JFC Global

2025/2026

ASSOCIATES BENEFITS GUIDE

INSIDE

INTRODUCTION

At JFC Global, we highly value our associates and are proud to offer benefit packages that provide stability and security for our team members and their families. Our associates have the flexibility to choose options that best fit their needs and circumstances.

This booklet provides an overview of the valuable benefits package available to eligible associates, effective from April 1, 2025 through March 31, 2026 except for dental and vision which will renew January 1, 2026. Eligible associates are defined as Full-Time Associates who regularly work at least 30 hours per week (0.75 - 1.0 FTE). Benefits are effective for eligible employees the first day of the month following 59 days of employment.

Please note that JFC Global reserves the right to modify, amend, suspend, or terminate any plan at any time and for any reason without prior notice. The plans described in this booklet are governed by insurance contracts and plan documents, which are available for review upon request. We have made every effort to present the plans accurately in this booklet. However, if there is any discrepancy between this booklet and the actual provisions of the insurance contract or plan documents, the provisions of the insurance contract or plan documents will take precedence.

If you have any questions, please contact Human Resources.

QUALIFIED LIFE EVENTS

Open Enrollment occurs once each year. You may change your benefit elections during the open enrollment period. Once you have made your selection, you may not change benefit elections until the next open enrollment unless you have a qualifying change in employment or family status. Qualifying Events include:

- Marriage, divorce or legal separation i.e. a change in your legal marital status
- Change in number of dependents meaning you can add a dependent child through birth, adoption or court-ordered custody
- Change in dependents due to the death of a spouse or child
- Your work schedule changes, affecting your benefits eligibility i.e. a permanent reduction or increase in hours
- Your dependent child loses eligibility for coverage
- Your spouse involuntarily loses health coverage through his/her employer
- You take an FMLA leave of absence
- You enroll in the Health Insurance Marketplace
- You and/or your spouse or dependents gain or lose coverage or subsidies through a Medicaid plan or the State Children's Health Insurance Program (SCHIP)

You may make a new election within 30 days of the occurrence of an event (election changes or events associated with Medicaid or SCHIP must be requested within 60 days and all others 30 days). Coverage begins on the date the event occurred. You are responsible to notify Human Resources. Otherwise, elections you make during the open enrollment will remain in effect for the entire plan year.

BENEFITS OVERVIEW

JFC Global strives to offer benefit options to provide for the well-being of you and your family. Our associates are our greatest resource and we take pride in being able to offer comprehensive and affordable benefits for all of our associates and their family including:

- Health Plans provided by SBMA Benefits
- Hospital Indemnity Plan provided by SBMA Benefits
- Patient Financial Payment Program provided by AblePay
- Dental Plan provided by United Concordia
- Vision Plan provided by VBA

SPECIAL ENROLLMENT RIGHTS NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

MEDICAL BENEFITS

JFC Global will offer medical benefits through **SBMA**. The plan utilizes the PHCS (Specific Services) Network. Locating a participating provider in the PHCS network at www.multiplan.com/sbmaspecificservices or 800-457-1309.

BENEFIT	SBMA EnhancedCare	SBMA EliteCare	SBMA Advantage MV Plan
Network	PHCS Specific Services	PHCS Specific Services	PHCS Practitioner & Ancillary Only
Deductible (Per Benefit Period)			
Individual	$0	$0	$1,500
Family	$0	$0	$3,000
Maximum Out of Pocket (Includes Coinsurance, certain exclusions may apply)			
Individual	$1,850	$1,850	$9,100
Family	$3,700	$3,700	$18,200
Coinsurance	100%	100%	100% after ded
Physician Visit	$15 copay	$15 copay	$15 copay
Specialist Visit	Network Discount	$15 copay	$15 copay
Virtual Care Urgent Care via Recuro Health	$0	$0	$0
Virtual Care Behavioral Health via Recuro Health	Not Covered	$0	$0
Preventative Care Services	Covered 100%	Covered 100%	Covered 100%
Laboratory	Network Discount	$50 copay	$50 copay then subject to RBP
High Tech Imaging/Radiology	Not Covered Medmo will offer a discounted rate	Not Covered Medmo will offer a discounted rate	$350 copay then subject to RBP ; Covered 100% with Medmo
Routine Diagnostic Screening	Network Discount	$50 copay	$50 then subject to RBP
Hospitalization	Not Covered	Not Covered	$500 copay after ded then subject to RBP
Emergency Room	Not Covered	Not Covered	$500 copay then subject to RBP (limit 1 per year)
Urgent Care	$50 copay	$50 copay	$50 copay
Prescription Benefits - To review the formulary please visit www.sbmabenefits.com/purerx-standard			
Deductible	None	None	None
Retail Drugs (31-day supply)	Generic preventative $0 Remaining tiers - Discount Only	Tier 1 $15 Tier 2 $30 Tier 3 $50 Tier 4 $75	Generic - $10 Remaining Tiers - Discount Only
Mail-Order or Retail Drugs (90-day supply)	Not Covered	Not Covered	3x Retail
Specialty Pharmacy (30-day supply)	Not Covered	Not Covered	Not Covered

*RBP stands for Referenced Based Pricing. All facility charges are subject to RBP.

