



COBRA Benefits Guide

YOUR 2026 BENEFITS CHOICES



Do Good. Bank Better.™



Important Information Regarding Your Benefits upon Separation of Employment

Medical, Dental, and/or Vision

These benefits will end as of the last day you are an active employee of VyStar.

Information will be mailed to you at your last known address of record regarding continuation of your benefit coverage under COBRA. The cost for COBRA continuation of these benefits valid from 1/1/2026 – 12/31/2026 are provided in this guide.

You will receive a COBRA election notice mailed to your last known home address from our COBRA administrator, Ameriflex containing election instructions.

Life, Disability & Voluntary Worksite Coverages (Accident, Critical Illness, Hospital, and Legal)

These benefits will end as of the last day you are an active employee of VyStar.

Life and Voluntary Worksite Coverages may be eligible to "port or convert" to individual life policies. You will have only 90 days from your last day of employment to apply. Don't miss your chance to keep this insurance. Contact Unum's Customer Contact Center at 1-866-220-8460 for a pre-filled application package. While there is a 90-day period to apply, coverage is not continued for the entire 90 days.

401(k)

If you have a balance in the VyStar Credit Union 401(k) Plan; you may roll your vested portion of your account balance into an IRA at a financial institution or another qualified plan, you may request a cash distribution of your vested account balance, less 20% mandatory Federal tax withholding and if your state requires, state taxes will be withheld as specified by state tax code. If the vested value of your account balance is greater than \$5,000 you may leave the money in the plan.

You are encouraged to speak with a Financial Advisor regarding your distribution options. Information will be mailed to you at your last known address regarding your 401(k) options. If you have any questions, please contact Michelle Hagan, VyStar 401K Manager at 904-420-5192. You will need to contact Fidelity at 800-835-5097 to select a distribution option.

HSA and FSA

Health Savings Accounts are employee-owned accounts and will be transferred to a direct account with Ameriflex upon termination, as of the last day you are an active employee of VyStar.

Healthcare & Dependent Care FSA's will end as of the last day you are an active employee of VyStar. You will be able to submit for reimbursement of expenses incurred prior to termination within the 90-day runout period.

Healthcare FSA accounts with a positive balance are COBRA eligible and will be included in your COBRA notice. To access those funds for the remainder of the plan year you will need to elect COBRA; otherwise, you will only be able to submit for reimbursement of expenses within the 90-day run-out period mentioned above.

Important Information Regarding Your Benefits upon Separation of Employment

EAP

EAP coverage is extended automatically for 18 months post termination of employment.

PTO & Time Off

Eligible employees will receive a PTO payout at 75% of their unused PTO hours. The PTO payout will be included in your final paycheck.

The extra 3 days (Celebrate You, Pay It Forward and Health Day) are not PTO. They are Floating Holidays. These days are not payable upon separation from VyStar.

Tuition Assistance

If your employment with VyStar Credit Union ends and payment has been made, you are required to repay VyStar for the amount paid. If your employment with VyStar Credit Union ends and payment has not been made but has been approved, we will instruct EdAssist to not make the payment. Please note that you will be responsible for paying the College for the courses you are enrolled in.

You are encouraged to speak with a Financial Advisor regarding your distribution options.

Update Your Contact Information

Please be sure your mailing address and personal email address is up to date in Workday.

Workday Access Post Employment

You will have access to Workday for a period of three years after leaving VyStar. Please use the below link to access the VyStar Workday Employee Portal. Your account will automatically be suspended at the end of the access period. Please make sure to save copies of pay slips, if required.

<https://www.myworkday.com/vystarcu/login.flex?redirect=n>

Username: last name first initial (your previous network log-in, aligns with email ID)

Password: #VyStarWDEmp5678

The system will prompt you to change your password upon first sign in. Please make a note of your new password.

If you have any questions regarding your Workday account during the three-year access period, please contact ITWorkday@vystarcu.org

MEDICAL

Quality health coverage is one of the most valuable benefits you enjoy as a VyStar employee. Our benefit programs offers plans to help keep you and your family healthy and provide important protection in the event of illness or injury.

