EVOLVED BENEFITS

Affordable Health Solutions

Group Name:

Effective Date:

Presenting Broker:

evolvedbenefits.com
Powered by SBMA

EVOLVED
BENEFITS

Minimum Essential Coverage

evolvedbenefits.com

MEC Plans

Low Cost • Great Flexibility • ACA Penalty A Protection

These plans are the perfect strategy for employers focused on cost containment, usable daily benefits and compliance with ACA mandates.

The plans outlined below are compliant with Employer Penalty “A” as outlined by ACA. They also satisfy the individual mandate penalty in applicable states.

Monthly Rates	WellCare	KeyCare	FlexCare	VitalCare
Employee only	$45	$75	$109	$139
Employee + Spouse	$90	$150	$218	$278
Employee + Child(ren)	$90	$150	$218	$278
Employee + Family	$135	$225	$327	$417
Medical Benefits	**WellCare**	**KeyCare**	**FlexCare**	**VitalCare**
Preventive / Wellness	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Primary Care Visits	-	$25 copay	$25 copay	$25 copay
Specialist Visits	-	-	Network discount	$25 copay
Urgent Care	-	-	$50 copay	$50 copay
Labs	-	-	Network Discount	$50 copay
X-Rays	-	-	Network Discount	$50 copay
Prescription Drug Benefits	**WellCare**	**KeyCare**	**FlexCare**	**VitalCare**
Copay By Drug Tier	Discount Only	$15 / $30 / $50 / $75	$15 / $30 / $50 / $75	$15 / $30 / $50 / $75
Virtual Health Program	**WellCare**	**KeyCare**	**FlexCare**	**VitalCare**
24/7 Virtual Urgent Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Virtual Behavioral Health	-	$0 Copay	$0 Copay	$0 Copay

1. Costs include plan documents, MultiPlan network, ID cards, HealthWallet mobile application, enrollment guides, COBRA administration and claims management.
2. Plans exclude out-of-network services and cover only the services listed above and on the Preventive Care Benefits page.
3. Claims are repriced through the MultiPlan PHCS network. For services covered at a network discount, members will be responsible for paying the remaining balance after the network discount is applied. Discounts vary based on provider contracts.
4. Prescription Drug Benefits are subject to the formulary. Copay amounts listed are based on a unit quantity of 30 for a 30-day supply. Pricing may vary based on quantity and supply.
5. Virtual Health Benefits are offered through Recuro Health. Members have unlimited 24/7 access to virtual urgent care with board-certified doctors via phone, video or messaging. It also connects members with a Therapist or Licensed Counselor through secure and private online video or phone sessions at a $0 copay. Psychiatric services are available at an additional cost. The WellCare plan does not include behavioral health services.
6. Minimum participation requirement of 10 lives enrolled. $750 annual fee paid at time of implementation.

