MYcroSchool
my school, my way

2026-2027 BENEFIT GUIDE

Benefits Designed for You

MYcroSchool, Inc

Table of Contents

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 35 for more details.

Welcome to Your Benefit Guide

MYcroSchool, Inc is proud to offer a comprehensive benefits package to you and your family through our 2026-2027 Health and Welfare Benefits Plan. We understand that our employees have diverse needs, and so we have developed a well-rounded plan capable of helping to protect you and your family members in the case of illness or injury.

This Benefits Information Guide provides necessary plan and program information to help you understand your many benefit options and ultimately enroll in the benefits that work best for you and your family for the 2026-2027 Plan Year. We hope that our guide can be an effective and comprehensive resource while you consider your benefit elections.

This document contains a summary in English of information about your upcoming benefits enrollment. If you have difficulty understanding any part of this document, contact your Plan Administrator:

Denise Castro
352-586-1364
Denise.Castro@newmycro.org

Benefit Offering Directory

Medical
UnitedHealthcare NHP
www.myuhc.com

Dental
Guardian
1-800-541-7846
www.guardiananytime.com

Vision
Guardian
1-800-877-7195
www.guardianlife.com

Life and AD&D
Guardian
1-800-627-4200
www.guardianlife.com

Disability
Guardian
1-800-627-4200
www.guardianlife.com

Health Savings Account (HSA)
HealthEquity
1-866-346-5800
www.healthequity.com

Legal Plan & ID Theft
LegalShield/IDShield
1-800-654-7757
1-888-494-8519

Worksite Products
Guardian
1-877-500-2386
www.guardianlife.com

Pet Insurance
Spot
888-343-2340
https://spotpet.link/mycroschool

What’s New

This section constitutes a Summary of Material Modifications (SMM) to the Summary Plan Description (SPD) for the Plan, thereby modifying the information previously presented in the SPD with respect to the Plan.

You should review this information carefully and share it with your covered dependents. Keep this information with your SPD for future reference. In the event of a conflict between the official Plan Document and this SMM, the SPD, or any other communication related to the Plan, the official Plan document(s) will govern.

The following updates to benefit coverage under the MYcroSchool, Inc health and welfare plans will take effect on October 1st, 2026.

MEDICAL PLAN CHANGES

This year, our Medical Benefits will be transitioning to UnitedHealthcare. Plan options and rates are detailed in the Medical Benefits section, and you can review the full Summary of Benefits and Coverage (SBC) for a comprehensive overview of this year's offerings.

If you have questions about any part of this document, contact your Plan Administrator:

Denise Castro
352-586-1364
Denise.Castro@newmycro.org

Benefit Enrollment Information

1. WHEN DO I ENROLL?

Current employees will make all your benefit elections for the upcoming plan year during Open Enrollment from September 2, 2026 to September 11, 2026. During this time, you will be able to enroll in new benefits or change your current elections as well as add or remove dependents. Any of these changes or additions will be effective from October 1, 2026 through September 30, 2027.

New hires must sign up for benefits by 1st day of the month following one-month of full-time employment.

2. HOW DO I ENROLL?

MYCROSCHOOL, INC provides one way to enroll in benefits, Employee Navigator.

• Use our company code: **MYcroSchool** to access Employee Navigator's user-friendly benefits portal where you can confirm your benefits plan and/or make qualified life event changes.

3. WHO CAN ENROLL?

There are certain restrictions surrounding eligibility for benefit enrollment. If you are an employee who regularly works 30 hours or more per week, you will be eligible for benefits on the 1st day of the month following 1 month of full-time employment.

If you meet the above requirements, your legal spouse, domestic partner, or dependent child(ren) are also eligible for our benefits plan. As a reminder, a dependent child is:

- your natural born child, legally adopted child, or stepchild
- a child you have been appointed legal guardian of as a foster parent,
- a child you are required to cover under a Qualified Medical Child Support Order, or
- a child who is totally and permanently disabled, incapable of self-support because of a mental or physical handicap, and is financially supported by you

NOTE*: Your dependent children are generally eligible only up until age 26, but can be eligible up until age 30 if they meet specific requirements. In Florida, unmarried dependent children may be covered for health insurance beyond age 26 up to age 30 if they meet certain criteria:*

- *They are a Florida resident or a full-time or part-time student*
- *They are not covered by any other group health insurance policy or individual health benefits plan*
- *They are not entitled to benefits under Title XVIII of the Social Security Act*
- *They are not married and have no dependents (i.e., children, spouse, or domestic partner)*

Benefit Enrollment Information

5. BENEFIT TERMINATION RULES

Should your employment terminate, or your work status change, making you ineligible for benefits, your benefits will terminate at the end of the month. Life and disability coverage will terminate on the date of employment termination.