Freedom of Choice

We offer three medical plans through Blue Cross Blue Shield, giving you the flexibility to choose what's best for your needs and your budget.

- BCBS 1250, an EPO (In-network only)
- BCBS 1500, a PPO
- BCBS HDHP, a PPO

Key features

All of VyStar's medical plans offer:

- Comprehensive, affordable coverage for a wide range of health care services.
- The same in-network providers and facilities under all three plan options, including Baptist Health and Mayo Clinic. Search network providers [here](#).
- In-network preventive care, with services covered at 100%, including annual physicals, recommended immunizations, well-woman and well-child exams, flu shots, and routine cancer screenings.
- Prescription drug coverage included with each medical plan.
- Financial protection through annual out-of-pocket maximums that limit the amount you'll pay each year.
- Choice of coverage levels
 - Self Only
 - Self + Spouse
 - Self + Child(ren)
 - Family

Which plan is right for you?

Consider which plan features are most important to you. Do you want to:	BCBS 1250	BCBS 1500	BCBS HDHP
Open and contribute to a tax-free HSA, which has no "use it or lose it" rule and offers the opportunity to invest money or future medical costs?			Yes
Pay the lowest premium cost, which may make it the least expensive option if you expect to have low health care usage?			Yes
Balance your out-of-pocket and paycheck costs with a moderate deductible and premium cost?		Yes	
Pay less out of pocket, co-pays, and deductibles by staying within the exclusive provider network when you need care?	Yes*	Yes	

*BCBS 1250 only provides in-network coverage

Medical plan costs: Monthly

You pay the full cost of your medical benefits including a 2% COBRA administration fee. Your specific cost is based on the plan and coverage level you selected.

Coverage level	BCBS 1250	BCBS 1500	BCBS HDHP
Self Only	\$882.68	\$856.65	\$745.56
Self + Spouse	\$1,853.62	\$1,798.95	\$1,570.76
Self + Child(ren)	\$1,677.06	\$1,627.61	\$1,411.44
Family	\$2,648.03	\$2,569.94	\$2,287.67

Compare Medical Plans

The chart below provides a comparison of key coverage features and costs.

	BCBS 1250 (In-network Only)		BCBS 1500 (PPO)		BCBS HDHP (PPO)	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Calendar Year Deductible (CYD)						
Per person/per family	\$1,250/\$2,500	No Coverage	\$1,500/\$3,000	\$5,000/\$10,000	\$3,400/\$6,800	\$6,800/\$13,600
Out-of-pocket maximum¹						
Per person/per family	\$5,000/\$10,000	No Coverage	\$6,750/\$13,500	\$13,500/\$27,000	\$6,550/\$13,100	\$13,100/\$26,200
Coinsurance %						
% you pay, if applicable	20%	No Coverage	20%	40%	30%	50%
Common Services						
Primary Care office visits	\$20 copay	No Coverage	\$30 copay	CYD + 40%	CYD + 30%	CYD + 50%
Preventive care	\$0 copay	No Coverage	\$0 copay	CYD + 40%	\$0 copay	CYD + 50%
Specialist office visits	\$40 copay	No Coverage	\$60 copay	CYD + 40%	CYD + 30%	CYD + 50%
Teladoc General Med	\$0 copay	No Coverage	\$0 copay	No Coverage	\$0 copay	No Coverage
Teladoc Primary Care	\$10 copay	No Coverage	\$15 copay	No Coverage	\$10 copay	No Coverage
Teladoc Mental Health & Dermatology	\$20 copay	No Coverage	\$30 copay	No Coverage	\$20 copay	No Coverage
Outpatient surgery	CYD + 20%	No Coverage	CYD + 20%	CYD + 40%	CYD + 30%	CYD + 50%
Inpatient hospital (per stay)	CYD + 20%	No Coverage	CYD + 20%	CYD + 40%	CYD + 30%	CYD + 50%
Urgent Care	\$30 copay	No Coverage	\$50 copay	CYD + 20%	CYD + 30%	CYD + 30%
Emergency room ³	\$500 copay	\$500 copay	CYD + 20%	CYD + 20%	CYD + 30%	CYD + 30%
X Rays (Independent / Hospital)	\$0 / CYD + 20%	No Coverage	\$0 / CYD + 20%	CYD + 40%	CYD + 30%	CYD + 50%
Advanced Imaging (Independent / Hospital)	\$150 / CYD + 20%	No Coverage	\$150 / CYD + 20%	CYD + 40%	CYD + 30%	CYD + 50%
Retail prescription drugs (31-day supply)⁵						
Generic	\$15 copay	No Coverage	\$15 copay	No Coverage	CYD + \$15 copay	No Coverage
Brand Formulary	\$35 copay	No Coverage	\$35 copay	No Coverage	CYD + \$35 copay	No Coverage
Non-formulary	\$60 copay	No Coverage	\$60 copay	No Coverage	CYD + \$60 copay	No Coverage
Specialty	\$200 copay	No Coverage	\$200 copay	No Coverage	CYD + \$60 copay	No Coverage