Preventive Care Benefits

Preventive Benefits for Adults

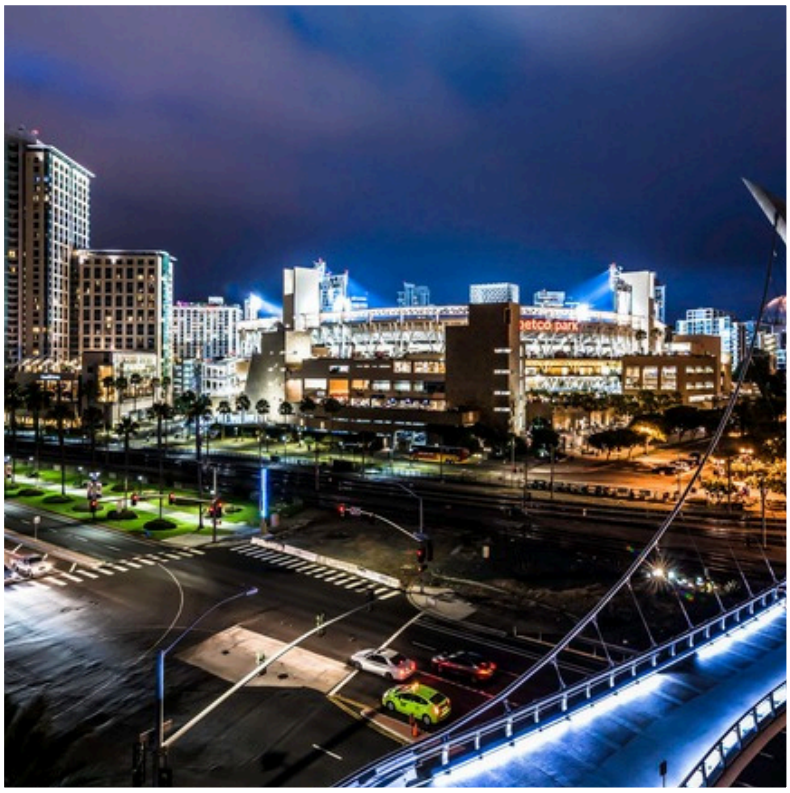
Abdominal aortic aneurysm, one-time screening for men of specified ages who have ever smoked
Alcohol misuse screening and counseling
Aspirin use to prevent cardiovascular disease and colorectal cancer for adults ages 50 to 59 with high cardiovascular risk
Blood pressure screening
Cholesterol screening for adults of certain ages or at higher risk
Colorectal cancer screening for adults ages 45 to 75
Depression screening
Type 2 diabetes screening for adults ages 40 to 70 who are overweight or obese
Diet counseling for adults at higher risk for chronic disease
Falls prevention, including exercise, physical therapy, and vitamin D use for adults age 65 and older living in a community setting
Hepatitis B screening for people at high risk
Hepatitis C screening for adults ages 18 to 79
HIV screening for individuals ages 15 to 65, and for other ages at increased risk
PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk
Immunizations for adults, with doses and timing based on age and risk, including: Chickenpox (Varicella), Diphtheria, Influenza (flu), Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Measles, Meningococcal, Mumps, Pertussis (whooping cough), Pneumococcal, Rubella, Shingles, and Tetanus
Lung cancer screening for adults ages 55 to 80 at high risk, including current or former heavy smokers
Obesity screening and counseling
Sexually transmitted infection (STI) prevention counseling for adults at higher risk
Statin preventive medication for adults ages 40 to 75 at high risk
Syphilis screening for adults at higher risk
Tobacco use screening and cessation interventions
Tuberculosis screening for adults at high risk

Preventive Benefits for Women

Bone density screening for women age 65 and older, and younger women who have gone through menopause and are at risk
Breast cancer genetic counseling (BRCA) for women at higher risk (counseling only)
Breast cancer mammography screenings every 2 years for women age 50 and older, or earlier based on provider recommendation
Breast cancer chemoprevention counseling for women at higher risk
Breastfeeding support, counseling, and supplies for pregnant and nursing women
Birth control, including FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling as prescribed (excludes certain religious employer plans)
Cervical cancer screening (Pap test) for women ages 21 to 65
Chlamydia screening for younger women and those at higher risk
Diabetes screening for women with a history of gestational diabetes
Folic acid supplements for women who may become pregnant
Gestational diabetes screening for pregnant women at 24 weeks or later, and earlier for those at high risk
Gonorrhea screening for women at higher risk
Hepatitis B screening for pregnant women at the first prenatal visit
Maternal depression screening at well-baby visits
Preeclampsia prevention and screening for pregnant women with high blood pressure
Rh incompatibility screening for all pregnant women, with follow-up testing as needed
Sexually transmitted infection (STI) counseling for sexually active women
Tobacco cessation interventions for pregnant women who use tobacco
Urinary incontinence screening annually
Urinary tract or other infection screening
Well-woman visits to receive recommended preventive services

Preventive Benefits for Children

Alcohol, tobacco, and drug use assessments for adolescents
Autism screening at 18 and 24 months
Behavioral assessments at regular intervals from infancy through age 17
Bilirubin screening for newborns
Blood pressure screening at regular intervals from infancy through adolescence
Blood screening for newborns
Depression screening for adolescents beginning at age 12
Developmental screening for children under age 3
Dyslipidemia screening once between ages 9 and 11, and again between ages 17 and 21 for those at higher risk
Fluoride supplements for children without fluoride in their water supply
Fluoride varnish for infants and children once teeth are present
Gonorrhea preventive eye medication for newborns
Hearing screening for newborns and ongoing screenings as recommended
Height, weight, and body mass index (BMI) measurements taken regularly
Hematocrit or hemoglobin screening
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 high-risk adolescents
Immunizations from birth to age 18, including: Chickenpox (Varicella), Diphtheria, Tetanus, and Pertussis (DTaP), Haemophilus influenzae type B, Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Inactivated Poliovirus, Influenza, Measles, Meningococcal, Mumps, Pneumococcal, Rubella, and Rotavirus
Lead screening for children at risk
Obesity screening and counseling
Oral health risk assessment for children ages 6 months to 6 years
Phenylketonuria (PKU) screening for newborns
Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
Tuberculosis testing for children at higher risk
Vision screening
Well-baby and well-child visits



