

2024 PLAN YEAR ANNUAL NOTICES

The attached notices are provided in order for FLYR, Inc. to satisfy its annual notice requirements to employees. Please read these notices as they contain important information about your benefits and rights associated with our benefits program.

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If you have any questions about any of these notices, please contact the FLYR People team at benefits@flyr.com.

The information in these notices is current as of November 2023 and is subject to change at any time.

2024 Annual Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November 2023 for coverage starting as early as January 1, 2024.

Can I Save Money on My Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and you may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 8.39% of your household income for the 2024 plan year health, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefits costs covered by the plan is no less than 60% of such costs.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution as well as your employee contribution to employer-offered coverage is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description; contact the Member Services Department of your health care provider as shown on your benefit ID card; or contact the FLYR People team at benefits@flyr.com.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov, or if you reside in California, www.CoveredCA.com, 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: FLYR, Inc.	4. EIN: 46-3271119
5. Employer Street Address: 3205 Pico Blvd.	6. Phone: 888-432-4062
7. City: Santa Monica Zip: 90405	8. State: CA
9.	
10. Who can we contact about employee health coverage at this job? Diana Yu	
11. Phone No. (if different from above): n/a	12. Email: benefits@flyr.com

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

- As your employer, we offer a health plan to:
 - All Employees.
 - Eligible employees are: Active, regular, full-time employees working a minimum of 30 hours per week.

- With respect to dependents:
 - We do offer coverage. Eligible dependents are: Spouses, domestic partners per FLYR rules, and children up to the age of 26 for medical, dental and vision.
 - We do not offer 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, or if you reside in California, www.CoveredCA.com will guide you through the process.

* An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60% of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

HIPAA Notice of Privacy Practices

This Plan is required by law to provide notice of the Plan's duties and privacy practices with respect to covered individuals' protected health information by providing a Notice of Privacy Practices (NOPP) to participants. The Plan's NOPP is available upon request. To obtain a copy of the NOPP, or for more information regarding the Plan's privacy policies or your rights under HIPAA, please contact the FLYR People team at benefits@flyr.com.

HIPAA Special Enrollment Rules

HIPAA requires that we notify you about your right to later enroll yourself and eligible dependents for coverage in FLYR's health plan under "special enrollment provisions" briefly described below.

- **Loss of Other Coverage.** If you decline enrollment for yourself or for an eligible dependent because you have other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents under FLYR's health plan if you or your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 30 days after you or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage.
- **New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents under FLYR's health plan. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse, if your spouse was not previously covered.
- **Enrollment Due to Medicaid/CHIP Events.** If you or your eligible dependents are not already enrolled in FLYR's health plan, you may be able to enroll yourself and your eligible dependents if: (i) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. The CHIP Model Notice containing additional information about this right as well as contact information for state assistance is included below. You may also request a copy from the Plan Administrator.

Please contact the FLYR People team at benefits@flyr.com for details, including the effective dates of coverage applicable to each of these special enrollment provisions. Additional information regarding your rights to enroll in group health coverage is found in the applicable group health plan summary plan description(s) or insurance contract(s).

Continuation of Coverage Rights under COBRA

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the FLYR People team at benefits@flyr.com.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan's coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Your notice must provide the type of qualifying event, the date of the qualifying event, and the name and address of the employee, spouse or dependent who underwent the qualifying event.

You must provide this notice to the FLYR People team.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- **Disability extension of 18-month period of continuation coverage:** If you or any one in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.
- **Second qualifying event extension of 18-month period of continuation coverage:** If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family may extend their COBRA continuation coverage, for a maximum of 36 months (as measured from the first qualifying event), if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

FLYR, Inc.
3205 Pico Blvd
Santa Monica, CA 90405
benefits@flyr.com

Continuation of Coverage under California Group Health Policies

COBRA Qualified Beneficiaries under federal law who are covered under a group health policy issued in California are eligible to receive up to 18 months of additional COBRA coverage for medical care upon completion of the 18 months received under federal COBRA. This provision does not apply to self-funded medical plans. The combination of federal and state COBRA coverage may not exceed 36 months in any event. The 36 month period dates back to the original qualifying event. The additional COBRA period of coverage terminates the earliest of:

- The date the maximum period of coverage expires;
- The date coverage ceases because a premium payment is not made on time;
- The date the employer no longer provides any group health plan; or,
- The date the employee or qualified beneficiary moves out of insurer's services area.

Shorter Maximum for Health FSAs

The maximum federal COBRA period for a health flexible spending arrangement (health FSA) maintained by the Employer (if there is a positive account balance as of the date of the qualifying event) ends on the last day of the plan year in which the qualifying event occurred. If there is a negative account balance as of the date of the qualifying event, no COBRA coverage will be offered.