4. MAKING PLAN CHANGES

Existing employees can only make plan changes during the Open Enrollment window and cannot make additional changes to your coverage during the year unless you experience a qualified family status change. Below, we have included a few examples of qualified family status change events:

1. Special Enrollment Events (Add coverage for yourself and/or dependents).
   - Involuntary loss of other group coverage
   - Acquisition of new dependent through marriage, birth, or adoption
   - Change in Medicaid or CHIP eligibility
2. Internal Revenue Code (IRC) Section 125 Status Change Events (Add, cancel, or change coverage for yourself and/or dependents).
   - Involuntary loss or gain of other group coverage
   - Divorce
   - Death of covered spouse or child
   - Change in employment status
   - Medicare entitlement

If you think you have experienced a qualified family status change event, you will need to verify the event with Human Resources within 30 days of its occurrence. (60 days in the case of Medicaid or CHIP eligibility).

IMPORTANT

This information is not accounting, tax, or legal advice—please contact your accounting, tax, or legal professional for such guidance. This information should not be relied upon as advice regarding any individual situation.

It is a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the policy. If there are any discrepancies between the illustrations contained herein and the insurance carrier proposal or contract, the insurance carrier materials prevail. See insurance company contract for full list of exclusions.

Insurance Glossary

Here is a list of relevant insurance-related terms to help you navigate the information provided in this guide.

Healthcare Provider

A healthcare provider is a person or company that provides a healthcare service to you, such as a dentist, primary care physician, chiropractor, clinical social worker, etc.

In-Network

Doctors, clinics, hospitals, and other providers are considered in network when they have made an agreement to care for the health plan's members. Health plans cover a greater share of the cost for using in-network healthcare providers than for providers who are out of network.

Out-of-Network

A health plan will cover treatment for doctors, clinics, hospitals and other providers who are out of network, but covered employees will pay more out of pocket to use out-of-network providers than for in-network providers. Employees are also responsible for any difference between what the provider charges and the insurance company pays.

Copay

A copay is a fixed-dollar amount that a plan member pays to a participating network doctor, caregiver, or other medical provider or pharmacy each time healthcare services are received.

Preventative Care Services

Covered services intended to prevent disease or to identify disease while it is more easily treatable. Examples of preventive care services include screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. Your policy specifies what qualifies as preventive coverage at a 100% level.

Deductible

A fixed-dollar amount that a plan member must pay for eligible services before the insurer begins applying insurance benefits. Deductibles are part of certain healthcare plans and based on a plan member's specific benefit period.

Out-of-Pocket Maximum

The highest dollar amount you will need to pay during your benefit period for covered medical services from network providers. See your plan benefit for a list of services included.

Coinsurance

The portion of an eligible medical bill a plan member must pay. Coinsurance amounts are usually a percentage of the total eligible medical bill, such as 20%. Coinsurance applies after the member meets a required deductible or copay amount. Coinsurance is part of certain healthcare plans.

HEALTH PLANS

Medical
Dental
Vision
Health Savings Accounts

Medical Plans

MYCROSCHOOL, INC offers two **UnitedHealthcare NHP** medical plans:

- A Health Maintenance Organization (HMO) plan; and
- A Point of Service (POS) plan

Here is a closer look at how **UnitedHealthcare's NHP** medical plan options work. You will find more plan highlights as well as your semi-monthly payroll contributions on the following page.

HMO Plan: This plan only covers services performed by health care providers in the plan's network, with the exception of true emergencies.

Note: This HMO plan requires you to select a Primary Care Provider (PCP).

POS Plan: This plan covers services performed by in-network and out-of-network health care providers. In-network services yield the highest level of benefits with the lowest out-of-pocket expenses because services are paid based on contracted rates, meaning the agreed-upon amount that the insurance company and health care provider have agreed to pay/be paid for the medical service. The plan begins to pay only after the deductible has been satisfied. Those who participate in this plan may be eligible to open a Health Savings Account (HSA).

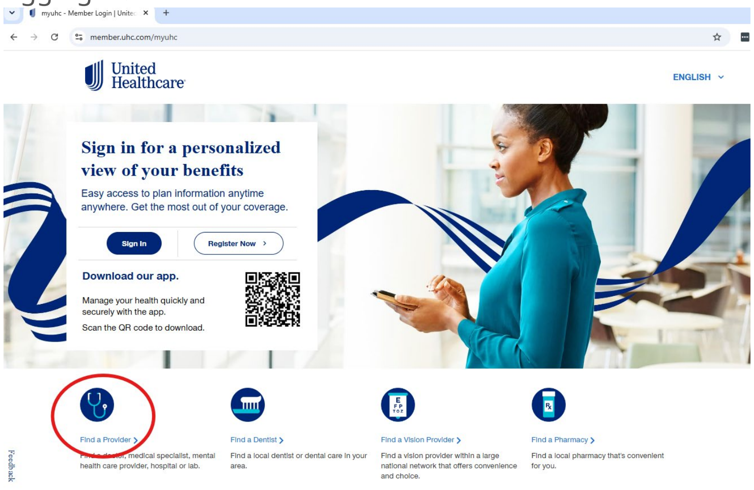
Note: This POS plan requires you to select a Primary Care Provider (PCP).