EVOLVED BENEFITS

Minimum Value Plans

evolvedbenefits.com

POWERED BY SBMA

Monthly Rates	Essential	Premium	Max
Employee Only	$389	$499	$639
Employee + Spouse	$785	$909	$1,241
Employee + Children	$739	$819	$1,091
Employee + Family	$995	$1,229	$1,707
General Information	**Essential**	**Premium**	**Max**
Annual Deductible [Ded] (individual/family)	$2,500/ $5,000	$0	$0
Out-of-Pocket Maximum (individual/family)	$9,100/ $18,200	$9,100/ $18,200	$9,100/ $18,200
Virtual Urgent Care/Behavioral Health	$0 Copay	$0 Copay	$0 Copay
Physician/Diagnostic (Non-Hospital Based)	**Essential**	**Premium**	**Max**
Preventive/Wellness	Covered 100%	Covered 100%	Covered 100%
Primary Care/Specialist Visits	$15 Copay	$15 Copay	$15 Copay
Urgent Care/Labs/Radiology (X-Ray, Ultrasound)	$50 Copay	$50 Copay	$50 Copay
Advanced Imaging[RBP1] (MRI, CT/PET scan)	30% Coinsurance (1/ year)	$350 Copay (2/year)	$350 Copay (3/ year)
Medmo2 Radiology/Imaging	Covered 100%	Covered 100%	Covered 100%
Surgery/Hospital/Emergency	**Essential**	**Premium**	**Max**
Outpatient Surgery[RBP1]	30% Coinsurance [Subj. to Ded] (1/ year)	$350 Copay (1/ year)	$350 Copay (2/ year)
Inpatient Hospitalization/Surgery[RBP1]	30% Coinsurance [Subj. to Ded](5 days/2 surgeries/ year)	$500 Copay (7 days/3 surgeries/ year)	$500 Copay (14 days/4 surgeries/ year)
Emergency Room[RBP]	30% Coinsurance (1/ year)	$500 Copay (1/ year)	$500 Copay (1/ year)
Emergency Transportation[RBP] (ground only)	30% Coinsurance (1/ year)	$500 Copay (1/ year)	$500 Copay (2/ year)
Maternity Services	**Essential**	**Premium**	**Max**
Professional Services[1]	$350 Copay	$350 Copay	$350 Copay
Inpatient Facility [RBP1]	30% Coinsurance [Subj. to Ded]	$500 Copay	$500 Copay
Additional Covered Services	**Essential**	**Premium**	**Max**
Chiropractic Services	$50 Copay (10/ year)	$50 Copay (10/ year)	$50 Copay (20/ year)
Physical/Speech/Occupational Therapy	$50 Copay (8/ year)	$50 Copay (12/ year)	$50 Copay (12/ year)
Inpatient Mental/Behavioral Treatment[RBP1]	30% Coinsurance [Subj. to Ded] (5 days/ year)	$500 Copay (7 days/ year)	$500 Copay (14 days/ year)
Outpatient Substance Abuse Treatment[1]	$75 Copay (8 days/ year)	$75 Copay (8 days/ year)	$75 Copay (12 days/ year)
Inpatient Substance Abuse Treatment[RBP1]	30% Coinsurance [Subj. to Ded] (5 days/ year)	$500 Copay (7 days/ year)	$500 Copay (14 days/ year)
Home Health Care	$50 Copay (10/ year)	$50 Copay (10/ year)	$50 Copay (20/ year)
Prescription Drug Coverage4	**Essential**	**Premium**	**Max**
Tier 1 Generic	$10 Copay	$10 Copay	$10 Copay
Tier 2 Generic & Preferred Brand	Discount Only	Discount Only	$50 Copay
Tier 3 Generic & Non-Preferred Brand	Discount Only	Discount Only	$75 Copay
Tier 4 Generic & Specialty	Discount Only	Discount Only	Discount Only

1. Specific services, including inpatient, surgical and maternity, require precertification. Failure to obtain precertification will result in a denial of benefits.
2. Medmo is a concierge scheduling service for radiology and imaging allowing members to maximize their benefits while minimizing costs. Subject to imaging limitations.
3. RBP reimburses providers using a percentage of Medicare coverage as the reference point for the reimbursement total. These plans pay up to 125% of the Medicare allowable coverage for applicable services. Patients will be responsible for paying any remaining balance beyond the provider reimbursement amount.
4. Prescription drug benefits are subject to the formulary. To review the formulary please visit www.sbmabenefits.com/purerx-base. Copay amounts listed are based on a unit quantity of 30 for a 30-day supply. Pricing may vary based on quantity and supply.
5. Minimum participation requirement of 5 lives enrolled in MV plans or 10 lives (5/5) when offered in combination with MEC plans. $750 annual fee paid at the time of implementation and renewal.

