening for children at risk of exposure
- Obesity screening and counseling
- Oral health risk assessment for young children from 6 months to 6 years
- Phenylketonuria (PKU) screening for newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Vision screening for all children
- Well-baby and well-child visits

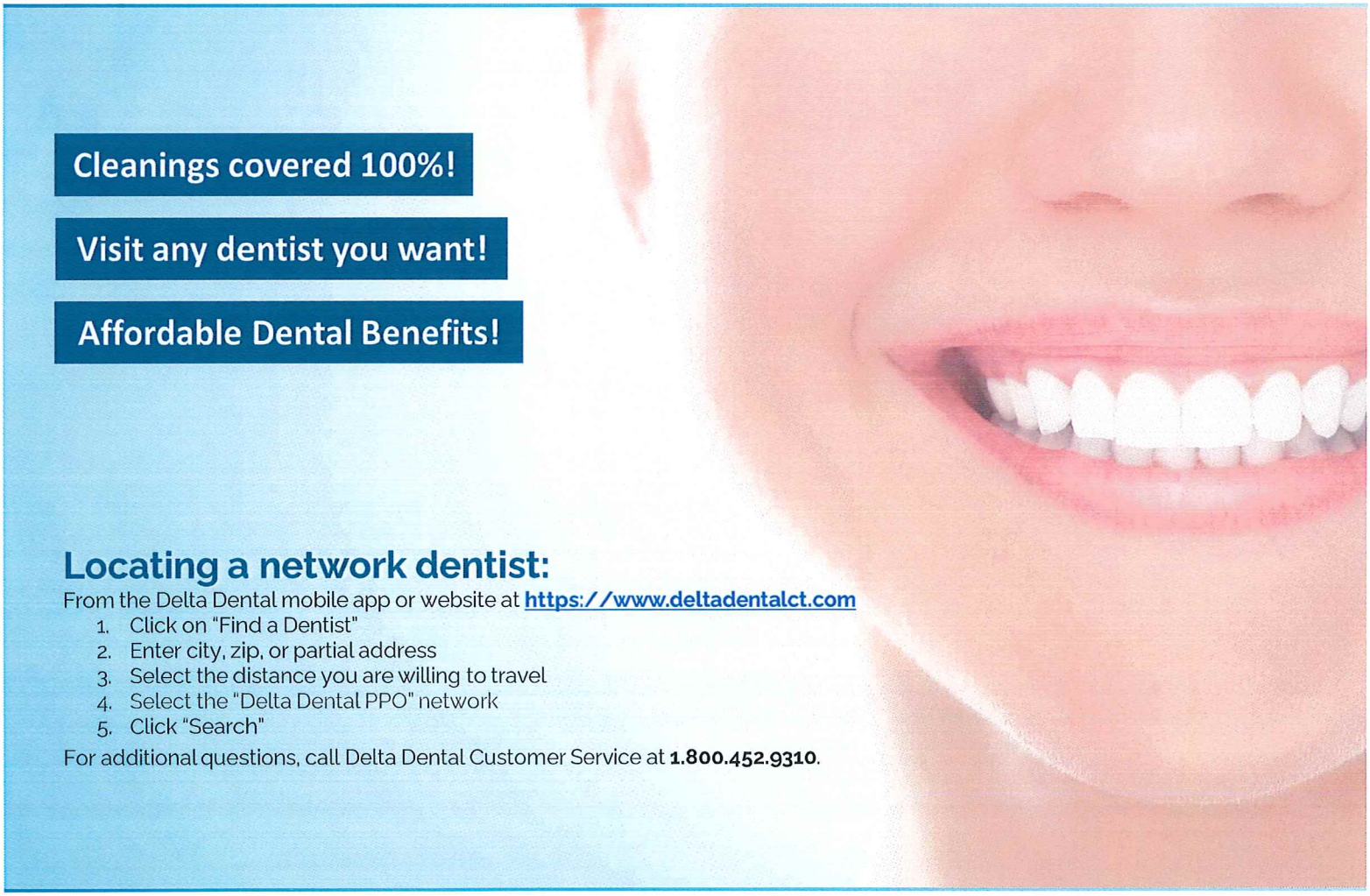
DELTA PREVENTIVE DENTAL

DELTA DENTAL®

Dental Benefits	In Network	Out of Network
Annual Deductible	$0	$0
Annual Maximum Benefit	$1,000 per insured person	$1,000 per insured person
Diagnostic & Preventive		
Exams / Cleanings (twice per year)	Covered 100%	Covered 100%
Bitewing X-Rays (once per year)	Covered 100%	Covered 100%
Full mouth X-Rays (once every 5 years)	Covered 100%	Covered 100%
Fluoride Treatment[1] (twice per year)	Covered 100%	Covered 100%
Space Maintainers[2] (once per space)	Covered 100%	Covered 100%

[1]Fluoride treatments are for eligible children to age 19 in combination with cleanings and subject to the same annual limitations.
[2]Space maintainers are once per space for missing posterior primary teeth for children under age 14.

This form is a benefit highlight representing a brief description of the coverage available. The controlling provisions will be in the group policy issued by Delta Dental.