NOTE: You can search for participating health care providers by visiting myuhc.com and clicking "Find a Provider". Choose "Employer and Individual" as coverage, select "Medical", enter your search criteria and select "NHP HMO/POS Access Network." For your reference, Quest Diagnostics and Labcorp are UnitedHealthcare's preferred lab facility.

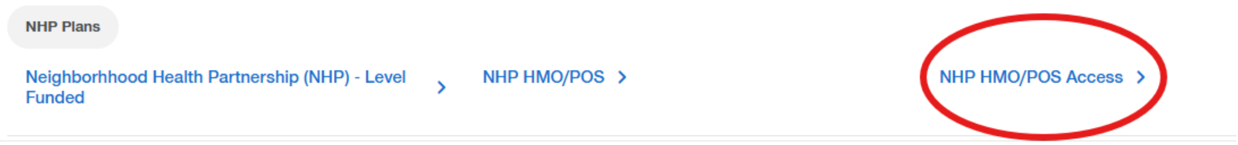
Medical Plans

Important: For both medical plans, you will be required to select a PCP at the time of enrollment. You can change your PCP at any time during the plan year. Below are the steps to locate a physician.

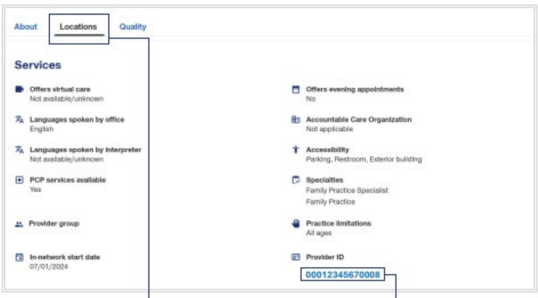
1. Go to myuhc.com and sign in for a personalized view of your benefits. If you don't have an account, select Register now to create one, or select Find a Provider to search without logging in.



2. On the provider search page, choose Employer and Individual as your type of coverage.
3. Select Medical as the type of care you're looking for.
4. Enter your location, then select the plan "NHP HMO/POS Access" network.



5. To find a PCP, click Primary Care.
    - If you already know your doctor's name, enter it and click Search.
6. Choose the type of PCP you want (based on the available options shown).
7. If you already know the doctor's name, medical group, or hospital, type it into the filter field and click Filter to narrow your results.
8. Once you have selected your provider, go to the Locations tab to find the Provider ID number.



Under the **Locations** tab, then within **Services**, you will find the Provider ID – the 14-digit number listed under Provider ID. Please indicate the PCP's name and Provider ID on your enrollment form. You must list the PCP name and the entire 14-digit Provider ID, including the last 3 digits, to avoid possible assignment errors.

Important: Some PCPs may have more than one Provider ID based on their medical group, location or hospital affiliation. Please be sure you select the Provider ID that aligns with the medical group, location and hospital of your choice.

Medical Plans

If you're enrolled in the POS – NHP FLEX EYZ5 NH11 plan and you're traveling outside Florida, use the steps below to find an in-network provider or pharmacy.

Health Plans | Neighborhood Health Partnership | Florida

Get greater access with NHP Network Flex

Neighborhood Health Partnership (NHP) Network Flex plans are direct-access point-of-service (POS) plans designed for members who temporarily spend time outside of Florida's NHP service area.

How the plans work

- NHP members must live and/or work in an approved NHP service area in Florida and must seek services from the NHP network of providers and facilities when within the NHP service area
- NHP members will need to select a network primary care physician (PCP), but referrals to specialists are not required
- NHP members traveling to or temporarily residing outside of Florida's NHP service area will use the UnitedHealthcare Choice Plus network for nonemergency care – including primary care, specialty care, urgent care and pharmacy services – at the member's network benefit level

Find an out-of-state network provider

To find a network provider when traveling outside of Florida's NHP service area:

1. Visit **myuhc.com®** (do not log in)
2. Select "Find a Provider"
3. Click on "Medical Directory"
4. Click on "Employer and Individual Plans"
5. Scroll down and click on "Choice Plus"
6. Update your location at the top of the page to view providers in that area

Find an out-of-state network pharmacy

To find a network pharmacy when traveling outside of Florida's NHP service area:

1. Visit **myuhc.com** (do not log in)
2. Select "Find a Pharmacy"
3. Click on "Search for Pharmacy by Name, ZIP Code, City and State, or address"