POWERED BY SBMA

Monthly Rates (California, Connecticut & New York)	Essential	Premium	Max
Employee Only	$428	$549	$703
Employee + Spouse	$864	$999	$1,365
Employee + Children	$813	$900	$1,201
Employee + Family	$1,095	$1352	$1,877
General Information	**Essential**	**Premium**	**Max**
Annual Deductible [Ded] (individual/family)	$2,500/ $5,000	$0	$0
Out-of-Pocket Maximum (individual/family)	$9,100/ $18,200	$9,100/ $18,200	$9,100/ $18,200
Virtual Urgent Care/Behavioral Health	$0 Copay	$0 Copay	$0 Copay
Physician/Diagnostic (Non-Hospital Based)	**Essential**	**Premium**	**Max**
Preventive/Wellness	Covered 100%	Covered 100%	Covered 100%
Primary Care/Specialist Visits	$15 Copay	$15 Copay	$15 Copay
Urgent Care/Labs/Radiology (X-Ray, Ultrasound)	$50 Copay	$50 Copay	$50 Copay
Advanced Imaging[RBP1] (MRI, CT/PET scan)	30% Coinsurance (1/ year)	$350 Copay (2/year)	$350 Copay (3/ year)
Medmo2 Radiology/Imaging	Covered 100%	Covered 100%	Covered 100%
Surgery/Hospital/Emergency	**Essential**	**Premium**	**Max**
Outpatient Surgery[RBP1]	30% Coinsurance [Subj. to Ded] (1/ year)	$350 Copay (1/ year)	$350 Copay (2/ year)
Inpatient Hospitalization/Surgery[RBP1]	30% Coinsurance [Subj. to Ded](5 days/2 surgeries/ year)	$500 Copay (7 days/3 surgeries/ year)	$500 Copay (14 days/4 surgeries/ year)
Emergency Room[RBP]	30% Coinsurance (1/ year)	$500 Copay (1/ year)	$500 Copay (1/ year)
Emergency Transportation[RBP] (ground only)	30% Coinsurance (1/ year)	$500 Copay (1/ year)	$500 Copay (2/ year)
Maternity Services	**Essential**	**Premium**	**Max**
Professional Services[1]	$350 Copay	$350 Copay	$350 Copay
Inpatient Facility [RBP1]	30% Coinsurance [Subj. to Ded]	$500 Copay	$500 Copay
Additional Covered Services	**Essential**	**Premium**	**Max**
Chiropractic Services	$50 Copay (10/ year)	$50 Copay (10/ year)	$50 Copay (20/ year)
Physical/Speech/Occupational Therapy	$50 Copay (8/ year)	$50 Copay (12/ year)	$50 Copay (12/ year)
Inpatient Mental/Behavioral Treatment[RBP1]	30% Coinsurance [Subj. to Ded] (5 days/ year)	$500 Copay (7 days/ year)	$500 Copay (14 days/ year)
Outpatient Substance Abuse Treatment[1]	$75 Copay (8 days/ year)	$75 Copay (8 days/ year)	$75 Copay (12 days/ year)
Inpatient Substance Abuse Treatment[RBP1]	30% Coinsurance [Subj. to Ded] (5 days/ year)	$500 Copay (7 days/ year)	$500 Copay (14 days/ year)
Home Health Care	$50 Copay (10/ year)	$50 Copay (10/ year)	$50 Copay (20/ year)
Prescription Drug Coverage4	**Essential**	**Premium**	**Max**
Tier 1 Generic	$10 Copay	$10 Copay	$10 Copay
Tier 2 Generic & Preferred Brand	Discount Only	Discount Only	$50 Copay
Tier 3 Generic & Non-Preferred Brand	Discount Only	Discount Only	$75 Copay
Tier 4 Generic & Specialty	Discount Only	Discount Only	Discount Only