¹ Includes your deductible, coinsurance and copays

² IMPORTANT: If a member requests multiple visits for the same service within a 24-hour period, the member will be asked to pay the full \$55 visit cost

³ Plan will pay 100% of billed charges for REAP Providers (Radiologists, Emergency Room Physicians, Anesthesiologists and Pathologists) when out-of-network REAP services are provided in the ER setting.

⁴ Will pay for out-of-network coverage in emergency situations (i.e. stroke, heart attack, other true emergency)

⁵ The prescription drug coverage for all group medical plans offered is considered to be Medicare Part D creditable coverage. Pharmacy Management Programs included in all group medical plans offered including Mandatory Generic, Prior Authorization, Step Therapy and Specialty Medications.

Money-saving tips - To stretch your health care dollars, remember to:

- **Visit in-network providers** who have agreed to accept lower negotiated rates. No balance billing!
- **Use the mail-order pharmacy** to save time and money when filling long-term prescriptions. Get a 90-day supply for 2.5x's the retail co-pay!
- Contribute into the HSA or Healthcare FSA to pay for out-of-pocket healthcare costs with pre-tax dollars!

Dental

Healthy teeth and gums are important to your overall wellness. That’s why it’s important to have regular dental checkups and maintain good oral hygiene. Learn about the dental plans available to help you maintain your oral health.

	Low Plan	High Plan
Annual deductible (per person/per family)	\$50/\$150	\$50/\$150
Calendar-year maximum (per person)	\$1,250	\$2,500
Preventive/diagnostic services	Covered in Full	Covered in Full
Basic services	80%	80%
Major services	50%	50%
Orthodontia (adult and children)	Not Covered	50%
Orthodontia Max	Not Applicable	\$2,000

Benefits shown are for in-network providers and are based on negotiated fees. Out-of-network coverage varies per plan. On the Low Plan, you are responsible for the difference between the amount your dentist charges and the in-network contracted amount. On the High Plan you are responsible for the difference between the amount your dentist charges and the usual and customary amount.

Examples of services:

- Preventive – Cleanings, exams, sealants, x-rays
- Basic – Fillings, extractions, endodontia, periodontia
- Major – Inlays, onlays, crowns, bridges, implants

Dental Costs: Monthly

You pay the full cost of your dental benefits including a 2% COBRA administration fee. Your specific cost is based on the plan and coverage level you selected.

Plan	Self Only	Self + Spouse	Self + Child(ren)	Family
Low Plan	\$23.56	\$40.79	\$53.61	\$75.09
High Plan	\$39.58	\$69.08	\$90.48	\$126.84

Vision

Having vision coverage allows you to save money on eligible eye care expenses, such as periodic eye exams, eyeglasses, contact lenses, and more for you and your covered dependents.