Learn more

Contact your UnitedHealthcare representative for more information

United Healthcare®

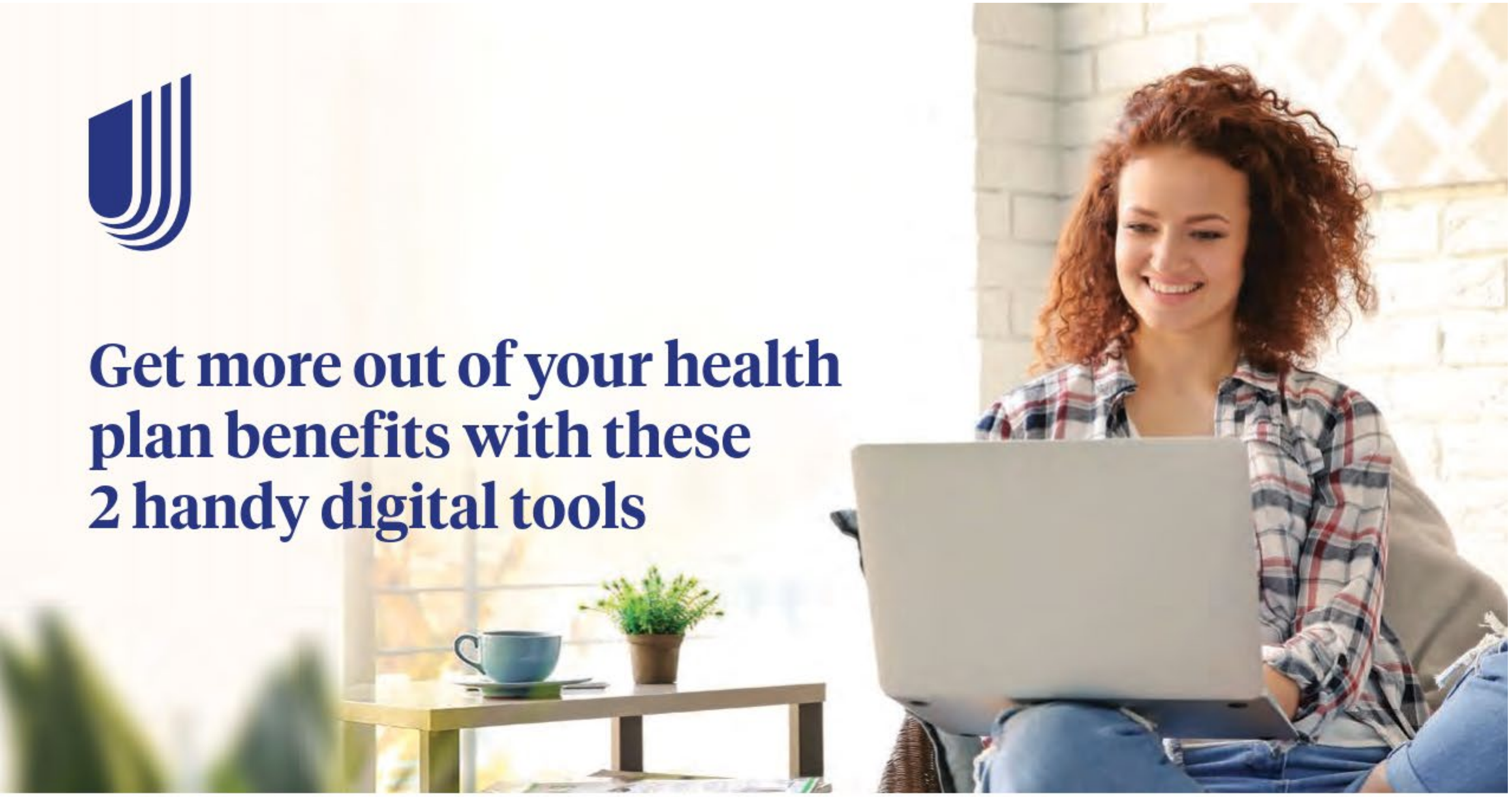
This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your broker or UnitedHealthcare sales representative. Employee benefits including group health plan benefits may be taxable benefits unless they fit into specific exception categories. Please consult with your tax specialist to determine taxability of these offerings. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by or through UnitedHealthcare of Florida, Inc. and Neighborhood Health Partnership, Inc.