1. Specific services, including inpatient, surgical and maternity, require precertification. Failure to obtain precertification will result in a denial of benefits.
2. Medmo is a concierge scheduling service for radiology and imaging allowing members to maximize their benefits while minimizing costs. Subject to imaging limitations.
3. RBP reimburses providers using a percentage of Medicare coverage as the reference point for the reimbursement total. These plans pay up to 125% of the Medicare allowable coverage for applicable services. Patients will be responsible for paying any remaining balance beyond the provider reimbursement amount.
4. Prescription drug benefits are subject to the formulary. To review the formulary please visit www.sbmabenefits.com/purerx-base. Copay amounts listed are based on a unit quantity of 30 for a 30-day supply. Pricing may vary based on quantity and supply.
5. Minimum participation requirement of 5 lives enrolled in MV plans or 10 lives (5/5) when offered in combination with MEC plans. $750 annual fee paid at the time of implementation and renewal.

POWERED BY SBMA

Notable Plan Exclusions

- Abortion
- Care outside the United States
- Chemotherapy/Radiation Therapy
- Cosmetic Surgery
- Dental Care (mouth, jaws, teeth, oral surgery)
- Dialysis
- Durable Medical Equipment
- Experimental/Investigational Treatments
- Eye Care & services related to vision care
- Hospice/Private Duty Nursing
- Infertility Services/Family Planning
- Nutritional Supplements/Vitamins
- Self-Injectable/GLP-1 Drugs
- Specialty Drugs
- Transplant Services

This form is a benefit highlight representing a brief description of the coverage available. Additional covered services, exclusions and limitations exist. Please refer to the plan administrator for additional plan information.

ACCESSING COVERAGE

HealthWallet

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 NETWORK PROVIDER

MultiPlan. PHCS Practitioner & Ancillary Only

Find the PHCS logo on your ID card and contact MultiPlan by calling 1-800-454-5231 or visiting www.multiplan.com/sbmapa and following the instructions below.

1. Read the acknowledgment at 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

PRESCRIPTION DRUG BENEFITS

PureRx

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

VIRTUAL HEALTH PROGRAM

RECURO HEALTH

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
- Virtual access to a Therapist or Licensed Counselor by appointment between 7 am – 7 pm

Access care via the HealthWallet mobile app or call 1-855-6RECURO

MV 6500 SBMA

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$595	$1,190	$1,190	$1,785

General Information	Coverage Information
Annual Deductible	$6,500 Individual / $13,000 Family
Out-of-Pocket Maximum'	$6,500 Individual / $13,000 Family
Physician & Diagnostic Benefits (Non-Hospital Based)	**In-Network Coverage**
Preventive / Wellness	Covered at 100% (not subject to deductible)
Primary Care / Specialist Visits	$50 Copay (not subject to deductible)
Urgent Care	Covered 100% after deductible is met
Laboratory Services / Radiology (X-ray, Ultrasound)	Covered 100% after deductible is met
Emergency / Hospital Benefits (Billed in a Hospital Setting)	**Non-Network Coverage**
Emergency Room (excluding emergency transportation)	Covered 100% of RBP[2] allowable after deductible is met
Inpatient Hospital Services including Physician/Surgeons	Covered 100% of RBP[2] allowable after deductible is met
Laboratory Services / Radiology (X-ray, Ultrasounds)	Covered 100% of RBP[2] allowable after deductible is met
Additional Benefits	**Non-Network Coverage**
Advanced Imaging (MRI, CT/PET scan)	Covered 100% of RBP[2] allowable after deductible is met
Durable Medical Equipment (including prosthetics & orthotics)	Covered 100% after deductible is met
Inpatient Mental Health / Substance Abuse Treatment[3]	Covered 100% of RBP[2] allowable after deductible is met
All additional covered services (may be subject to RBP)	Covered 100% of RBP[2] allowable after deductible is met
Prescription Drug Benefits	**PureRx**
Annual Deductible	$0
Copy by Drug Tier	$15 / $30 / $50 / $75
Virtual Health Programs	Recuro Health
24/7 Virtual Urgent Care	$0 Copay

1. The out-of-pocket maximum refers to covered services only. Specific services are subject to Reference-Based Pricing (RBP) and patients may be billed beyond the out-of-pocket maximum for these services.
2. Reference-Based Pricing (RBP) reimburses providers using a percentage of Medicare coverage as the reference point for the reimbursement total. This plan pays up to 125% of the Medicare allowable coverage for applicable services. Patients will be responsible for paying any remaining balance beyond the provider reimbursement amount.
3. Specific services require pre-certification. Failure to obtain precertification will result in a denial of benefits.
4. 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. The formulary is subject to change at any time without notice. Additional restrictions or limitations may apply.
5. Recuro Health's Virtual Care Program includes unlimited 24/7 access to virtual urgent care with board-certified doctors via phone, video, or messaging. It also connects members with a Therapist or Licensed Counselor through secure and private online video or phone sessions at a $0 copay. Psychiatric services are available at an additional cost.