Locating a network dentist:

From the Delta Dental mobile app or website at https://www.deltadentalct.com

1. Click on "Find a Dentist"
2. Enter city, zip, or partial address
3. Select the distance you are willing to travel
4. Select the "Delta Dental PPO" network
5. Click "Search"

For additional questions, call Delta Dental Customer Service at **1.800.452.9310**.

DELTA DENTAL 1000

DELTA DENTAL®

Dental Benefits	In Network	Out of Network
Annual Deductible	$50 individual / $150 family	$100 individual / $300 family
Annual Maximum Benefit	$1,000 per insured person	$1,000 per insured person
Diagnostic & Preventive		
Exams / Cleanings (twice per year) Bitewing X-Rays (once per year) Full mouth X-Rays (once every 5 years)	Covered 100% (deductible waived)	Covered 80% (deductible waived)
Basic Services		
Fillings (once per tooth in 365 days) Extractions Root Canal (once per tooth per lifetime)	Covered 80% after deductible is met	Covered 50% after deductible is met
Major Services		
Crowns (once per tooth every 5 years) Dentures (once every 5 years) Bridges (once every 5 years) Implants (once every 5 years)	Covered 50% after deductible is met	Covered 50% after deductible is met
Orthodontic Services	Not Covered	Not Covered

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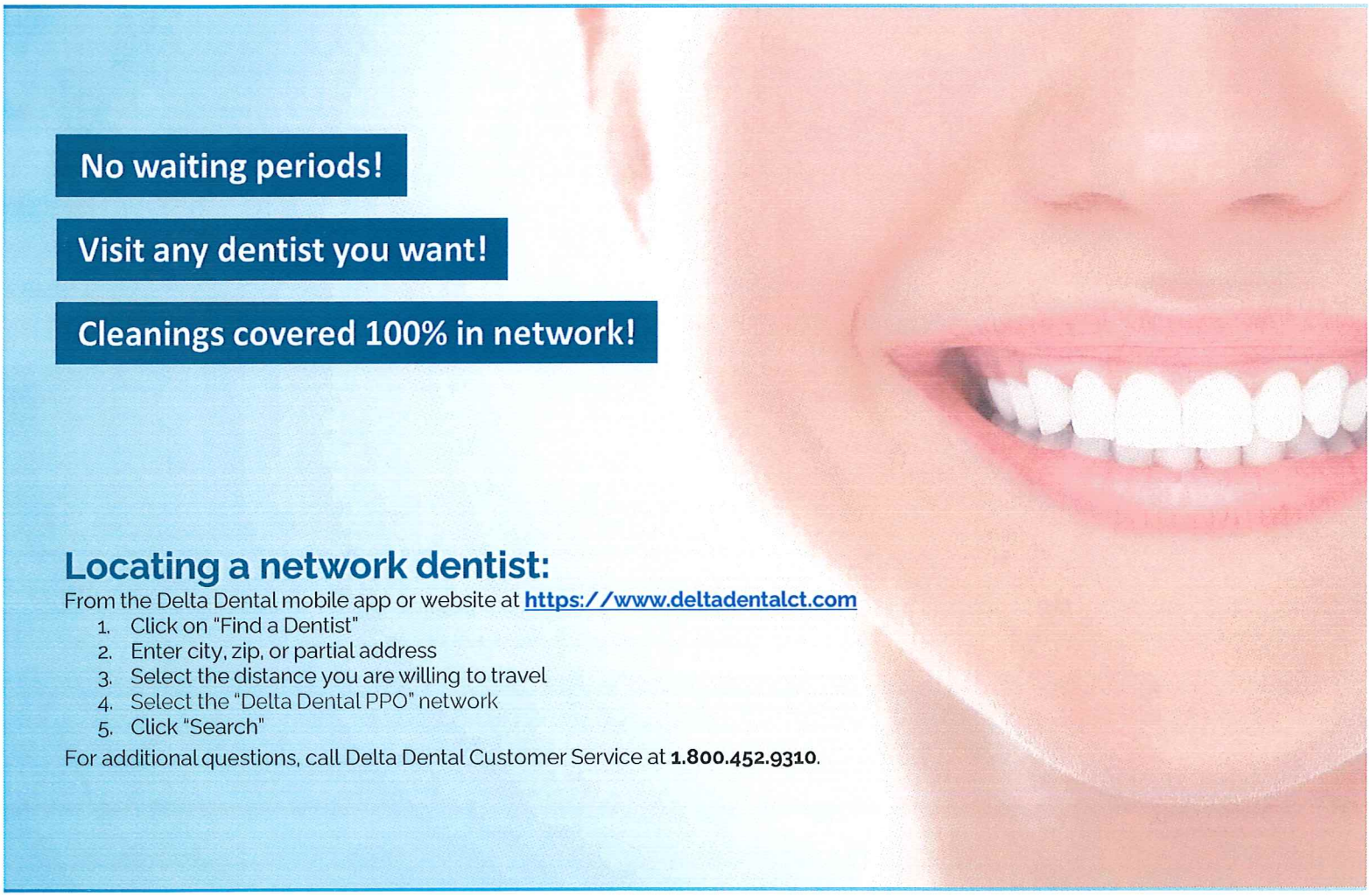