Medical Plans

COVERAGE	HMO – NHP EY1E NHGA	POS – NHP FLEX EYZ5 NH11	
	In-Network Only NHP NETWORK	In-Network NHP FLEX NETWORK	Out-of-Network
Member Costs			
Calendar Year Deductible Individual / Family	$1,000 / $3,000	$2,000 / $4,000*	$5,000 / $10,000*
Member Coinsurance	20%	20%	50%
Calendar Year Out-of-Pocket Maximum Individual / Family	$6,000 / $12,000	$4,000 / $6,000*	$10,000 / $20,000
Physician Visit			
Preventive Care Services	Covered in Full	Covered in Full	50% after DED
Primary Care Physician (PCP)	$25 copay	20% after DED	50% after DED
Specialist	$45 copay	20% after DED	50% after DED
Lab Work & Diagnostic Imaging			
Independent Lab i.e., blood work, X-ray	Covered in Full	20% after DED	50% after DED
Advanced Services Includes MRI, PET, CT	Designated Network: 20% after DED Network: 40% after DED	Designated Network: 20% after DED Network: 50% after DED	50% after DED
Hospital & Emergency Services			
Inpatient Hospital	$250 copay	20% after DED	50% after DED
Outpatient Surgery	$250 copay	20% after DED	50% after DED
Urgent Care	$75 copay	20% after DED	50% after DED
Emergency Room (waived if admitted)	$400 copay	20% after DED	20% after DED
Prescription RX			
Tier 1	$10 copay	$10 copay after DED	Not Covered
Tier 2	$60 copay	$60 copay after DED	Not Covered
Tier 3	$90 copay	$100 copay after DED	Not Covered
Tier 4	$250 copay	Not Covered	
Semi-Monthly Payroll Contributions	**HMO**	**POS**	
Employee Only	$47.47	$9.54	
Employee + Spouse	$305.36	$244.57	
Employee + Child(ren)	$156.02	$123.71	
Family	$656.91	$520.67	

*If you are enrolling 1 or more dependents in the POS NHP FLEX plan, you must satisfy the full family deductible and out of pocket maximum before benefits are paid.

Get more out of your health plan benefits with these 2 handy digital tools



The UnitedHealthcare® app and myuhc.com®

Whether on the go or online, you'll have access to resources designed to help you:

- View benefit info, claim details and account balances
- Search network providers and facilities for the type of care you may need
- Quickly compare cost estimates before you get care
- Learn about covered preventive care
- Access your health plan ID card and add your plan details to your smartphone's digital wallet

Register once to access both tools

Start by downloading the UnitedHealthcare app or going to **myuhc.com** and then:

- Tap **Register Now** on the app, or select **Register** on the website
- Fill in the required fields and create your username and password
- Enter your contact information and select SMS text or phone call for two-factor authentication—then, agree to the terms and conditions
- Opt in to paperless delivery from your communication preferences

Now you're registered for—and connected to—the app and the website.

Get connected

Scan this code to download the app and register, or visit **myuhc.com**

United Healthcare

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under the Find Care & Costs section. Available only for insured plans and self-funded plans with Optum Rx integrated pharmacy benefits.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

Health Plan coverage provided by or through a UnitedHealthcare company. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.

Get in on UHC Rewards

Good news—your health plan comes with a way to earn up to $300. UnitedHealthcare Rewards is included in your health plan at no additional cost.

There's so much good to get

With UHC Rewards, a variety of actions—including things you may already be doing, like tracking your steps or sleep—lead to rewards. The activities you go for are up to you, and the same goes for ways to spend your earnings.

Here are just a few of the ways you can earn:

Connect a tracker	**$25**
Take a health survey	**$15**
Get an annual checkup	**$25**
Get a biometric screening	**$50**