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SCAN HERE

MV 6500 SBMA

Notable Plan Exclusions

- Notable Plan Exclusions
- Abortion
- Care related to or for the purpose of travel outside of the United States
- Chiropractic care including acupuncture
- Cosmetic Surgery including cosmetic components of gender transition
- Dental care or services related to the mouth, jaws, and teeth (oral surgery procedures, medical in nature)
- Dialysis
- Emergency transportation
- Experimental / Investigational Treatments
- Eye care and services related to vision care
- Infertility Services / Family Planning
- Nutritional Supplements / Vitamins (except as specified under preventive care)
- Non-Preferred Brand / Specialty / Self-Injectable / GLP-1 Prescription Drugs
- Out-of-network services except for services where there is no network (emergency room/hospital)
- Outpatient Hospital Services (any outpatient charge billed from a hospital including surgery performed in an outpatient office or surgical facility)
- Rehabilitation / Habilitation services including occupational, physical and speech therapies
- Skilled / Private Duty Nursing Care

This form is a benefit highlight representing a brief description of the coverage available. Additional covered services, exclusions and limitations exist. Please refer to the plan administrator for additional plan information.

LOCATING A NETWORK PROVIDER

MultiPlan. PHCS Practitioner & Ancillary Only

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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

PRESCRIPTION DRUG BENEFITS

PureRx

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VIRTUAL HEALTH PROGRAM

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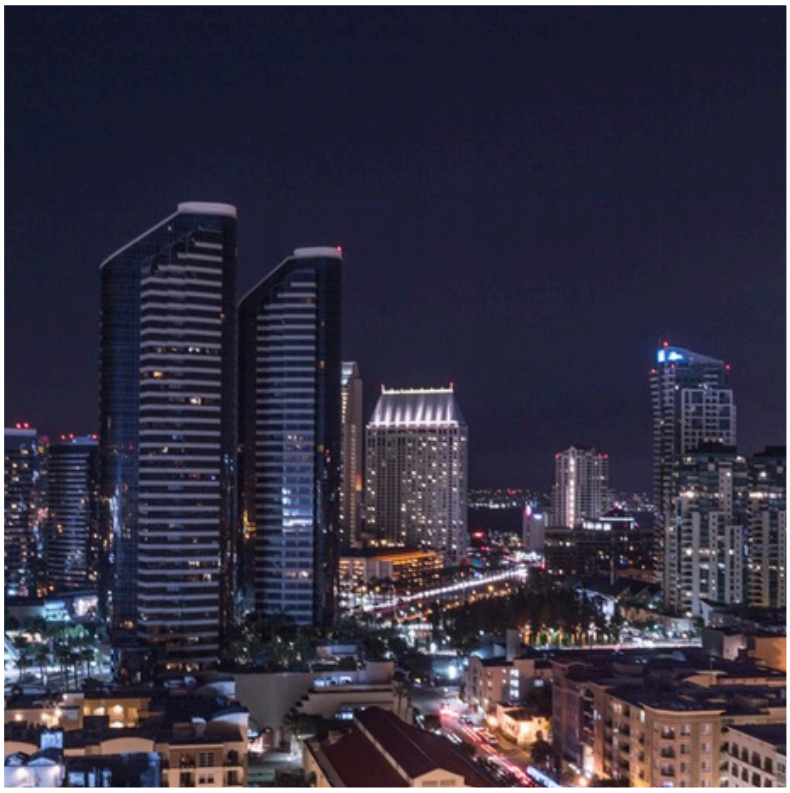

