

## ENROLL NOW!

**You are eligible for benefits under your employer's open enrollment effective October 1<sup>st</sup> or the first day of the month following 60 days from your date of hire.**



**ACCESS YOUR VIRTUAL ID  
CARD IN HEALTHWALLET**



**COVERAGE YOU NEED AT  
A PRICE YOU CAN AFFORD**

## MEDICAL COVERAGE

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

**ValueCare:** 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. Visit limitations exist; refer to plan summary for additional details.

**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

**ExtraCare:** This supplemental coverage provides specific benefit amounts, in the form of direct payments to members, for additional medical services. Refer to summary page for additional information.

**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



## 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

### Medical Election (choose 1)

| Biweekly Rates   | Employee Only                    | Employee/Spouse                   | Employee/Child(ren)               | Family                            |
|------------------|----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| <b>WellCare</b>  | <input type="checkbox"/> \$20.77 | <input type="checkbox"/> \$41.54  | <input type="checkbox"/> \$41.54  | <input type="checkbox"/> \$62.31  |
| <b>ValueCare</b> | <input type="checkbox"/> \$39.23 | <input type="checkbox"/> \$78.46  | <input type="checkbox"/> \$78.46  | <input type="checkbox"/> \$117.69 |
| <b>EliteCare</b> | <input type="checkbox"/> \$71.08 | <input type="checkbox"/> \$142.15 | <input type="checkbox"/> \$142.15 | <input type="checkbox"/> \$213.23 |

### Ancillary Elections (choose only 1 dental plan)

| Biweekly Rates                 | Employee Only                    | Employee/Spouse                  | Employee/Child(ren)              | Family                           |
|--------------------------------|----------------------------------|----------------------------------|----------------------------------|----------------------------------|
| <b>ExtraCare</b>               | <input type="checkbox"/> \$18.00 | <input type="checkbox"/> \$36.00 | <input type="checkbox"/> \$36.00 | <input type="checkbox"/> \$54.00 |
| <b>Delta Preventive Dental</b> | <input type="checkbox"/> \$10.32 | <input type="checkbox"/> \$19.57 | <input type="checkbox"/> \$18.40 | <input type="checkbox"/> \$30.70 |
| <b>Delta Dental 1000</b>       | <input type="checkbox"/> \$20.33 | <input type="checkbox"/> \$40.80 | <input type="checkbox"/> \$38.34 | <input type="checkbox"/> \$61.82 |
| <b>VSP Vision</b>              | <input type="checkbox"/> \$4.59  | <input type="checkbox"/> \$9.18  | <input type="checkbox"/> \$9.65  | <input type="checkbox"/> \$16.08 |

☐ 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 \_\_\_\_\_

| Medical Benefits                        | WellCare      |
|-----------------------------------------|---------------|
| Preventive / Wellness                   | Covered 100%  |
| Prescription Discount Program by PureRx | Included      |
| Virtual Health Benefits                 | Recuro Health |
| 24/7 Virtual Urgent Care                | \$0 Copay     |
| Virtual Behavioral Health               | \$0 Copay     |

<sup>1</sup>The WellCare plan excludes out-of-network services and covers only the services listed above and on the Preventive Care Benefits page.

<sup>2</sup>The PureRx prescription discount program offers discounts up to 80% on most FDA-approved prescription medications.

<sup>3</sup>Recuro Health's Virtual Care program includes unlimited 24/7 access to virtual urgent care with board-certified doctors via phone, video or messaging and connects members with a Psychiatrist or Licensed Counselor through secure and private online video or phone sessions at no cost.



Health**Wallet**

**The HealthWallet mobile app puts your coverage in the palm of your hands**

- Scan the QR code to the right, or search "The HealthWallet" in your app store
- Download the HealthWallet mobile app
- Login in with your social security number and date of birth
- Access your ID card(s), benefit information, and ancillary vender services



SCAN HERE

**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.**



**By phone:** call **1.800.371.2507**

**Online:** visit [www.multiplan.com/sbmapreventiveservices](http://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



**Recuro Health's Virtual Urgent Care and Virtual Behavioral Health** provide members with:

- 24/7 access to board-certified doctors for treatment of urgent medical concerns
- No-cost virtual access to a Psychiatrist or Licensed Counselor whenever and wherever they need it

**Access care via the HealthWallet mobile app (scan the QR code above) or call 1-855-6RECURO**



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.

| Medical Benefits             | ValueCare                                                                        |
|------------------------------|----------------------------------------------------------------------------------|
| Preventive / Wellness        | Covered 100%                                                                     |
| Primary Care Visits          | \$15 copay (3 per year), then subject to network discount                        |
| Specialist Visits            | Network Discount                                                                 |
| Urgent Care                  | \$50 copay (3 per year), then subject to network discount                        |
| Laboratory Services / X-Rays | Network Discount                                                                 |
| Prescription Drugs           | Tier 1: \$15 Copay, Tier 2: \$30 Copay<br>Tier 3: \$50 Copay, Tier 4: \$75 Copay |
| Virtual Health Benefits      | Recurro Health                                                                   |
| 24/7 Virtual Urgent Care     | \$0 Copay                                                                        |
| Virtual Behavioral Health    | \$0 Copay                                                                        |

<sup>1</sup>The ValueCare plan excludes out-of-network services and covers only the services listed above and on the Preventive Care Benefits page.