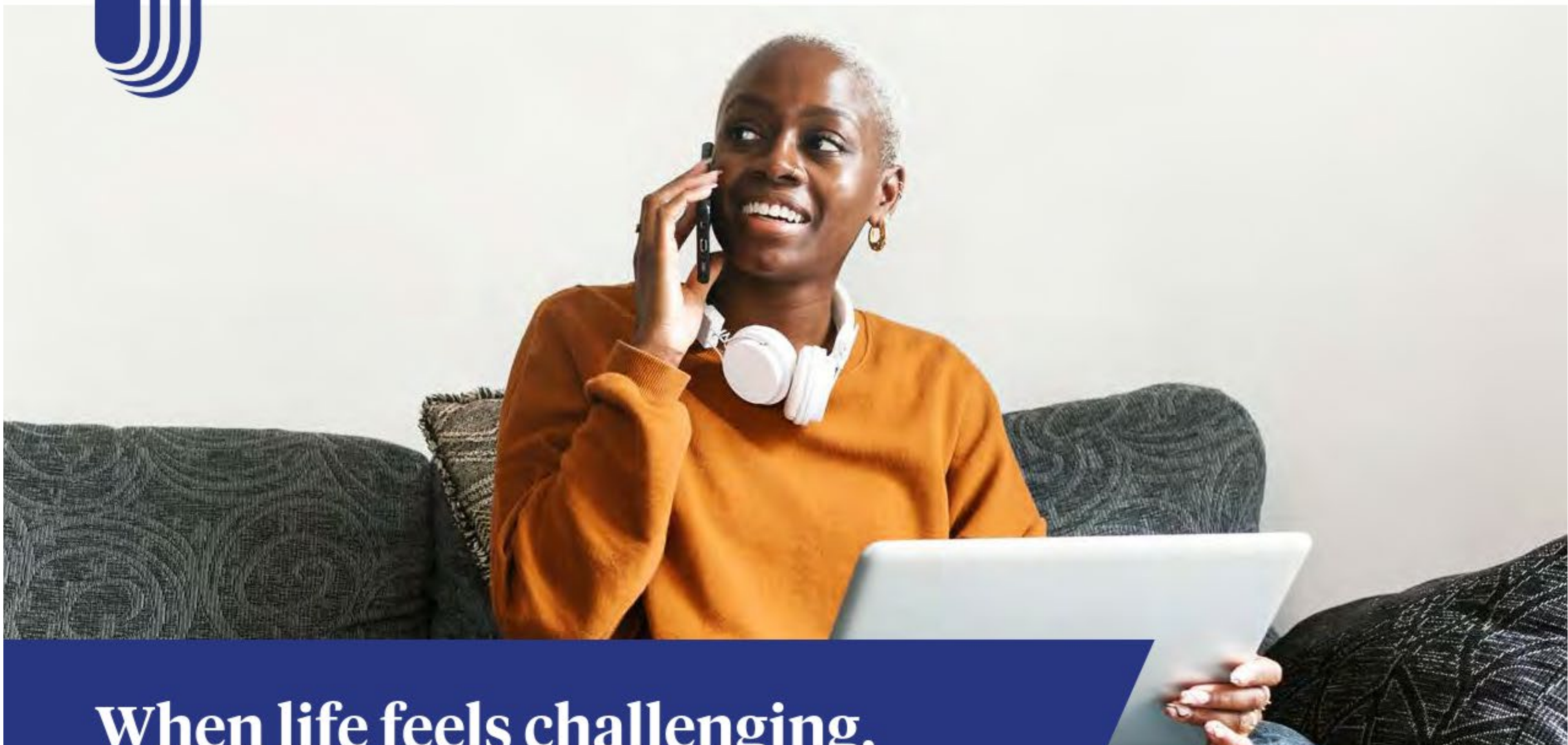
Visit UHC Rewards for the full list of rewardable activities that are available to you—and look for new ways of earning rewards to be added throughout the year.

Earn up to

$300

United Healthcare

continued



When life feels challenging, get caring and confidential help

Your Employee Assistance Program (EAP) offers access to personalized support, resources and no-cost referrals. It's confidential one-on-one help from a master's-level specialist.

No-cost, 24/7 access to support in the moments that matter

EAP helps you and your family with a range of issues, including:

- Identifying resources for managing stress, anxiety and depression
- Offering specialized help in improving relationships at home or work
- Providing guidance on legal and financial concerns
- Finding ways to help you cope with occupational stress and burnout
- Connecting you with care for addressing substance use issues

Call EAP at 1-888-887-4114

- 3 free counseling sessions per incident, per year
- Confidential and private; services will not be shared with your employer

Scan for more info

Use your phone's camera to scan this code and learn more.

The material provided through this program is for informational purposes only. EAP staff cannot diagnose problems or suggest treatment. EAP is not a substitute for your doctor's care. Employees are encouraged to discuss with their doctor how the information provided may be right for them. Your health information is kept confidential in accordance with the law. EAP is not an insurance program and may be discontinued at any time. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against UnitedHealthcare or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and is subject to change. Coverage exclusions and limitations may apply.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

United Healthcare

Visit with a provider 24/7 — whenever, wherever

With 24/7 Virtual Visits, you can connect to a provider by phone or video[1] through **myuhc.com**® or the UnitedHealthcare® app

Another way to get care

Providers can treat a wide range of health conditions—including many of the same conditions as an emergency room (ER) or urgent care—and may even prescribe medications,[2] if permitted needed. **With a UnitedHealthcare plan, your cost for a 24/7 Virtual Visit is usually $0.[3]**

Consider 24/7 Virtual Visits for these common conditions and more

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches

$0 cost

An estimated 25% of ER visits could be treated with a 24/7 Virtual Visit—bringing a potential $2,000[4] cost down to $0.

Get started

Sign in at **myuhc.com/virtualvisits** | Call the number on your health plan ID card | Download the UnitedHealthcare app

United Healthcare®

[1] Data rates may apply.

[2] Certain prescriptions may not be available, and other restrictions may apply.

[3] The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change.

[4] Average allowed amounts charged by UnitedHealthcare Network Providers are not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. Estimated urgent care savings are based on the difference between an average urgent care visit cost of $180 and a Virtual Visit cost of $0; $2,000 difference between the average emergency room visit and the average urgent care visit. The information and estimates provided are for general informational and illustrative purposes only and are not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

24/7 Virtual Visits is a service available with a Designated Virtual Network Provider via video, or audio-only where permitted under state law. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

Ways to Save

Outside of an HSA, there are additional ways for you to save on health care expenses and stay on budget.

In-Network Providers

In-Network provider is a provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates. In general, if you visit an In-Network provider, you will get your healthcare at a lower price.