Benefits At-A-Glance is intended only to highlight your Benefits and should not be relied on to fully determine your coverage. If this summary conflicts in any way with the Certificate of Coverage (COC), the COC shall prevail.

PREVENTIVE CARE BENEFITS

Take advantage of your medical benefits through SBMA, which cover essential preventive care services at no cost to you. When you receive these services from a doctor or provider in your plan's network during preventive screening appointments, you ensure your health is prioritized without any financial burden. We highly recommend contacting SBMA to clarify any specific limitations or requirements, so you can fully benefit from these valuable services.

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

MEDICAL BENEFITS

HealthWallet

HOW TO LOGIN TO HealthWallet

In HealthWallet you'll have access to

- Digital ID Cards
- Explanations of Benefits
- Provider Searches
- Prescription Benefits
- Virtual Care Options
- and more

1. **Type in get.thehealthwallet.com in your browser on your phone**
2. **Download the app that the above web address brings you to**
3. **Open "the Health Wallet App"**
4. **To Login, Choose your login option instructed by your benefit plan.**
5. **Access your Health Wallet Services & Features.**

If you need assistance with the HealthWallet app please call us at **1-866-918-7735 or email us at support@thehealthwallet.com.**

+1-866-918-7735 www.thehealthwallet.com **support@thehealthwallet.com**

VIRTUAL URGENT CARE

ALL PLANS

The **SBMA** utilizes **Recuro Health** for virtual urgent care.

Benefits

Virtual Urgent Care

Our Virtual Urgent Care solution connects patients with tools and services for a smoother, more cost-effective healthcare experience quickly. Patients connect to board-certified doctors for treatment of urgent medical concerns with ongoing communication with their doctor for follow-up.

Our urgent care solution provides unlimited 24/7 access for patients and their families. When you or a family member is sick, how can you get expert help and guidance? Recuro's urgent care is available virtually and quickly at the touch of a button.

$0 Copay

Example Conditions Treated

- Acne, Rashes, Allergies
- Fever, Headache, Nausea
- Cold, Flu, Cough
- Gastrointestinal Issues
- Respiratory Issues
- UTIs, Vaginitis & More!

RECURO HEALTH

What's Included

- ✔ 24/7 Access
- ✔ Phone, Video, Messaging
- ✔ Integrated Prescriptions
- ✔ Primary Care Coordination

Service Highlights

Easy Prescriptions & Transcripts

Prescriptions are immediately sent to the patient's preferred pharmacy for easy pickup. Consults can be recorded and transcribed, allowing patients access post-appointment.

24/7/365 Access

Recuro physicians are available whenever our patients need them, day or night. Live video, phone, and messaging options available.

RECURO HEALTH

info@recurohealth.com | +1-855-6RECURO | recurohealth.com | Scan QR Code

VIRTUAL BEHAVIORAL HEALTH

The **SBMA EliteCare and Advantage MV Plan** utilize **Recuro Health** for virtual behavioral health.

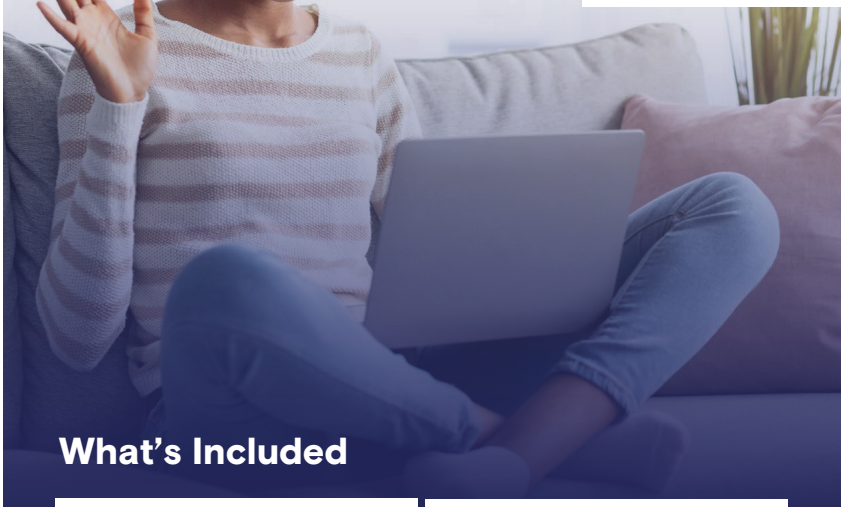
Benefits

RECURO HEALTH

Virtual Behavioral Health

Counseling (Only)

Recuro's comprehensive behavioral health care offers a wide spectrum of coverage, including therapy and counseling. Recuro's Behavioral Health solution gives members virtual access to connect with a Licensed Counselor through secure and private online video and phone sessions, whenever and wherever they need it in all 50 states. Our virtual services are available whenever and wherever it is convenient for you on a digital device.