EVOLVED
BENEFITS

Voluntary Benefits

evolvedbenefits.com

DELTA DENTAL® Preventive

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$22.37	$42.41	$39.87	$66.51

Plan Information	Coverage Amount/Frequency
Annual Deductible	$0
Annual Maximum Benefit	$1,000/ insured person
Dental Services	**Coverage Amount/Frequency**
Exams / Cleanings (twice/ year)	Covered 100% / 2 times per year
Bitewing X-Rays	Covered 100% / 1 time per year
Full Mouth X-Rays (once every 5 years)	Covered 100% / 1 time every 5 years
Flouride Treatments (for dependents up to age 19)	Covered 100% / 2 times per year with cleanings
Space Maintainers (dependent children under age 14)	Covered 100% / 1 time per space
Basic Services (Fillings, Extractions & Root Canals)	Not Covered
Major Services (Crowns, Dentures, Bridges & Implants)	Not Covered
Oral Surgery & Orthodontic Services	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.

LOCATING A NETWORK DENTIST

From the Delta Dental mobile app or 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 at **1.800.452.9310.**

✓ **Cleanings covered 100%!**

✓ **Visit any dentist you want!**

DELTA DENTAL® 1000

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$44.04	$88.41	$83.06	$133.94

Plan Information	In Network	Out of Network
Annual Deductible	$50 individual / $150 family	$100 individual / $300 family
Annual Maximum Benefit	$1,000/ insured person	$1,000/ insured person
Diagnostic & Preventive Services	**In Network**	**Out of Network**
Exams / Cleanings (twice/ year) Bitewing X-Rays (once/ year) Full mouth X-Rays (once every 5 years)	Covered 100% (deductible waived)	Covered 80% (deductible waived)
Basic Services	**In Network**	**Out of Network**
Fillings (once/ tooth in 365 days) Extractions Root Canal (once/ tooth/ lifetime)	Covered 80% after deductible is met	Covered 50% after deductible is met
Major Services	**In Network**	**Out of Network**
Crowns (once/ 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

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 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 at **1.800.452.9310.**

✓ **No waiting periods!**

✓ **Cleanings covered 100% in Network**

✓ **Visit any dentist you want!**

DELTA DENTAL® 1500

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$49.89	$99.67	$94.32	$152.54

Plan Information	In Network	Out of Network
Annual Deductible	$50 individual / $150 family	$100 individual / $300 family
Annual Maximum Benefit	$1,500/ insured person	$1,500/ insured person
Diagnostic & Preventive Services	**In Network**	**Out of Network**
Exams / Cleanings (twice/ year) Bitewing X-Rays (once/ year) Full mouth X-Rays (once every 5 years)	Covered 100% (deductible waived)	Covered 80% (deductible waived)
Basic Services	**In Network**	**Out of Network**
Fillings (once/ tooth in 365 days) Extractions Root Canal (once/ tooth/ lifetime)	Covered 80% after deductible is met	Covered 50% after deductible is met
Major Services	**In Network**	**Out of Network**
Crowns (once/ 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

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 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 at **1.800.452.9310.**

✓ **No waiting periods!**

✓ **Cleanings covered 100% in Network**

✓ **Visit any dentist you want!**

vsp vision care

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$9.95	$19.90	$20.90	$34.85

Vision Benefits	In Network	Out of Network	Frequency
Comprehensive eye exam	$10 copay	$45 allowance	Once every 12 months
Eyeglass Frames	**In Network**	**Out of Network**	**Frequency**
One pair of eyeglass frames	$130 allowance ($70 allowance at Walmart / Costco)	$70 allowance	Once every 24 months
Eyeglass Lenses (instead of contacts)	**In Network**	**Out of Network**	**Frequency**
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)	**In Network**	**Out of Network**	**Frequency**
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 Low

SBMA

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$39.00	$78.00	$78.00	$117.00

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

1. **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.**
2. **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.**

ExtraCare High

SBMA

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

1. **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.**
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Critical Care 10,000

SBMA

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$20.00	$40.00	$26.00	$60.00

Employee Benefit:	$10,000	Spouse Benefit:	$10,000	Child(ren) Benefit:	$5,000

Covered Conditions	Initial Benefit	Recurrence Benefit
Invasive Cancer	100%	50%
Heart Attack	100%	50%
Stroke	100%	50%
End Stage Renal Failure	100%	50%
Carcinoma In Situ	25%	12.50%