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VSP Vision

Vision Benefits	In Network	Out of Network	Frequency
Comprehensive eye exam	$10 copay	$45 allowance	Once every 12 months
Eyeglass Frames			
One pair of eyeglass frames	$130 allowance ($70 allowance at Walmart / Costco)	$70 allowance	Once every 24 months
Eyeglass Lenses (instead of contacts)			
Single	$25 copay	$30 allowance	Once every 12 months
Bifocal	$25 copay	$50 allowance	Once every 12 months
Trifocal	$25 copay	$65 allowance	Once every 12 months
Contact Lenses (instead of glasses)			
Contact Fitting & Evaluation	Maximum $60 copay	Applied to contact lens allowance	Once every 12 months
Elective disposable	$130 allowance	$105 allowance	Once every 12 months
Non-elective (medically necessary)	Covered 100% after copay	$210 allowance	Once every 12 months

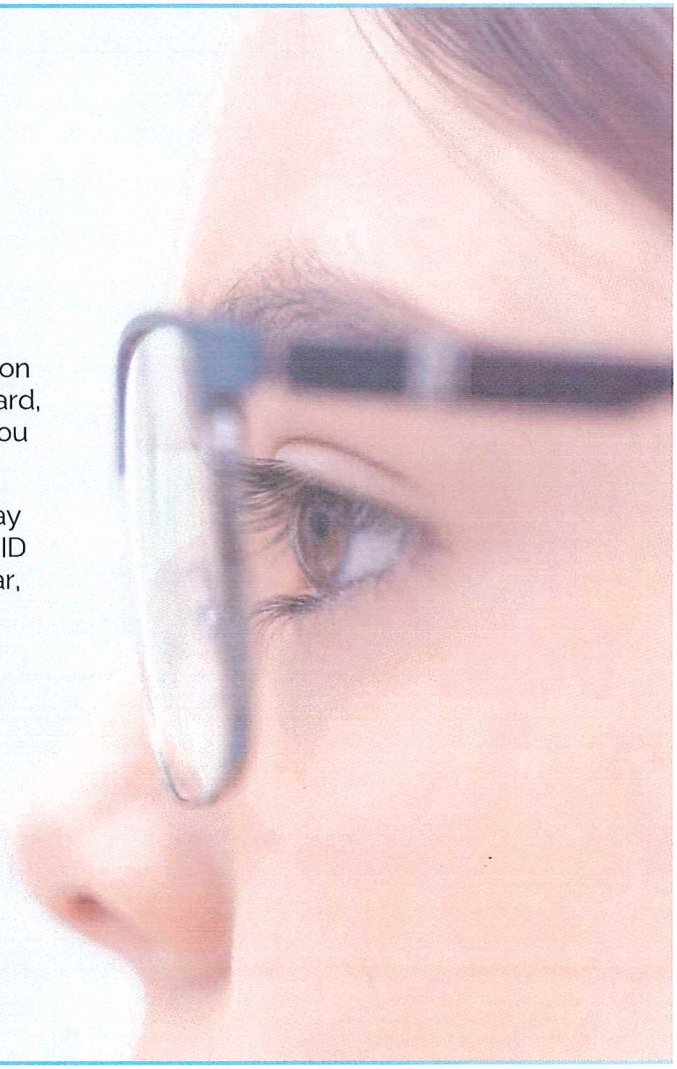
This overview contains a general description of your vision care program for your use as a convenient reference. Complete details of your program appear in the group contract between your plan sponsor and Delta Dental of Connecticut, Inc., which governs the benefits and operation of your program. Please contact your SBMA representative for additional information.

USING YOUR COVERAGE

As a VSP member, you have access to **vsp.com** and the VSP Vision Care App. Both offer easy navigation and a personalized dashboard, so you can get the benefit information you need, exactly when you need it.

Download the VSP Vision Care App from the Apple or Google Play stores and get instant access to your benefit coverage, member ID card, exclusive member extras like savings on additional eyewear, laser vision correction, and more.

For additional information, you may also call **1.800.877.7195**.



EXTRACARE HIGH

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$49.00	$98.00	$98.00	$147.00

Hospital Benefits	Benefit Amount / Limit
Hospital Admission – requires claim separation of 30 days	$2,500 / up to 3 admissions per year
Hospital Confinement	$200 per day / up to 30 days per year
Inpatient Surgical Benefits	**Benefit Amount / Limit**
Inpatient Surgery	$1,000 / 1 time per year
Inpatient Anesthesia	$300
Outpatient Surgical Benefits – limited to 1 combined per year	**Benefit Amount / Limit**
Outpatient Surgery – Hospital or Ambulatory Surgical Center	$1,000 / 1 time per year
Outpatient Surgery – Physician Office	$300 / 1 time per year
Outpatient Anesthesia	35% of outpatient surgery benefit
Initial Care & Emergency Transportation	**Benefit Amount / Limit**
Emergency Room	$100 / up to 2 times per year
Ground Ambulance	$200 / up to 2 times per year
Air Ambulance	$1,000 / 1 time per year