Continuation of Coverage for Military Service

A federal law called the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) gives you certain rights to maintain health plan coverage (this would include medical, dental, vision, and health care spending account coverage) during military leaves covered by USERRA.

If you are covered under the FLYR Plan's health benefits and become absent from employment with your employer due to USERRA-covered military service for a period of more than thirty-one (31) days, you will be deemed to be on an approved unpaid leave of absence while performing the military services. You will be entitled to all of the rights and benefits under the Plan's health benefits that are available to a covered employee on an unpaid leave of absence for the duration of the military leave or, if less, twenty-four (24) months, provided you elect to continue the coverage and pay the required premiums within the time and in the manner required for electing COBRA continuation coverage as described in the previous section of this SPD under "COBRA Continuation Coverage." Coverage elected in this manner will be treated as running concurrently with your COBRA coverage (so that, for example, if your military leave lasts for twenty (20) months, the first eighteen (18) months will be considered as both USERRA and, if applicable, COBRA continuation coverage, and the remaining coverage will be provided solely under USERRA rules). For the duration of the military leave, or twenty-four (24) months, if less, the participant's applicable premium will equal 102% of the cost of coverage.

Except to the extent the health coverage for your spouse or your dependents under the FLYR Plan is further extended under the COBRA continuation coverage provisions (for example, because of a qualifying event such as your death or divorce), your coverage will terminate after twenty-four (24) months on military leave or, if sooner, on the date after you fail to return to active employment after your military leave.

If you return to active employment within the time required for reinstatement under USERRA at the expiration of your military service or twenty-four (24) months, if less, your coverage and your spouse's and dependent's coverage will be immediately reinstated to the extent you and your spouse and dependents were covered under the FLYR Plan on the day before your military leave began. If you return to active employment after more than twenty-four (24) months of military service, but within the period required for reinstatement under USERRA (generally five (5) years), you will, upon qualifying as an eligible employee, become a participant under the same provisions as if you were a new employee, except that no waiting period or exclusions shall apply unless permitted under USERRA.

Refer to FLYR's leave policies and employment policy notices for further information about USERRA, including its effect on your rights, such as reinstatement rights, under other benefit programs.

Women's Health & Cancer Rights Act of 1998

In the case of an employee or dependent who receives benefits under the plan in connection with a mastectomy and who elects breast reconstruction (in a manner determined in consultation with the attending physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which mastectomy has been performed, including nipple and areola reconstruction and re-pigmentation to restore the physical appearance of the breast;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary". Benefits will be provided on the same basis as for any other illness or injury under the Plan.

If you would like more information on WHCRA benefits, contact the FLYR People team at benefits@flyr.com.

Newborns' and Mothers' Health Protection Act of 1996

Under federal law (Newborns' Act), group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan, or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification.

A number of states adopted requirements for benefits covering maternity stays prior to the enactment of the Newborns' Act. The federal law does not preempt state law if the state law meets certain criteria. For more information, contact the FLYR People team at benefits@flyr.com.

Patient Protection Disclosure – Non-Grandfathered Plans

Your Health Plan generally requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you and/or your family members. Until you make this designation, your Health Plan may designate one for you. For information on how to select a primary care provider, and for a list of participating primary care providers, contact the phone number or website on the back of your ID card or contact the FLYR People team at benefits@flyr.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your Health Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network or those who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the phone number on the back of your ID card.

Rebates for Failure to Meet Medical Loss Ratio Requirements

In the event that FLYR, Inc. qualifies and receives a return of premium (Rebate) as a result of an insurance issuer's failure to meet the Medical Loss Ratio requirements under the Affordable Care Act, FLYR, Inc., at its option, shall either:

- Reimburse Plan participants through a payroll adjustment in the amount determined under the Affordable Care Act regulations;
- Reduce employee contributions by an amount determined under Affordable Care Act regulations to reflect the employee's share of the Rebate; or
- Use the Rebate to enhance benefits under the Plan by an amount determined under Affordable Care Act regulations.

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 balance billed for these post-stabilization services.

In addition to federal law, California law protects members who get emergency services from an out-of-network provider or facility, the most they can bill you is your plan’s in-network cost-sharing amount (such as copayments, coinsurance and deductibles). 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 balance billed for these post-stabilization services.

For other state laws, please contact the FLYR People team at benefits@flyr.com for more information.

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, the 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.

In addition, California law generally contains balance billing protections similar to those under the No Surprises Act, except that the balance billing prohibitions also apply to services received in additional in-network facilities, including laboratories or radiology imaging centers. California also has an independent dispute resolution process to resolve claims-related issues, including disputes with your provider pertaining to receipt of improper balance bills, which can be initiated through the California Department of Insurance.

