Benefit Guide

SBMA

JFC Staffing Companies

Welcome to your 2021 Health Insurance Benefits! This guide provides an outline of benefits available to you and your eligible dependents. We encourage you to review this guide to educate yourself about your options and choose the coverage that best fits your needs.

ENROLL NOW!
Time is limited

GET YOUR ID CARD IN DAYS

COVERAGE YOU NEED AT A PRICE YOU CAN AFFORD

ELIGIBILITY

You're eligible for benefits during the open enrollment period effective January 1, 2021 or the first of the month following 59 days from your date of hire. Eligible employees must work at least 30 hours per week.

HOW TO ENROLL

To enroll into benefits, make changes, or waive coverage for you and your eligible dependents, please follow one of the methods below.

Make elections via the EaseCentral Benefits Portal:

If you have your email address on file with JFC, you will receive an email directly from Wanda Ortiz with a link to the benefits portal. Once you click this link, the system will ask you to create your password and proceed with making your elections. After your initial login, you may access the benefits portal by visiting https://jfctemps.ease.com

- If you do not have your email address on file, you may obtain your login credentials by contacting SBMA's customer service team at (888) 385-1125.

Speak with a Licensed Representative:

- Schedule an appointment at https://booknow.appointment-plus.com/b82bz0h8/ and a licensed SBMA representative will call at the time that works best for you

Or

- Call the SBMA Call Center available Monday – Friday, 10 AM – 9 PM ET at (888) 385-1125

ENROLLMENT INFORMATION

If you don't make elections during open enrollment, you will not have another opportunity to make changes until the next open enrollment (January 1, 2022) or due to a qualifying event. See examples of qualifying events below:

- Marriage, divorce, legal separation, annulment or death of a spouse
- Birth, adoption or placement for adoption
- Change in residence or workplace (if your benefit options change)
- Loss of other qualified health coverage
- Change in your dependent's eligibility status because of age, student status or similar circumstance

BENEFIT GUIDE

THE AFFORDABLE CARE ACT (ACA) & MINIMUM ESSENTIAL COVERAGE (MEC)

According to the Affordable Care Act (ACA), more commonly referred to as Obamacare, all individuals must be offered at least Minimum Essential Coverage (MEC). MEC provides coverage for preventive/wellness screenings, immunizations, and other services.

COVERAGE OPTIONS

MEC Excel: Covers all preventive services at 100% as outlined in ACA and provides 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. MEC Excel also includes telemedicine through HealthiestYou and prescription discounts through SingleCare.

MEC Plus15: Covers all preventive services at 100% as outlined in ACA and provides additional medical services such as office visits, urgent care, labs, x-rays and generic prescription drugs offered at various copays. Prescription drugs are covered through SmithRx.

Minimum Value (MV): This PPO plan covers all services outlined in MEC Plus and provides additional medical services such as emergency room care, hospitalization and inpatient services at referenced-based pricing paying 125% of the Medicare allowable fee schedule. Please note, patients will be balanced billed for any costs greater than Medicare allowable. Cost of the plan is based on affordability as mandated by ACA. Employees will not pay greater than 9.83% of their pay toward employee only coverage.

MetLife Hospital Indemnity: This indemnity plan can complement existing medical coverage and help fill financial gaps caused by out-of-pocket expenses such as copayments and non-covered medical services. Benefits are paid regardless of what is covered by medical insurance. Payments are made directly to covered employees to spend as they choose.

Please note: The MEC Excel and MEC Plus15 plans do NOT cover hospitalization, emergency room or surgical services. Out-of-network services and specialty drugs are not covered on any plan. Dental and Vision coverage are available for Ameritas. Please logon to JFC's website and click on resources for additional information. Employees will be responsible for remitting premium directly to the provider.

EMPLOYEE ACKNOWLEDGMENT

Upon receipt of this guide, employees attest:

- I have been provided with the Benefit Guide and with the information pertaining to the plan offering and enrollment deadline.
- I have been offered a plan for myself and my qualified dependents that provides both Minimum Essential Coverage (MEC) and Minimum Value Plans.
- I understand the cost to me will not be greater than 9.83% of my pay.

I authorize my employer to make salary reductions on a pre-tax basis for my portion of the group insurance premiums. I understand that:

- I cannot change this election during the plan year unless I have a change in status as provided in the Internal Revenue Code and Regulations.
- My Social Security benefits may be reduced by this election.
- This election replaces any previous elections and will terminate on the earlier of (1) when I am no longer being paid compensation in an amount at least equal to my total salary reduction or (2) termination of the plan.
- My employer may reduce or cancel this election, if necessary, to comply with provisions of the Internal Revenue Code.
- I understand if I decline medical coverage, I will not be able to enroll in benefits until January 1, 2021 or due to a qualifying event.