What's Included

- ✔ Therapy & Counseling
- ✔ Health Risk Assessment
- ✔ Risk Stratification
- ✔ Primary Care Coordination

$0 Copay

Service Highlights

Psychiatry
Psychotherapy and mental health medication management.

Therapy & Counseling
Therapy and counseling services from social workers and mental health psychologists.

Health Risk Assessment
Behavioral health-focused risk assessment including depression and anxiety.

Example Conditions Treated

- Depression & Anxiety
- Stress Management
- Eating Disorders
- Anger Management
- Grief or Loss
- Marriage Counseling

RECURO HEALTH

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REFERENCE BASED PRICING (RBP)

The **SBMA Advantage MV Plan** is a Referenced Based Price (RBP) plan. **Zelis** is a healthcare technology company that helps payers, providers, and consumers manage costs and payments.

Reference Based Pricing(RBP) works by setting spending limits on specific medical procedures or services—meaning you would only be covered up to the established limit for these services and would have to pay the cost difference out of pocket. However, limits are only set on "shoppable" services. These are services where you can take time to make a decision based on price and quality, like prescriptions, lab tests, or joint replacements. In all of these examples, there are lower-cost options that are typically the same quality as the more expensive alternatives.

RBP is most commonly applied to procedures with fluctuating costs. For instance, colonoscopies may range from $400 to $6,000, depending on the physician. In this case, an organization using RBP might set the spending limit to the median price of the procedure based on market findings.

Suppose you use a health facility that charges above the spending limit for a specific procedure. In that case, you will need to cover the difference out of pocket. The RBP method helps encourage participants to shop for the most affordable procedure, instead of simply choosing the most expensive option without comparing alternatives. This method saves you money while lowering overall costs.

RBP pays doctors and hospitals for your care, based on the Medicare Fee Schedule allowed amount, plus an added percentage on top of that payment rate. The Medicare Fee Schedule is universally understood by most doctors and hospitals.

How Your Reference Based Pricing Plan Works

With a clear understanding of your Reference Based Pricing health plan, you'll be more comfortable using your health benefits to seek care, supporting a healthier version of you!

zelis

01 Identify Your Provider

Choose any hospital or doctor, current physician included, without restriction. You aren't forced to choose from an approved list of networks or providers. All hospitals and doctors are covered under your health plan up to the plan's allowable reimbursement amount.

02 Schedule Your Visit

Make an appointment. Share your new health plan information with the facility. The facility can call the toll-free Customer Service number on your ID card to verify your eligibility and benefits.

03 Need Support?

Member Advocates are available to answer your questions about your health plan. They can also reach out to your doctor regarding your health plan and try to gain their acceptance of your plan rate as payment in full. No need to wait to schedule your appointment.

04 Provider Education

Member Advocates can help educate your doctor or hospital about your health plan and answer questions about how your plan reimburses, or pays, them.

05 Billing

You are responsible for:

- Co-pays
- Co-insurance to be applied to the outstanding claim
- Any remaining amount to be applied to your deductible

Most facility providers accept the Plan allowable amount in full. If you receive a balance bill, contact your administrator using the Customer Service number on your ID card to be assigned to a dedicated Member Advocate. Your Advocate will communicate with the facility provider in an effort to write off or lower the balance bill amount.

06 Healthier, Happier You

zelis

How Your Reference Based Pricing Plan Works

Frequently Asked Questions

What if my doctor asks if they are in my health plan's provider network?

Simply tell your doctor that your health plan does not have any networks and that all providers (doctors/hospitals) are covered under your health plan up to the plan's allowable amount. Share with your doctor that your plan's Member Advocate can give them a call to further explain the plan. Then, call a Member Advocate to provide them with your doctor's information and ask them to reach out to your doctor. A Provider Outreach Request form is attached for you to complete and email to **pc-providerrequest@zelis.com**

What if my doctor asks what type of health plan I have?

Let your doctor know that your health plan is a self-funded plan provided through your employer. Point out the toll-free customer service phone number on your ID card that they can call to verify your eligibility and benefits.