<sup>2</sup>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.

<sup>3</sup>Prescription drug benefits are subject to the formulary drug list. To review the formulary please visit [www.sbmabenefits.com/purerx-standard](http://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.

<sup>4</sup>Recurro Health's Virtual Care program includes unlimited 24/7 access to virtual urgent care with board-certified doctors via phone, video or messaging and connects members with a Psychiatrist or Licensed Counselor through secure and private online video or phone sessions at no cost.



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By phone: call **1.800.457.1309**

Online: visit [www.multiplan.com/sbmaspecificservices](http://www.multiplan.com/sbmaspecificservices) and follow the steps below

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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.

| 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<br>Tier 3: \$50 Copay, Tier 4: \$75 Copay |
| Virtual Health Benefits          | Recuro Health                                                                    |
| 24/7 Virtual Urgent Care         | \$0 Copay                                                                        |
| Virtual Behavioral Health        | \$0 Copay                                                                        |

<sup>1</sup>The EliteCare plan excludes out-of-network services and covers only the services listed above and on the Preventive Care Benefits page.

<sup>2</sup>Prescription drug benefits are subject to the formulary drug list. To review the formulary please visit [www.sbmaenefits.com/purerx-standard](http://www.sbmaenefits.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 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

| Hospital Benefits                                               | Benefit Amount / Limit                |
|-----------------------------------------------------------------|---------------------------------------|
| Hospital / ICU Admission – requires claim separation of 30 days | \$2,000 / up to 3 admissions per year |
| Hospital / ICU Confinement                                      | \$50 per day / up to 30 days per year |
| Inpatient Surgical Benefits                                     | Benefit Amount / Limit                |
| Inpatient Surgery                                               | \$1,000 / 1 time per year             |
| Inpatient Anesthesia                                            | 30% of surgery benefit                |
| Outpatient Surgical Benefits – limited to 1 combined per year   | Benefit Amount / Limit                |
| Outpatient Surgery – Hospital or Ambulatory Surgical Center     | \$250 / 1 time per year               |
| Outpatient Surgery – Physician Office                           | \$75 / 1 time per year                |
| Outpatient Anesthesia                                           | 20% of surgery benefit                |

<sup>1</sup>This form is a benefit highlight representing a brief description of the coverage available. The controlling provisions are governed by a general policy issued by United of Omaha Life Insurance Company, a Mutual of Omaha Company.

<sup>2</sup>Payments for eligible approved covered services will be issued as reimbursements by submission of a claim form. To request a claim form please email SBMA at [updates@sbmamec.com](mailto:updates@sbmamec.com).



| 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 <sup>1</sup> (twice per year) | Covered 100%               | Covered 100%               |
| Space Maintainers <sup>2</sup> (once per space)  | Covered 100%               | Covered 100%               |

<sup>1</sup>Fluoride treatments are for eligible children to age 19 in combination with cleanings and subject to the same annual limitations.

<sup>2</sup>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.

**Cleanings covered 100%!**

**Visit any dentist you want!**

**Affordable Dental Benefits!**

## Locating a network dentist:

From the Delta Dental mobile app or website at [deltadentalct.com](https://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**.

| 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          |
| <b>Diagnostic &amp; Preventive</b>                                                                                                      |                                     |                                     |
| Exams / Cleanings (twice per year)<br>Bitewing X-Rays (once per year)<br>Full mouth X-Rays (once every 5 years)                         | Covered 100%<br>(deductible waived) | Covered 80%<br>(deductible waived)  |
| <b>Basic Services</b>                                                                                                                   |                                     |                                     |
| Fillings (once per tooth in 365 days)<br>Extractions<br>Root Canal (once per tooth per lifetime)                                        | Covered 80% after deductible is met | Covered 50% after deductible is met |
| <b>Major Services</b>                                                                                                                   |                                     |                                     |
| Crowns (once per tooth every 5 years)<br>Dentures (once every 5 years)<br>Bridges (once every 5 years)<br>Implants (once every 5 years) | Covered 50% after deductible is met | Covered 50% after deductible is met |
| Orthodontic Services                                                                                                                    | Not Covered                         | Not Covered                         |

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.

**No waiting periods!**

**Visit any dentist you want!**

**Cleanings covered 100% in network!**

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From the Delta Dental mobile app or website at [deltadentalct.com](https://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**.

| Vision Benefits                              | In Network                                              | Out of Network                    | Frequency            |
|----------------------------------------------|---------------------------------------------------------|-----------------------------------|----------------------|
| Comprehensive eye exam                       | \$10 copay                                              | \$45 allowance                    | Once every 12 months |
| <b>Eyeglass Frames</b>                       |                                                         |                                   |                      |
| One pair of eyeglass frames                  | \$130 allowance<br>(\$70 allowance at Walmart / Costco) | \$70 allowance                    | Once every 24 months |
| <b>Eyeglass Lenses (instead of contacts)</b> |                                                         |                                   |                      |
| 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 |
| <b>Contact Lenses (instead of glasses)</b>   |                                                         |                                   |                      |
| 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](https://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**.