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BENEFIT PLAN COMPARISON

Medical Benefits	MEC Excel	MEC Plus15	Minimum Value Zero
Annual Deductible	$0	$0	$0
Out-of-Pocket Maximum[1]	-	$1,850 individual / $3,700 Family	$7,150 individual / $14,300 Family
Wellness and Preventive	Covered 100%	Covered 100%	Covered 100%
Rx Discount Plan	Included through SingleCare	Included through SmithRx	Included through SmithRx
Telehealth Program[2]	Included through HealthiestYou	-	-
Primary Care Visits	$15 copay	$15 copay	$15 copay
Specialists Visits	Network Discount[3]	$15 copay	$15 copay
Urgent Care Visits	$50 copay	$50 copay	$50 copay
Emergency Room (excludes emergency transportation)	-	-	$400 copay, then subject to Reference-based pricing[4]
Laboratory Services / X-Rays	Network Discount[3]	$50 copay	$50 copay
Advanced Diagnostic Imaging (Ultrasounds, MRI, CT)	-	-	-
Hospital Facility Fees, Physician / Surgeon Fees, Maternity[5]	-	-	$1,000 copay, then plan covers 80% of referenced based-pricing[4] allowable amount
Outpatient Surgery, Mental Health / Substance Abuse Rehabilitation / Physical Therapy	-	-	-
Prescription Drugs	Discounts only	$15 copay for generic $50 copay for preferred brand[6]	$40 copay generic only

[1] Out-of-pocket maximum is for covered services only. Certain services are subject to reference-based pricing and may result in members being balance-billed beyond the out-of-pocket maximum.
[2] For additional information on the HealthiestYou telehealth program please call (855) 894-9627 or visit www.healthiestyou.com
[3] The MEC Excel plan covers services that are subject to the network discount. Discounts will vary based on provider contracts. Patients will be responsible for paying the remaining balance after the network discount is applied.
[4] Reference-based pricing reimburses providers using a percentage of Medicare coverage amounts as a reference point for the reimbursement totals on emergency and inpatient services. The MV Zero plan pays 125% of the Medicare allowable coverage amount for such services. Patients will be responsible for paying the remaining balance beyond the provider reimbursement amount.
[5] Inpatient hospital services, including maternity, require pre-certification. Failure to obtain pre-certification may result in a reduction or denial of benefits.
[6] The maximum annual benefit for preferred brand drugs is $300 ($600/family) and may only be filled when a generic alternative is not available.

Indemnity Benefit	Benefit Limits	Benefit Amounts
Admission Benefit	1 time per calendar year	$2,500 - additional $500 if admitted to ICU
Confinement Benefit	15 days per calendar year	$100 per day - additional $100 per day if admitted to ICU
Inpatient Rehabilitation Benefit (Injury Only)	15 days per calendar year	$50 per day
Inpatient Surgery Benefit	1 time per calendar year	$1,000
Outpatient Surgery Benefit	1 time per calendar year	$1,000
Ambulance Benefit (Ground Only)	1 time per calendar year	$100
Diagnostic Procedure	1 time per calendar year	$150

COSTS FOR COVERAGE

Weekly Rates	MEC Excel	MEC Plus	Minimum Value Zero[1]	Hospital Indemnity[2]
Employee only	$21.23	$35.54	$93.72	$18.35
Employee + Spouse	$41.53	$86.13	$191.76	$38.67
Employee + Child(ren)	$42.74	$90.32	$167.07	$30.51
Family	$62.11	$130.54	$268.99	$50.83

[1] Rates of Minimum Value Plan are subject to affordability and may differ from indicated rates based on an employee's rate of pay. For more information regarding affordability please contact your employer.
[2] The MetLife Hospital Plan may be chosen as a stand-alone option or may be chosen in addition to the MEC Excel, MEC Plus or Minimum Value plan options.

