OPTIMACARE

SBMA

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$120	$225	$225	$330

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. 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).

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 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
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.
Behavioral Telehealth: Schedule consultations with therapists at a fraction of the cost of typical in-person visits.
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.

ELITECARE

SBMA

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$140	$265	$265	$390

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. Copay amounts listed are based on a unit quantity of 30 for a 30-day supply. Pricing may vary based on quantity and supply.

[3]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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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

EXTRACARE LOW

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 Admission – requires claim separation of 30 days	$2,000 / up to 3 admissions per year
Hospital 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	$300
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 outpatient surgery benefit

DELTA DENTAL 1000

DELTA DENTAL®

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$38.97	$78.24	$73.50	$118.53

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

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.

How to find a network dentist:

From the Delta Dental mobile app or website at https://www.deltadentalnj.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**

No waiting periods!

Exams & Cleanings covered 100% in network

See any dentist in or out of network

DELTA1000

DELTA DENTAL 1500

DELTA DENTAL®

Coverage Tier	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Monthly Rates	$44.15	$88.20	$83.47	$134.99

Dental Benefits	In Network	Out of Network
Annual Deductible	$50 individual / $150 family	$100 individual / $300 family
Annual Maximum Benefit	$1,500 per insured person	$1,500 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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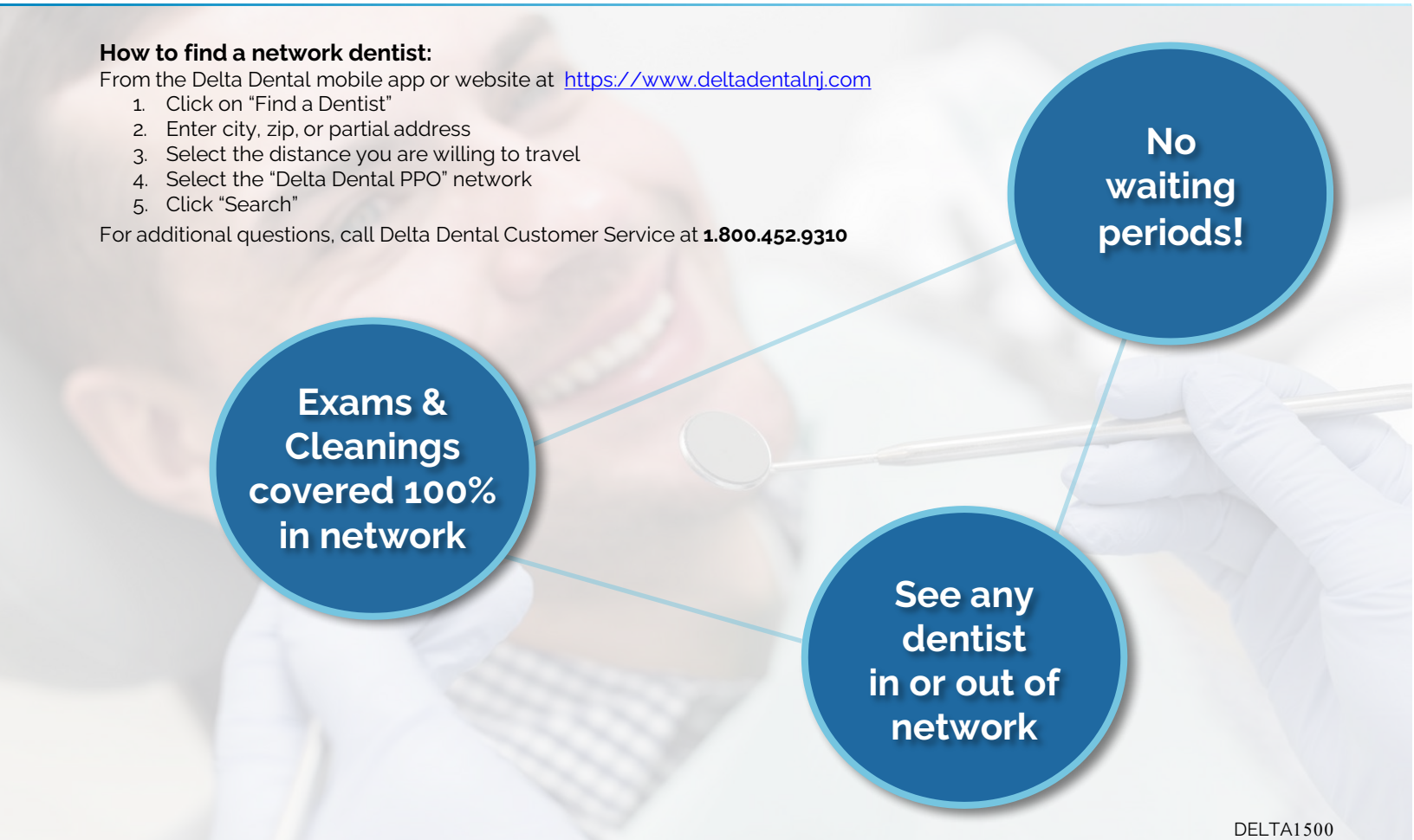