	Vision Plan
Exam (once every 12 months)	\$10 copay
Lenses (once every 12 months), standard	\$15 copay
Lenses (once every 12 months), progressive	\$30 copay
Frames (once every 24 months)	\$0 copay, \$130 allowance, 20% discount off remainder
Contact lenses (instead of glasses), disposable	\$0 copay; \$130 allowance, 15% discount off remainder
Contact lenses (instead of glasses), conventional	\$0 copay; \$130 allowance, 15% discount off remainder

Benefits shown are for in-network providers and are based on negotiated fees. Costs savings will be the highest when you use a provider that participates in the Eyemed Insight Network.

Discounts:

- Contacts Direct: Save \$20 of your next order of contacts and free shipping, [ContactsDirect.com](#)
- Eye Rewards: \$25 off any purchase or \$50 off purchases of \$200+ at [Sunglass Hut](#)
- Lasik Plus: Eyemed has partnered with the U.S. Laser Network to make laser vision corrections more affordable to its members

More discounts available at [EyeMedVisionCare.com](#).

Vision Costs: Monthly

You pay the full cost of your vision benefits including a 2% COBRA administration fee. Your specific cost is based on the coverage level you selected.

Plan	Self Only	Family
Vision	\$6.38	\$18.24



Important Contacts

Please contact the appropriate provider listed below to learn more about a specific benefit plan.

Benefit Plan	Provider	Phone Number	Website
Medical & Prescription	BCBS (Group #6024N)	877-317-7453	Myhealthtoolkitfl.com
Savings Accounts (HSAs and FSAs)	Ameriflex	888-868-3539	MyAmeriflex.com
Dental	Delta Dental (Group #10-0419)	800-521-2651	Deltadentalins.com
Vision	EyeMed (Group #1018633)	866-939-3633	Eyemedvisioncare.com
Employee Assistance Program (EAP)	ComPsych	866-380-1275	Guidanceresources.com Web ID: VyStarEAP
Telemedicine services	Teladoc	800-Teladoc (800-835-2362)	myhealthtoolkitfl.com
Life and AD&D insurance	UNUM (Group #997956)	For Existing Life Claims ONLY: 866-868-6737 *Note: Life & AD&D claims are submitted by VyStar HR	
401(k) savings plan	Fidelity (Plan #32302)	800-835-5097	401k.com
COBRA Administration	Ameriflex	888-868-3539	MyAmeriflex.com
Tuition Assistance	EdAssist	877-348-0756 855-687-7636 (Fax)	
Internal Contacts			
VyStar Benefits Team	76 S. Laura Street Jacksonville, FL 32202		Benefitsadmin@VyStarcu.org
Lisa Morris	VP of Benefits	904-420-5056	morrisl@vystarcu.org
Brendi Mowles	Sr. Benefits Specialist	904-908-2592	mowlesb@vystarcu.org
Martina Montgomery	Benefits Specialist	904-474-6320	montgomerym@vystarcu.org
Michelle Hagan	AVP, Employee Financial Wellness	904-420-5192	haganm@vystarcu.org
Liz Ross	AVP, Leave of Absence	904-908-2415	rossl@vystarcu.org
Melanie Crum	Sr. Leave of Absence Specialist	904-474-6389	crumm@vystarcu.org
Jordyn Strommer	Recognition & Wellness Supervisor	904-908-2642	taylorj@vystarcu.org
Julia Jackson	Recognition & Wellness Coordinator	904-474-6325	jacksonj5@vystarcu.org
VyStar Investment Services (VIS)		904-908-2495	vismarketing@vystarcu.org
VyStar Insurance Agency		877-997-2221, option 2	insurance@vystarcu.org
VyStar Everyday Heroes		(800) 445-6289, option 3	Vystarcu.org/heroes
VyStar Military Heroes		(800) 445-6289, opt 4 then ext. 2660	Vystarcu.org/heroes

Need Healthcare Advocate Support?