Preventive Services

Covered Services for Adults

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
2. Alcohol Misuse screening and counseling
3. Aspirin use to prevent cardiovascular disease for men and women of certain ages
4. Blood Pressure screening for all adults
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal Cancer screening for adults over 50
7. Depression screening for adults
8. Diabetes (Type 2) screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over
11. Hepatitis B screening for people at higher risk
12. Hepatitis C screening for adults at increased risk, and one time for everyone born 1945 –1965
13. HIV screening for everyone ages 15 to 65, and other ages at increased risk
14. Immunization vaccines for adults — doses, recommended ages, and recommended populations vary: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma virus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis and Varicella
15. Lung cancer screening for adults 55 - 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
16. Obesity screening and counseling for all adults
17. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
18. Statin preventive medication for adults 40 to 75 years at higher risk
19. Syphilis screening for all adults at higher risk
20. Tobacco use screening for all adults and cessation interventions for tobacco users
21. Tuberculosis screening for certain adults with symptoms at higher risk

Covered Services for Women

1. Anemia screening on a routine basis for pregnant women
2. Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer (counseling only; not testing)
3. Breast Cancer Mammography screenings every 1 to 2 years for women over 40
4. Breast Cancer chemoprevention counseling for women at higher risk
5. Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
6. Cervical Cancer screening
7. Chlamydia Infection screening for younger women and other women at higher risk
8. Contraception: 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."
9. 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
10. Domestic and interpersonal violence screening and counseling for all women
11. Folic Acid supplements for women who may become pregnant
12. Gestational diabetes screening for women 24 to 28 months pregnant and those at high risk of developing gestational diabetes
13. Gonorrhea screening for all women at higher risk
14. Hepatitis B screening for pregnant women at their first prenatal visit
15. HIV screening and counseling for sexually active women
16. Human Papilloma virus (HPV) DNA Test every 5 years for women with normal cytology results who are 30 or older
17. Osteoporosis screening for women over age 60 depending on risk factors

Covered Services for Women (continued)

18. Preeclampsia prevention and screening for pregnant women and follow-up testing for women at higher risk
19. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
20. Sexually Transmitted Infections counseling for sexually active women
21. Syphilis screening for all pregnant women or other women at increased risk
22. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
23. Urinary tract or other infection screening, including urinary incontinence
24. Well-woman visits to get recommended services for women under 65

Covered Services for Children

1. Alcohol and Drug Use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
4. Bilirubin concentration screening for newborns
5. Blood Pressure screening for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
6. Blood screening for newborns
7. Cervical Dysplasia screening for sexually active females
8. Depression screening for adolescents
9. Developmental screening for children under age 3
10. Dyslipidemia screening for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
11. Fluoride Chemo prevention supplements for children without fluoride in their water source
12. Fluoride varnish for all infants and children as soon teeth are present
13. Gonorrhea preventive medication for the eyes of all newborns
14. Hearing screening for all newborns; and for children once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years
15. Height, Weight and Body Mass Index measurements for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
16. Hematocrit or hemoglobin screening for all children
17. Hemoglobinopathies or sickle cell screening for newborns
18. Hepatitis B screening for adolescents ages 11 to 17 years at high risk
19. HIV screening for adolescents at higher risk
20. Hypothyroidism screening for newborns
21. Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Meningococcal, Pneumococcal, Rotavirus and Varicella
22. Iron supplements for children ages 6 to 12 months at risk for anemia
23. Lead screening for children at risk of exposure
24. Maternal depression screening for mothers of infants at 1, 2, 4, and 6-month visits
25. Medical History for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
26. Obesity screening and counseling
27. Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
28. Phenylketonuria (PKU) screening for this genetic disorder in newborns
29. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
30. Tuberculin testing for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
31. Vision screening for all children.

For more information on covered preventive services visit: https://www.healthcare.gov/coverage/preventive-care-benefits/

ADDITIONAL INFORMATION ABOUT THE MEC EXCEL PLAN

hy healthiestyou

Your healthcare just got a whole lot easier!

With HealthiestYou you can connect to a doctor, get treatment, and get prescriptions, 24 hours a day, 7 days a week over the phone or via the mobile app. Using HealthiestYou can SAVE YOU TONS OF MONEY and no more siting around in waiting rooms.

24x7 UNLIMITED DOCTOR ACCESS

Are you sick? Call HealthiestYou first! Our physician network can diagnose, treat, and prescribe with no consult fees, anytime, anywhere. Really!

LOCATE PROVIDERS

Need to search for a doctor? Our app knows best and will easily lead you through the process. You can even research your doctor first!

Register and access your account
member.healthiestyou.com
(855) 894-9627

singlecare

Welcome to your prescription drug savings program!

This program entitles you, and your covered dependents, to discounts on ALL FDA-APPROVED PRESCRIPTION MEDICATON sold at the largest pharmacy chains in the United States.