Ask the Right Questions

- Why is this treatment necessary?
- How much will my treatment cost?
- Can I be treated another way that is equally effective but less costly?

Keep Prescription Costs Down

- Shop around at local pharmacies to find the best price on your prescription.
- Ask your doctor about generic or over-the-counter drug alternatives to brand name prescriptions.
- Look into discount prescription programs.

Practice Prevention

Prevention includes a healthy lifestyle, exercise, diet and other similar efforts. When preventive care services like physical examination, screenings and immunizations are combined with a lifestyle that is focused on wellness, significant savings can be achieved.

Take Control of Your Healthcare

Learn to shop for value when it comes to healthcare. Ask your doctor the right questions, conduct price comparisons, read reviews, and review all the medical bills carefully. With a little effort, you can ensure that you are getting the best value for your healthcare dollars.

Research brand name drug rebates online

Website	Offer
www.needymeds.org	Find help with the cost of medicine
www.gskforyou.com	Help with GSK medications and vaccines for qualified patients
www.rxpharmacycoupons.com	Search for drug coupons to use at your local pharmacy
www.goodrx.com	Compare Rx prices, print free coupons and save on your meds
https://perks.optum.com/	Hundreds of free manufacturer drug coupons

Where to Go for Care

Virtual Visits

When you need care for minor illnesses but prefer not to leave home.

Types of Care*

- Cold & flu symptoms
- Allergies
- Bronchitis

Costs and Time Considerations**

- Usually a flat fee or copay
- Usually immediate access to care
- Prescription through telemedicine or virtual visits not allowed in all states

Primary Care Center

When you need routine care or treatment for a current health issue.

Types of Care*

- Annual physicals
- Immunizations
- Preventative Services

Costs and Time Considerations**

- Often requires copay and/or coinsurance
- Normally requires an appointment
- Usually little wait time with scheduled appointment

Urgent Care Center

When you need care quickly but is not a true emergency.

Types of Care*

- Strains and Sprains
- Minor infections
- Minor burns or cuts

Costs and Time Considerations**

- Often requires a copay and/or coinsurance usually higher than an office visit
- Walk-in patients welcome, but waiting periods may be longer (urgency decides order)

Emergency Room

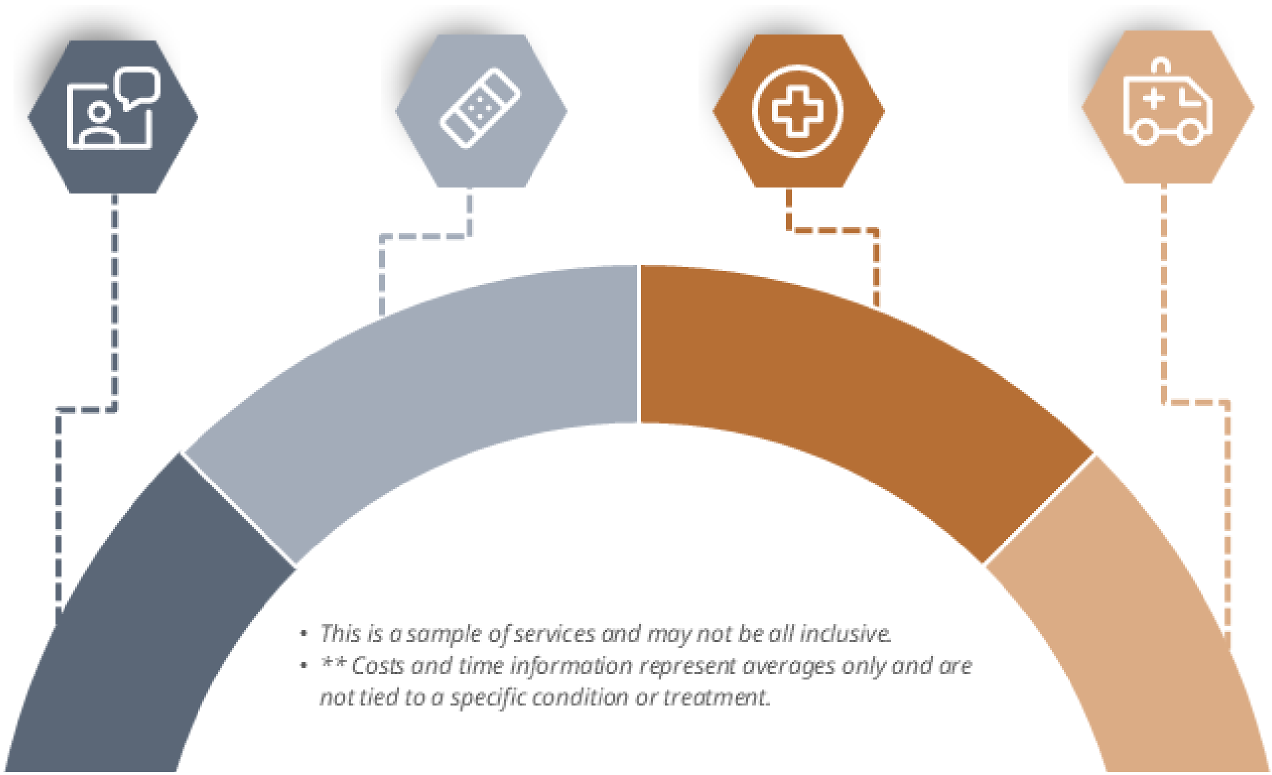
When needing immediate treatment for a serious condition. If life-threatening, call 911