For other state laws, please contact the FLYR People team at benefits@flyr.com for more information.

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, contact the phone number on the back of your health care ID Card. You may also file a complaint with California Department of Managed Healthcare at 1-888-466-2219 or California Department of Insurance (800) 927-4357.

Visit <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act> for more information about your rights under federal law.

Your Rights under The Family and Medical Leave Act

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

You must meet all of the following criteria to be eligible:

1. Have worked for FLYR for at least 12 months as of the leave start date (the 12 months need not be consecutive for full-time)
2. Have at least 1,250 hours of service for FLYR during the 12 months immediately before the leave start date
3. Works at a location where FLYR employs at least 50 employees within 75 miles on the date notice is given

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with job-protected leave for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take up to **12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 workweeks** of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA **leave intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different “hours of service” requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, to **request FMLA leave you must**:

- Follow your employer’s normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, **your employer must notify you in writing:**

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit www.dol.gov/fmla to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process.**

DEPARTMENT OF LABOR
UNITED STATES OF AMERICA
WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

SCAN ME



WH1420

Medicare Part D Annual Notice: Creditable Coverage

Important Notice from FLYR, Inc. about your Creditable Prescription Drug Coverage and Medicare

If you or your dependents have Medicare or will become eligible for Medicare within the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please read the following notice for more details.

Please read this notice carefully. It has information about your prescription drug coverage under the FLYR health plan (Employer Plan) and the coverage options available to Medicare Part-D eligible individuals. This notice also provides information on additional resources that may help you decide which prescription drug coverage to choose.

You should keep this notice with your important records. If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Notice of Creditable Coverage

The purpose of this notice is to advise you that the Employer Plan prescription drug coverage listed below is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay. This is known as “creditable coverage.”

FLYR Medical Plans for January 1, 2024 - December 31, 2024:

- Cigna Base PPO
- Cigna Buy-up PPO
- Cigna HSA
- Kaiser HMO California
- Kaiser HMO Northwest

Why this is important: Coverage under one of these plans may help you avoid a Medicare Part D late enrollment penalty. If you or your covered dependent(s) are enrolled in the Employer Plan and are currently or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty—as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment.

Late Enrollment Penalty (Higher Premium Charge)

You should know that if you waive or drop coverage under the Employer Plan and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Medicare Part D premium may go up by at least 1% per month for every month that you do not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium may consistently be at least 19% higher than what most other people pay. You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Medicare Part D.

Medicare Prescription Drug Coverage

You may have heard about Medicare's prescription drug coverage called Medicare Part D and wondered how it would affect you. Medicare offers prescription drug coverage to everyone with Medicare. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become Part D eligible, and each year thereafter during Medicare open enrollment (October 15 through December 7). Individuals who decide to drop their creditable employer/union coverage may be eligible for a two-month Medicare Special Enrollment Period.

Interaction Between Coverages

If you are covered by a FLYR medical plan, you will be interested to know that prescription drug coverage in the FLYR medical plan is, on average, at least as good as standard Medicare prescription drug coverage. This is called creditable coverage. Coverage under a FLYR medical plan will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop FLYR coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the FLYR plan.

You should know that if you waive or drop coverage with FLYR Medical Incorporated and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium may go up by at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium may consistently be at least 19% higher than what most other people pay. You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

Additional Information

NOTE: You may receive this notice at other times in the future—such as before the next period you can enroll in Medicare prescription drug coverage, if the FLYR coverage changes, or upon your request.

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. Medicare participants will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For information about this extra help, contact the Social Security Administration (SSA) online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan, you may be required to provide a copy of this notice when you join a Part D plan to show that you have maintained creditable coverage and, therefore, may not be required to pay a higher Part D premium.

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

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, you can 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)**.

If you live in California, you can contact the California Department of Health Care Services for further information on eligibility at: www.dhcs.ca.gov, Email: HIPP@dhcs.ca.gov
 U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.gov, 1-877-267-2323, Menu Option 4, ext. 61565

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
<p>Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442</p>	<p>Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268</p>
GEORGIA – Medicaid	INDIANA – Medicaid
<p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>	<p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-for-ms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
MONTANA – Medicaid	NEBRASKA – Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218</p>
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>	<p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
<p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
<p>Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)</p>	<p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)</p>
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
<p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
TEXAS – Medicaid	UTAH – Medicaid and CHIP
<p>Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493</p>	<p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
<p>Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427</p>	<p>Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924</p>
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
<p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>	<p>Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
<p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>	<p>Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269</p>

To see if any other states have added a premium assistance program since July 31, 2023, 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