SAVE UP TO
80%
ON PRESCRIPTIONS

- No claim forms
- No deductibles
- No limitations or maximums
- No preexisting condition
- exclusions

www.singlecare.com/sbma

(866) 978-0843

ADDITIONAL INFORMATION ABOUT THE MEC PLUS AND MINIMUM VALUE PLANS

SmithRx

Using Your Prescription Drug Card at Retail

You will receive a prescription card from your employer. Please present your new prescription card along with your prescription to any of our 67,000+ retail pharmacies every time you fill your prescription. You can access a participating pharmacy list at www.mysmithrx.com.

Online Tools at www.mysmithrx.com

Secure online connection, protecting your confidentiality and providing:

- Drug formulary & lookup tools
- Trusted drug and health condition information & education
- Real-time benefit information
- View and download pharmacy claims
- Find a participating pharmacy
- Download claim reimbursement, prior authorization request, specialty
- pharmacy enrollment, and mail order forms

For additional support, call (844) 454-5201 any time.

LOCATING NETWORK PROVIDERS

MEC Excel & MEC Plus

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 **1.888.263.7543**
Online: visit www.multiplan.com and click "Find a Provider" located in the top right-hand corner and follow the steps below

1. After acknowledging you have read the disclaimer at the bottom of the screen, click on the green "Select Network" button
2. When selecting your network, choose "PHCS," then "Specific Services"
3. Enter one of the search criteria suggested in the search box to begin your search
4. If your browser settings don't allow your location to be detected, enter a zip code

Minimum Value

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 Practitioner & Ancillary Only

By phone: call **1.877.952.7427**
Online: visit www.multiplan.com/phcspracanc and click "Find a Provider" located in the top right-hand corner and follow the steps below

1. After acknowledging you have read the disclaimer at the bottom of the screen, click on the green "Select Network" button
2. When selecting your network, choose "PHCS," then "Practitioner & Ancillary"
3. Enter one of the search criteria suggested in the search box to begin your search
4. If your browser settings don't allow your location to be detected, enter a zip code

Notices and Disclosures

COORDINATION OF BENEFITS

Coordination of Benefits applies if you or your covered dependents are insured under more than one health insurance plan. The plans coordinate with each other on payments so that there are not duplicate payments for the same medical service.

The order in which payments are made is determined as follows:

- The plan that covers the patient as an employee (non-dependent) is considered the primary plan, initially responsible for payment.
- The plan that covers the patient as a dependent is the secondary plan.
- When a dependent child is covered by the plan of more than one parent, (unless court ordered) generally the plan of the parent whose birthday falls earlier in the year is considered the primary plan.

NOTE: When an individual is covered by more than one plan, the combined payment of both plans generally will not exceed 100% of the total balance due; and often the secondary plan actually has no remaining payment obligation beyond the primary plan's payment. Plan participants will want to take Coordination of Benefits processes into consideration when deciding whether to enroll in the same type of plan sponsored by more than one employer.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Federal law (Newborns' and Mothers' Health Protection Act of 1996) prohibits the plan from limiting a mother's or newborn's length of hospital stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery or from requiring the provider to obtain preauthorization for a stay of 48 or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for cesarean delivery.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protection to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies both to persons covered under group health plans and to persons with individual health insurance coverage. However, WHCRA does NOT require health plans or issuers to pay for mastectomies. If WHCRA applies to you and if you are receiving benefits in connection with a mastectomy and you elect breast reconstruction, coverage must be provided for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses (e.g. breast implant); and
- Treatment for physical complications of the mastectomy, including lymph edema.

NOTICE OF AVAILABILITY OF NOTICE OF PRIVACY PRACTICES

The Innovative Solutins Employee Group Health Plan (the "Plan") provides health benefits to eligible employees and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about Plan participants in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a notice of privacy practices, which describes the ways that the Plan uses and discloses PHI. To receive a copy of the Plan's notice of privacy practices you should contact your employer's Privacy Official, who has been designated as the Plan's contact person for all issues regarding the Plan's privacy practices and covered individuals' privacy rights.

Notices and Disclosures

PREMIUM ASSISTANCE UNDER MEDICAID & THE CHILDREN'S HEALTH INSURANCE PROGRAM

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

PENNSYLVANIA - Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx
Phone: 1-800-692-7462

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours to work. Certain qualifying events, or a second qualifying event during the initial period of coverage may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee's becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it with the appropriate premium to TASC. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, federal law stipulates that your coverage will be cancelled after a 30-day grace period.

If you have any questions about COBRA or the Plan, please contact Human Resources. Please note, if the terms of the Plan and any response you receive from the Human Resources Representative conflict, the Plan document will control.