What if my doctor tells me that they do not accept my health plan?

Suggest that your doctor call the toll-free customer service phone number on your ID card to verify your eligibility and benefits. Advise your doctor that a Member Advocate with your health plan will be reaching out to them to educate them about the plan and answer their questions. Then, call a Member Advocate to provide them with your doctor's information so that they can reach out to your doctor. A Provider Outreach Request form is attached for you to complete and email to **pc-providerrequest@zelis.com**

Member Advocates can also refer you to a Safe Harbor Provider if one is available. Safe Harbor Providers are plan-accepting doctors and hospitals that are close to home, meet your health needs and accept your RBP plan.

Do I need to wait to schedule an appointment with my doctor until a Member Advocate reaches out?

The beauty of your health plan is that all doctors and hospitals are covered under it up to the plan's allowable amount. Seek care and schedule your appointment at any time.

Do I need to wait to schedule an appointment with my doctor until I know if they will accept the reimbursement rate of my health plan as payment in full?

No, all doctors and hospitals are covered under your health plan up to the plan's allowable amount. You are free to schedule your appointment at any time and do not need to wait on any prior rate acceptance or member advocacy outreach.

What happens if my doctor will not accept my health plan's reimbursement rate as payment in full?

You can still go to your doctor since all hospitals and doctors are covered under your health plan up to the plan's allowable amount.

zelis

How Your Reference Based Pricing Plan Works

Frequently Asked Questions

What is a balance bill?

A balance bill is the difference between your doctor's charge and your RBP plan's allowable amount. It is not:

- Any remaining amount you are responsible for applying to your deductible
- Any co-pay you owe
- Any co-insurance to be applied to the outstanding claim amount
- Services not covered by your health plan

If you receive a balance bill, contact your health plan at the toll-free customer service number on your ID card to guide you through the process. Follow these steps to help you if a balance bill occurs:

1. Contact your health plan as soon as you receive notification that you are receiving a balance bill from your doctor or hospital. They can look it over to see if you have the member responsibility to pay a deductible/copay/coinsurance.

2. If this applies to you, pay the doctor the amount owed from your deductible/copay/coinsurance.

3. If, after you pay your member responsibility, you still receive a balance bill from your doctor or hospital, send this to your health plan upon receipt.

4. Your health plan will communicate with Zelis Member Advocacy Team, and they will send you paperwork to complete and return. If you have questions, please contact your assigned, dedicated Member Advocate, and they will be happy to help you. The phone number and email address are listed on all paperwork.

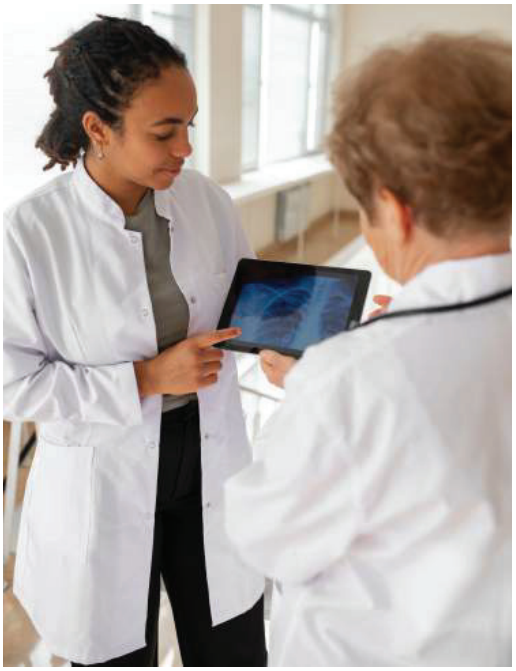
5. Send all correspondence concerning the balance bill to your Member Advocate at this email address: **pc-patientadvocacy@zelis.com**

HIGH TECH IMAGING/RADIOLOGY

The **SBMA Advantage MV Plan** utilizes **Medmo** for medical imaging.

medmo SBMA

Medmo Provides Access To The Best Medical Imaging Appointment For You



For most patients, getting medical imaging is a painful and frustrating experience. Many times, patients wait longer, travel farther, and pay more than what they should.

Medmo is here to make imaging easy and affordable.

High-value imaging—without breaking the bank

Medmo helps you understand your options so that you can maximize your benefits and reduce your patient responsibility.

Find a time, location, and price that works for you

Medmo's sole purpose is to ensure the medical imaging process is as pleasant and seamless as possible.