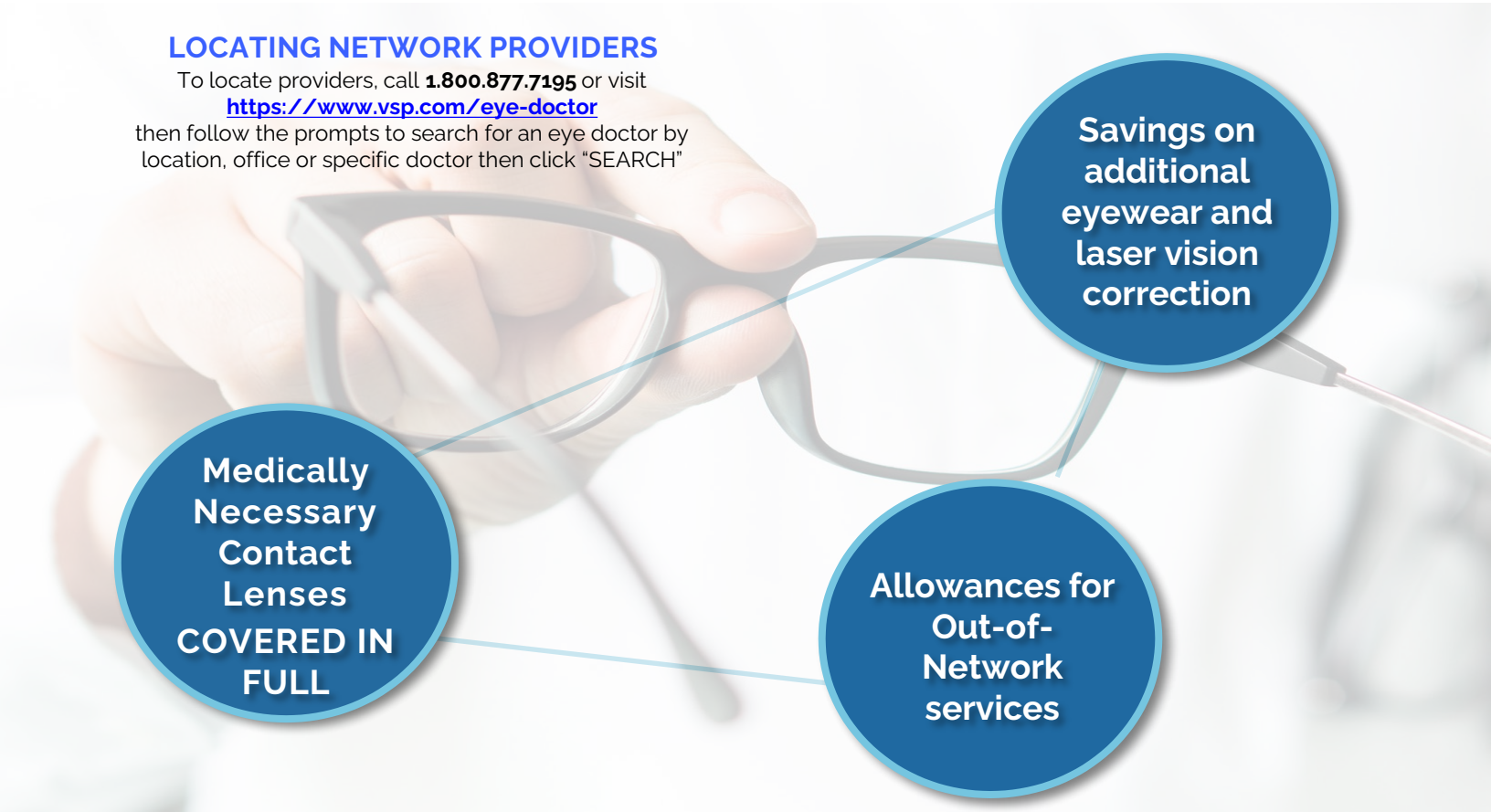
VSP Vision

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			
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

LOCATING NETWORK PROVIDERS

To locate providers, call **1.800.877.7195** or visit
https://www.vsp.com/eye-doctor
then follow the prompts to search for an eye doctor by location, office or specific doctor then click "SEARCH"



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.

VSPVIS130