VyStar is pleased to offer access to MyAdvocate from CareNet. MyAdvocate is a confidential - no cost - benefit available to VyStar employees that delivers personalized, compassionate support - working closely with you, your insurance carriers and your healthcare providers to navigate the complex world of healthcare. Advocates are available to help you with Benefits education and navigation Billing and claims assistance Coordination of care ...and more!

Phone: 833-968-1775 (24/7 intake)
Website: MyAdvocateServices.com

NOTICES & DISCLOSURES

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other medical insurance or group medical plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for the other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after your coverage or your dependents' coverage ends (or after the employer stops contributing toward the other coverage).

In addition, you may be able to enroll yourself and your dependents if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, if your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption or within 60 days of the date of loss of CHIP coverage. To request a special enrollment or obtain more information, contact Human Resources.

Portability of Coverage

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 entitles you to a complete transfer of benefits (no pre-existing condition exclusions) if you change jobs or your employer changes insurance carriers. To guarantee the portability of your benefits, your previous coverage must not have lapsed for more than 63 days prior to your new eligibility date, and you must provide proof of prior coverage to your new employer.

HIPAA Notice of Privacy Practices

The HIPAA Notice of Privacy Practices is posted on Workday. Paper copies are also available, free of charge, from Human Resources.

Medicare Part D Credible Coverage Disclosure Notice

What is considered creditable coverage? Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Medicare Part D) prescription drug coverage is considered creditable if the amount the plan expects to pay on average for prescription drugs for individuals covered by the plan in the applicable year for which the disclosure notice is being provided is the same or more than what standard Medicare prescription drug coverage would be expected to pay on average. If the prescription drug coverage does not meet these standards it is considered to be non-creditable. VyStar's prescription drug plans are considered creditable coverage under Medicare Part D standards. Why is creditable coverage important? Making sure you have creditable coverage is important. If you fail to enroll in Medicare Part D when you first become eligible or if you drop or lose your creditable coverage and don't join a Medicare drug plan within 63 continuous days after your creditable coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later, which can only be done from October 15th through December 7th of each year. How can I find out more? 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

Benefits Termination & COBRA

When does coverage end?

Your benefits will end as of the last day you are an active employee, the day you either elect not to participate in the plan, or end of month for ineligible dependents of an active employee.

What is COBRA Continuation Coverage?

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) provides insured employees and their covered spouse and child(ren) ("qualified beneficiaries"), the opportunity to continue group medical, dental, and vision coverage when a "qualifying event" would normally result in the loss of coverage eligibility. Common qualifying events include, but are not limited to, resignation or termination from employment, the death of an employee, a reduction in employee's hours, an employee's divorce, and dependent children no longer meeting eligibility requirements. Under COBRA, the employee and/or dependent pays the full cost of coverage at the current group rates plus a 2% administrative fee.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Employer and Plan Administrator have been notified that a qualifying event has occurred. COBRA continuation coverage generally lasts for up to a total of 18 months, which can be extended for a total of 36 months in certain circumstances, or a total of 29 months due to disability.

Keep Human Resources Informed of Address Changes

In order to protect your family's rights, you should keep Human Resources informed of any address changes for you or your family members. You should also keep a copy, for your records, of any notices you send.

You Must Give Notice of Certain Qualifying Events

For the certain qualifying events, such as divorce or legal separation of the employee and spouse, dependent child's losing eligibility for coverage as a dependent child, or if you or a covered dependent becomes disabled before the 60th day of COBRA continuation coverage, you must notify the Plan Administrator within 60 days after the qualifying event occurs. Your notification must include a description and date of the event, documentation to validate the event (divorce decree, court order, death certificate, Social Security award letter, etc.), and must be sent to your plan administrator (see the contact list on the last page). How can I find out more? This is a general explanation. For more information on COBRA and the group medical, dental and vision plans contact your plan administrator, our benefits agency, Mercer. The contact information for both parties is listed on the last page of this booklet. More information can also be found at www.dol.gov/ebsa/cobra.html.

Newborns' and Mothers' Health Protection

Group health plans and health insurance issuers generally may not, under federal law, 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 cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICES & DISCLOSURES

Children's Health Insurance Program

The notice that describes this program is posted on Workday. Paper copies are also available, free of charge, from Human Resources.

Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage will be subject the same benefit levels deemed appropriate for other medical and surgical procedures that are covered under this plan.

A Note About Social Security

Pre-tax deductions taken from your paycheck lowers your taxable income. Therefore, your Social Security taxes (and, consequently, your future Social Security benefits) may be lower. How you are affected depends on your pay and the amount of pre-tax contributions you make.

The reduction on Social Security benefits, if any, for most employees will be minimal – a few dollars a month. Younger employees who use large amounts of tax-free dollars to pay for benefits over a long period (20 to 30 years) may experience a greater reduction in benefits when they retire. However, for most people, the benefit reduction has been more than offset by the tax savings. For more information, please contact your local Social Security Administration office.

Pre-Tax or Post-Tax?

For some benefits, you can use pre-tax dollars from your pay. For others, you must use after-tax dollars. When you pay for benefits with pre-tax dollars, money is deducted from your pay before taxes are taken out. This way, you avoid paying Federal Income taxes on what you spend on qualified benefits.

With after-tax contributions, just the opposite is true. They're deducted from your pay after Federal Income taxes are calculated and deducted from your gross pay.

Health Care Reform: Affordable Care Act Summaries of Benefits and Coverage

The Patient Protection and Affordable Care Act (PPACA) requires health plans and health insurance issuers to provide uniform summaries of benefits and coverage (SBC). These SBCs are provided by our medical insurance carrier. You can access the SBCs on Workday. Paper copies are also available, free of charge, by calling Blue Cross Blue Shield Member Services. This notice is provided to eligible employees. It is the responsibility of the employee to share this information with eligible dependents. You can request a copy of this notice to be sent to eligible dependents that reside at an address other than your own by contacting Human Resources and providing the separate mailing address.

Health Insurance Marketplace (Exchange)

This section provides some basic information about the new Health Insurance Marketplace and employment-based health coverage offered by your employer. The Exchange Notice of Coverage Options is available on Workday and from the Human Resources Department.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. You may also be eligible for a tax credit that lowers your monthly premium. The annual open enrollment periods are listed below. An individual generally cannot enroll in a QHP outside of the open enrollment period, unless a special enrollment period applies.

2026 Coverage: November 1, 2025 – December 15, 2025

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 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 the least expensive plan that meets "minimum value" standards offered by your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, 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.

Our group medical coverage has been determined to meet affordability and "minimum" value standards as required by the Affordable Care Act. This means that employees eligible for participation in our group medical coverage are not eligible for a premium reduced policy through the Marketplace. Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you will lose the employer contribution 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. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost.

Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace.

NOTICES & DISCLOSURES

No Surprises Act

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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 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.

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 can 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 types of 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 are never required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have these protections:

You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

Generally, your health plan must:

— Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the Employee Benefits Security Administration at 1-866-444-EBSA(3272) for group health plans that are subject to ERISA, or the Department of Health and Human Services at 1-888-393-2789 for group health plans that are not subject to ERISA. The federal phone number for information and complaints is: 1-800-985-3059.

You may also receive help through an applicable state consumer assistance program. Visit <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc> for contact information by state.

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

Summary of Material Modifications

This enrollment guide does not constitute a Summary of Material Modifications (SMM) to the carrier summary plan descriptions (SPD) for any of the benefit plans offered, which govern the plans' operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will prevail.

Wellness Program Notices

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Human Resources and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Note: when outcome-based programs inform enrollees of their failure to meet the original standard, the notice must indicate the availability of a reasonable alternative to qualify for the reward (and, if applicable, the possibility of a waiver).



This guide is intended to describe the eligibility requirements, enrollment procedures, plan highlights, and coverage effective dates for the benefits offered by VyStar. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While the guide is a tool to answer many of your benefit questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern the plans' operation. The noted plan changes in this guide do not serve as a Summary of Material Modifications (SMM) to the SPD. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will prevail.