Simple and Straightforward Process

- Call Medmo at **(844) 248-2292** to share your imaging (Xray, Mammogram, Ultrasound, CT and MRI) prescription information and availability
- Medmo will find imaging centers to determine the best match based on quality, your availability, network status and pricing
- Pre-authorization requirements apply
- Simply show up for your appointment and Medmo will have a copy of the results available for both your and your physician

MAIL ORDER PHARMACY

The **SBMA Advantage MV Plan** utilizes **ProCare PharmacyCare**. ProCare PharmacyCare (PPC) is a mail order and specialty pharmacy that is patient-oriented, focused on optimizing drug therapies and providing member health education. Our dispensing partner is Thrifty White Pharmacy.

How to Register

- You can register for the mail order program via phone, mail, or fax. It's easy! Just call 800-662-0586, option 2.
- Obtain mail order prescriptions from your doctor and clearly write your name, date of birth, and member ID number (listed on your Member ID Card) on the back of your prescription and send to:

  2850 N Commerce Parkway, Miramar, FL 33025

- For schedule II medications, prescriptions need to be sent to:

  Thrifty White Pharmacy, 706 38th St, NW, Unit A, Fargo, ND 58102

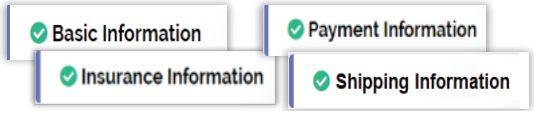
- Orders are shipped at no charge in secure, confidential, tamper-evident packaging, unless expedited shipping is requested.

Easy Online Prescription Ordering

1 Have your doctor send your prescription to ProCare PharmacyCare through the ePrescribe system or fax
- eRx: PPC-ProCare PharmacyCare (Miramar)
- Include PPC NPI and eRx identifier

2 Go to the Patient Portal at https://portal.procarerx.com/, sign up and log in *OR* scan the QR Code below.

3 Fill out the requested information needed to process your prescription and manage your refills.



You can also use the Patient Portal to:

- Request a prescription to be filled
- View Rx and order history
- View the status of orders in progress
- View tracking for shipped orders
- Request information from the pharmacist
- Enter insurance and payment information

Text/Email Messaging

No more waiting on hold with an automated phone system. You can quickly order your refills online or via SMS messaging to expedite your order.

800-662-0586

TTY Line: 711

Fax: 800-662-0590

24/7 Customer Service
855-828-1484

Hours

Monday through Friday
9:00 am – 6:00 pm ET

Saturday
9:00 am – 1:00 pm ET

Get Medications Shipped to Your Door

MEDICAL CONTRIBUTIONS

Associate contributions are weekly on a pre-tax basis.

WEEKLY ENHANCEDCARE PLAN COST	PER PAY
Associate Only	$22.38
Associate + Spouse	$43.83
Associate + Child(ren)	$45.03
Associate + Family	$65.57

WEEKLY ELITECARE PLAN COST	PER PAY
Associate Only	$45.36
Associate + Spouse	$98.05
Associate + Child(ren)	$100.11
Associate + Family	$147.63

WEEKLY ADVANTAGE MV PLAN COST	PER PAY*
Associate Only	$92.07
Associate + Spouse	$181.15
Associate + Child(ren)	$170.53
Associate + Family	$229.61

*Rates are adjustable according to ACA guidelines. Contact HR for more information.

HOSPITAL INDEMNITY BENEFITS

JFC Global will offer hospital indemnity benefits through **SBMA**. Hospital indemnity insurance is a type of supplemental insurance that can be added to your existing health insurance plan to help cover the costs of a hospital stay. It is important to note that it does not replace your primary health insurance.

Hospital indemnity insurance plans may cover various types of admissions, including inpatient hospital stays, intensive care unit (ICU) and critical care unit (CCU) admissions. Additionally, it covers expenses related to outpatient surgery, emergency room visits, and ambulance transportation.

The payouts from this insurance are most often used to cover health insurance deductibles, copays, household bills, and other out-of-pocket expenses. One key advantage of this policy is that the benefit payouts are not tied to specific services, allowing you to use the funds as you see fit.

Benefits	SBMA/Mutual Of Omaha
Admission	$2,500 (up to 3x per year) (claim separation of 30 days)
ICU Supplemental Admission	
Daily Stay (per day)	$200 (up to 30 days)
Daily Stay - ICU (per day)	Included
Inpatient Rehabilitation (Injuries Only) (per day)	Not Covered
Inpatient Surgery (1 per year)	$1,000
Outpatient Surgery	Limit to 1 Combined per Year
Hospital or Ambulatory Surgical Center	$1,000
Physician Office	$300
Anesthesia	35% of surgery benefit
Emergency Room	$100 (up to 2x per year)
Ambulance (ground only)	$200 (up to 2x per year)
Ambulance (Air only)	$1,000 (1x per year)
Diagnostic Procedure	Not Covered

Associate contributions are weekly on a pre-tax basis.