- Maximum benefit amount is $10,000.
- Benefits for pre-existing conditions are not payable for 12 months after the effective date of coverage.
- Benefit amounts are paid 100% up to age 65.
- Benefit amounts are reduced to 50% between ages 65-70.
- Benefits are terminated on the date the member turns 70 years of age.
- 30-Day waiting period for Invasive Cancer benefit.
- 90-Day waiting period for additional occurrences.
- Annual Wellness Benefit of $50 for both employee and spouse.
- Benefits will not be paid for any of the following circumstances:
  - Suicide, attempted suicide or intentional self-inflicted injuries
  - Injury resulting from being legally intoxicated as defined by the laws of the state of jurisdiction in which the injury occurs
  - Cosmetic/elective surgery
  - Any act of war or participation in a riot, insurrection or rebellion

1. **Additional exclusions and limitations exist. Contact plan administrator for additional information regarding this policy.**
2. **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.**

Critical Care 25,000

SBMA

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$45.00	$90.00	$58.00	$135.00

Employee Benefit:	$25,000	Spouse Benefit:	$25,000	Child(ren) Benefit:	$12,500

Covered Conditions	Initial Benefit	Recurrence Benefit
Invasive Cancer	100%	50%
Heart Attack	100%	50%
Stroke	100%	50%
End Stage Renal Failure	100%	50%
Carcinoma In Situ	25%	12.5%

- Maximum benefit amount is $25,000.
- Benefits for pre-existing conditions are not payable for 12 months after the effective date of coverage.
- Benefit amounts are paid 100% up to age 65.
- Benefit amounts are reduced to 50% between ages 65-70.
- Benefits are terminated on the date the member turns 70 years of age.
- 30-Day waiting period for Invasive Cancer benefit.
- 90-Day waiting period for additional occurrences.
- Annual Wellness Benefit of $50 for both employee and spouse.
- Benefits will not be paid for any of the following circumstances:
  - Suicide, attempted suicide or intentional self-inflicted injuries
  - Injury resulting from being legally intoxicated as defined by the laws of the state of jurisdiction in which the injury occurs
  - Cosmetic/elective surgery
  - Any act of war or participation in a riot, insurrection or rebellion

1. **Additional exclusions and limitations exist. Contact plan administrator for additional information regarding this policy.**
2. **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.**

EVOLVED
BENEFITS

Life Insurance AD&D

evolvedbenefits.com

Term Life and AD&D 10,000

Protect Your Loved Ones
Term Life Insurance with Accidental Death & Dismemberment coverage from Amalgamated Life Insurance Company helps to provide
extra financial security for you and your loved ones in the event of an accident or death.

- Maximum benefit amount is $10,000
- Coverage age limitation is age 70 (coverage for all enrollees will terminate the first day of the month following the member's 70th birthday)

- Enrollment age limitation is up to 65 years
- Child age limitation is 14 days to 26 years (child coverage will terminate the first day of the month following the child's 26th birthday)

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$6.00	$9.00	$9.00	$12.00

Covered Individual	Covered Amount
Member	$10,000
Spouse	$5,000
Child / Children	$2,000

Amalgamated Life
Life • Accident • Disability

Amalgamated Life Insurance Company is a leading provider of life and health insurance serving working men and women since 1943. Amalgamated Life has consistently earned the "A" (Excellent) rating from A.M. Best Company since 1975, attesting to our proven policies and procedures, adherence to the industry's highest standards, strong fiscal condition and excellent claims-paying ability. Amalgamated Life is licensed in 50 states and the District of Columbia. The information in this product sheet is in an abbreviated form only. The actual coverage and amounts are subject to all the terms, limitations and exclusions in the group policy. If the information in this product sheet differs from the Group Term Life and Accidental Death & Dismemberment Policy, the terms of the policy govern. Policy Form #ALTLP-05 or state variations. Rider Form #ALTLADDRC-XX-05 or state variations.
Amalgamated Life Insurance Company
333 Westchester Avenue, White Plains, NY 10604
www.amalgamatedlife.com

Term Life and AD&D 20,000

Protect Your Loved Ones
Term Life Insurance with Accidental Death & Dismemberment coverage from Amalgamated Life Insurance Company helps to provide
extra financial security for you and your loved ones in the event of an accident or death.

- Maximum benefit amount is $20,000
- Coverage age limitation is age 70 (coverage for all enrollees will terminate the first day of the month following the member's 70th birthday)

- Enrollment age limitation is up to 65 years
- Child age limitation is 14 days to 26 years (child coverage will terminate the first day of the month following the child's 26th birthday)

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$12.00	$18.00	$18.00	$24.00

Covered Individual	Covered Amount
Member	$20,000
Spouse	$10,000
Child / Children	$5,000

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