WEEKLY PLAN COST	PER PAY
Associate Only	$11.29
Associate + Spouse	$22.60
Associate + Child(ren)	$22.60
Associate + Family	$33.91

NEW - VISION

JFC Global is pleased to offer a voluntary vision plan through **Vision Benefits of America (VBA)**. The plans provide in and out-of-network benefits. Members have access to any vision provider but benefit financially by using VBA participating providers. Associate's are responsible for plan costs. The effective date of this plan is April 1, 2025. However, rates will renew on January 1 ,2026.

vba

VBA# 4804

$0 Exam / $0 Materials Copay
Dependent Age: 26 (EOBM)

Frequency Type: Last Date of Service	Employee	Spouse	Children
Vision Exam	12 Months	12 Months	12 Months
Lenses	12 Months	12 Months	12 Months
Frames	12 Months	12 Months	12 Months

Benefits: Employee Can Select Either	VBA Participating Provider Amount Covered/Benefit (Zero Copay)	Out-of-Network Max Reimbursement (Zero Copay)
Vision Exam (Glasses or Contacts)	Covered in Full	$40
Clear Standard Lenses (Pair):		
Single Vision	Covered in Full	$40
Bifocal	Covered in Full	$60
Blended Bifocal	Covered in Full	$60
Trifocal	Covered in Full	$80
Progressives	Partially-Covered	$80
Lenticular	Covered in Full	$120
Polycarbonate	Covered in Full for Persons Up to Age 19	N/A
Basic Scratch Coating	Covered in Full	N/A
Frame (Wholesale Allowance)	Up to $ 50	$50
-OR-		
Elective Contacts (in lieu of eyeglass benefits)		
Material Allowance	Up to $ 110[A]	$110
Elective Fitting Fee and Evaluation	15% off UCR	N/A
-OR-		
Medically Necessary Contacts	Covered in Full[B]	$450
Low Vision Aids (Per 24 Months. No Lifetime Max)	N/A	$650
-AND-		
Lasik Surgery (once every 8 years)	N/A	$125

Where an "allowance" is shown above, the Member is responsible for paying any charges in excess of the allowance less any applicable copay.

Benefits and participation may vary by location, including, but not limited to, Costco® Optical, Pearle Vision, LensCrafters®, Target Optical® and Boscov's™ Optical.

A The allowance is applied to all services/materials associated with contact lenses, including, but not limited to, contact fitting, dispensing, cost of the lenses, etc. No guarantee the allowance will cover the entire cost of services and materials.

B Requires prior approval. May only be selected in lieu of all other material benefits listed herein.

VISION

vba — Limitations

This plan is designed to cover your visual needs rather than cosmetic options.

Additional Charges

You may incur out-of-pocket charges when selecting any of the following:

- Tinted Lenses
- Photochromic/Polarized Lenses
- Polycarbonate (covered under age 19)
- Hi-index Lenses
- Progressive (available starting at $29)
- The coating of the lens or lenses (except Basic Scratch Coating)
- A frame that costs more than the plan allowance
- Rimless Frames
- Anti-Reflective

Additionally, costs for contact lenses/services in excess of the plan's scheduled reimbursement allowances are the responsibility of the patient.

Not Covered

The contract gives VBA the right to waive any of the plan limitations if, in the opinion of our optometric consultants, it is necessary for the patient's welfare. VBA provides no benefit for professional services or materials connected with the following:

- Orthoptics or vision training
- Non-prescription lenses
- Two pair of glasses in lieu of bifocals
- Medical or surgical treatment of the eyes
- An eye examination, or corrective eyewear, required by an employer as a condition of employment
- Services of materials provided as result of any Worker's Compensation Law or similar legislation
- Glasses and contacts during the same eligibility period

Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.

Additional Terms and Conditions

Frame allowance is based on wholesale pricing at non-retail locations. Frame allowance, contact lens pricing and policies vary by location. Contact your provider before requesting services.

Benefits may only be used for contact lenses when selected in lieu of eyeglasses (spectacle lenses and frames). If purchased at the same time from a single provider, your plan will cover up to $110 towards the cost of contact fitting fees and contact lenses. Any provider contact lens charges that exceed this amount shall be the responsibility of the member. Members may be required to pay contact fitting fees out of pocket at some locations.

Benefits and participation may vary by location and where prohibited by state law.

LASIK benefits may be limited to no more than 50% per eye.

A 15% discount off the provider's usual, customary and reasonable contact lens fitting fee may be available in some locations. Void where prohibited by law.

Benefits may only be used for medically necessary contact lenses when selected in lieu of all other materials.

Additional terms and conditions apply. Contact VBA at 412-881-4900 for more information.

Associate contributions are weekly on a pre-tax basis.

WEEKLY PLAN COST PER PAY	Associate ONLY	Associate + 1	Associate + FAMILY
Vision	$1.68	$3.20	$4.21

DENTAL

JFC Global is pleased to offer a comprehensive dental plan through **United Concordia**. Members have access to any dentist but benefit financially by using United Concordia participating dentists. The effective date of this plan is April 1, 2025. However, rates will renew on January 1 ,2026.

United Concordia		
Benefit Category	In-Network	Non-Network
Class I – Diagnostic/Preventive Services		
Exams	100%	100%
Bitewing X-rays		
All Other X-rays		
Cleanings & Fluoride Treatments (includes 1 additional cleaning during pregnancy)		
Sealants		
Palliative Treatment		
Class II – Basic Services		
Basic Restorative (Fillings)	80%	80%
Posterior Resins (Included)		
Simple Extractions		
Space Maintainers		
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures		
Endodontics		
Nonsurgical Periodontics		
Surgical Periodontics		
Complex Oral Surgery		
General Anesthesia		
Class III – Major Services		
Inlays, Onlays, Crowns	50%	50%
Prosthetics (Bridges, Dentures)		
TMJ/TMD	Not Covered	
Implants	Not Covered	
Orthodontics for dependent children to age 19		
Diagnostic, Active, Retention Treatment to age 19	50%	50%
Maximums & Deductibles (cumulative of network and non-network)		
Annual Program Deductible (per person/per family)	$50/$150 Excludes Class I & Orthodontics	$50/$150 Excludes Class I & Orthodontics
Annual Program Maximum (per person)	$1,500	$1,500
Lifetime Orthodontic Maximum (per person)	$1,500	$1,500
Network	AdvantagePLUS	Advantage
Annual Maximum Option	Preventive Incentive	
Smile for Health - Wellness	Standard	
College Tuition Benefit Program	Included	

Associate contributions are weekly on a pre-tax basis.

WEEKLY PLAN COST PER PAY	Associate ONLY	Associate + SPOUSE	Associate + CHILD(REN)	Associate + FAMILY
Dental	$7.56	$15.08	$16.39	$25.65

PATIENT FINANCIAL PAYMENT PROGRAM

All associates are eligible to use **AblePay**, even if they haven't enrolled in medical benefits. This service is provided to you and your dependents at no charge. AblePay can be used to cover any out-of-pocket medical expenses, **regardless of whether you have insurance or not.**

AblePay®
SIMPLE HEALTH SAVINGS

- ☑ **Save money!** At AblePay Health, we believe your financial wellness is just as important as your physical wellness. We provide our members with options that meet their current financial needs on every bill. Members who have the ability to pay in one payment save up to 13% on their out-of-pocket expenses.
- ☑ **We offer flexible payment options on every bill**. If you are unable to pay your bill in one payment to maximize savings, we also offer 3, 6, or 12 month payment options. Members still save money by paying over 3 months or 6 months. Although you won't receive savings by paying over 12 months, there is no interest charged.
- ☑ **Advocacy.** We know that many people have questions and need help understanding their medical bills and the overall billing process. Our team is here to support our members when they have a questions. If there is an issue with a bill, we will contact the providers billing office on your behalf to help get it resolved.
- ☑ **Convenience**. Our secure and convenient member portal makes tracking and paying bills easier than ever before!
- ☑ **There is no cost to you**, and you can add anyone on your account, even if they have different insurance providers.
- ☑ **Everyone with primary health insurance** is eligible to take advantage of the benefits AblePay Health provides.

Scan the below QR code or click enroll.ablepay-health.com/apply to enroll

AblePay Health helps you manage out-of-pocket medical expenses, saving you money and time! The NO-COST program allows you to save up to 13% on out-of-pocket medical expenses (deductible, coinsurance, and copays).

PAYMENT TERMS AND DISCOUNTS

- 1 Pay: 13% Bank ACH, 10% Card
- 3 Pays: 10% Bank ACH, 7% Card
- 6 Pays: 8% Bank ACH, 5% Card

Payment Terms up to 12 Months - no discount/ no interest

Provider Network Includes Hospitals & Physician Groups

ACMH · Punxsutawney Area Hospital · St Luke's University Health Network · Penn Medicine · GVH Grand View Health · Tower Health · Penn Medicine Lancaster General Health · PennState Health · Main Line Health Well ahead. · Orthopedic Associates of Lancaster, Ltd · May-Grant Obstetrics | Gynecology · IRMC · epgi Eastern Pennsylvania Gastroenterology and Liver Specialists · Warren General · Lehigh Valley Health Network · ChristianaCare · LOG Lancaster Orthopedic Group · Nemours Children's Health

Check often as more provider networks are available.

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 lymphedema.

NOTICE OF AVAILABILITY OF NOTICE OF PRIVACY PRACTICES

The JFC Global 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

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network. Contact the Pennsylvania Insurance Department at www.insurance.pa.gov/nosurprises or by phone at 1-877-881-6388 or TTY/TDD: 717-783-3898 if you have difficulty finding a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Pennsylvania Insurance Department at www.insurance.pa.gov/nosurprises or by phone at 1-877-881-6388 or TTY/TDD: 717-783-3898.

Visit www.insurance.pa.gov/nosurprises for more information about your rights under federal and state law. You may also visit https://www.cms.gov/nosurprises for information from the federal government.

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 www.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 and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: https://www.pa.gov/en/agencies/dhs/resources/chip.html
CHIP Phone: 1-800-986-KIDS (5437)

To see if any other states have added a premium assistance program since January 1, 2025, 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. 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.

NOTICES AND DISCLOSURES

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace").To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings on your premium that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit, that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace? You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

Please note: the most recent copy of the notice is available on the Associate Resource Page.

NOTICES AND DISCLOSURES

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE - *CONTINUED*

What about Alternatives to Marketplace Health Insurance Coverage? If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information? The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name JFC Pro Temps, Inc. dba JFC Global	4. EIN 251695448	
5. Address 1520 Market Street	6. Phone Number 717-761-8095	
7. City Camp Hill	8. State PA	9. Zip Code 17011
10. Who can we contact about employee health coverage at this job? Wanda Ortiz		
11. Phone number (if different from above) SAME	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. FULL TIME ASSOCIATES
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are: LEGAL SPOUSES ARE ELIGIBLE AND CHILD DEPENDENTS UNDER AGE 26.
  - ☐ We do not offer dependent coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

Please note: the most recent copy of the notice is available on the Associate Resource Page.

NOTICES AND DISCLOSURES

NON-CREDITABLE COVERAGE DISCLOSURE NOTICE

IMPORTANT NOTICE FROM JFC GLOBAL ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with JFC Global and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. JFC Global has determined that the prescription drug coverage offered by the MEC EliteCare, MEC EhancedCare, or Advantage Minimum Value PPO plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage**. **This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the MEC EliteCare, MEC EhancedCare, or Advantage Minimum Value PPO plan. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**
3. You can keep your current coverage from the MEC EliteCare, MEC EhancedCare, or Advantage Minimum Value PPO plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you decide to drop your current coverage with JFC Global, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under MEC EliteCare, MEC EhancedCare, or Advantage Minimum Value PPO plan.

NOTICES AND DISCLOSURES

NON-CREDITABLE COVERAGE DISCLOSURE NOTICE

IMPORTANT NOTICE FROM JFC GLOBAL ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under MEC EliteCare, MEC EhancedCare, or Advantage Minimum Value PPO plan is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current JFC Global coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current JFC Global coverage, be aware that you and your dependents will be able to get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through JFC Global changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	4/1/2025
Name of Entity/Sender:	JFC Global
Contact--Position/Office:	Wanda Ortiz – Human Resources Manager
Address:	1520 Market Street, Camp Hill, PA, 17011
Phone Number:	717-761-8095

BENEFITS CONTACTS

BENEFIT	CARRIER/COMPANY	CONTACT INFORMATION
Medical	SBMA	Customer Service: 1-844-995-5836 Opt 2 Website: www.sbmabenefits.com
Advantage MV **Reference Based Pricing**	SBMA Zelis	Customer Service: 1-844-995-5836 Opt 2 Website: www.sbmabenefits.com Customer Service: Email: pc-providerrequest@zelis.com Website: www.zelis.com/
Virtual Urgent Care **Virtual Behavioral Health**	Recuro	Customer Service: 1-855-673-2876 Email: info@recurohealth.com Website: recurohealth.com
Mail Order Pharmacy	ProCare PharmacyCare	Customer Service: 800-662-0586 Fax: 1-800-662-0590 Patient Portal: portal.procarerx.com
Hospital Indemnity	SBMA	Customer Service: 1-844-995-5836 Opt 2 Website: www.sbmabenefits.com
Vision Plan	VBA	Group Number: 4804 Customer Service: 1-800-432-4966 Website: www.VBAplans.com
Dental Plan	United Concordia	Group Number: Active #847547000 Customer Service: 1-800-332-0366 Website: www.unitedconcordia.com

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This booklet is intended as a brief summary of your benefits. Benefits are subject to the contractual terms, limitations and exclusions as set forth in the master contracts. This booklet also serves as a Summary of Material Modifications ("SMM") and includes updates that affect JFC Global's summary plan descriptions. This SMM is effective the first of the plan year and describes the changes to JFC Global's plan in very general terms.