Types of Care*

- Heavy Bleeding
- Chest Pain
- Major burns or cuts
- Broken bones

Costs and Time Considerations**

- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because of patients with life-threatening emergencies will be treated first
- Ambulance charges, if applicable, will be separate and may not be in-network



- *This is a sample of services and may not be all inclusive.*
- *** Costs and time information represent averages only and are not tied to a specific condition or treatment.*

Dental Plans

MYcroSchool, Inc offers two **Guardian** Dental Plans:

- Two Dental Preferred Provider Organization (DPPO)

We have included an explanation of each plan below. The next page provides plan highlights and your semi-monthly payroll contributions.

DPPO Plan: The DPPO plan gives you the freedom to receive dental care from any licensed dentist of your choice. You will receive the highest level of benefit from the plan if you select an in-network, contracted PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rates. A calendar year maximum benefit will apply to in- and out-of-network services.

NOTE: You can search for dental providers by visiting guardianlife.com, select “Resources” from the top menu bar, and click “**Find a Dentist**.” Select “Dental Benefits bought through your workplace”. Enter your search criteria and select “PPO: DentalGuard Preferred” as your plan to view your options.

Dental Plans

Plan Highlights	DPPO – Low Plan	
	In-Network	Out-of-Network
Calendar Year Maximum Benefit	$2,000	$2,000
Calendar Year Deductible (DED) Individual / Family	$50 / $150	$50 / $150
Preventive Services		
Exams	Plan pays 100%, DED waived	Plan pays 80%, DED waived
Cleanings (1 Every 6 Months)	Plan pays 100%, DED waived	Plan pays 80%, DED waived
X-Rays	Plan pays 100%, DED waived	Plan pays 80%, DED waived
Basic Services		
Fillings (anterior)	Plan pays 80% after DED	Plan pays 80% after DED
Surgical Extractions	Plan pays 80% after DED	Plan pays 80% after DED
Root Canal	Plan pays 80% after DED	Plan pays 80% after DED
Major Services		
Crowns, Dentures, Implant Prosthetics	Plan pays 50% after DED	Plan pays 50% after DED
Implants	Not Covered	
Orthodontics (Children Only up to Age 19)		
Comprehensive	50%; $1,000 Lifetime Maximum	
Semi-Monthly Payroll Contributions		
Employee Only	$2.59	
Employee + Spouse	$5.58	
Employee + Child(ren)	$4.08	
Family	$11.62	

Dental Plans

Plan Highlights	DPPO – High Plan	
	In-Network	Out-of-Network
Calendar Year Maximum Benefit	$2,500	$2,500
Calendar Year Deductible (DED) Individual / Family	$50 / $150	$50 / $150
Preventive Services		
Exams	Plan pays 100%, DED waived	Plan pays 100%, DED waived
Cleanings (2 per calendar year)	Plan pays 100%, DED waived	Plan pays 100%, DED waived
X-Rays	Plan pays 100%, DED waived	Plan pays 100%, DED waived
Basic Services		
Fillings (anterior)	Plan pays 90% after DED	Plan pays 80% after DED
Surgical Extractions	Plan pays 90% after DED	Plan pays 80% after DED
Root Canal	Plan pays 90% after DED	Plan pays 80% after DED
Major Services		
Crowns, Dentures, Implant Prosthetics	Plan pays 60% after DED	Plan pays 50% after DED
Implants	Not Covered	
Orthodontics (Children Only up to Age 19)		
Comprehensive	50%; $1,000 Lifetime Maximum	
Semi-Monthly Payroll Contributions		
Employee Only	$11.64	
Employee + Spouse	$25.86	
Employee + Child(ren)	$23.38	
Family	$43.97	

Vision Plan

You can receive the following vision benefits when enrolled in **Guardian's** vision plan:

- Every 12 months, **Guardian** covers your eye exam and either lenses or contact lenses
- Every 24 months, **Guardian** covers your frames

Below are plan highlights and your semi-monthly payroll contributions.

Plan Highlights	Vision	
	In-Network	Out-of-Network
Exam (One every 12 months)	$10 Copay	Up to $39
Single Lenses (One every 12 months)	$10 Copay	Up to $23
Bifocal Lenses (One every 12 months)	$10 Copay	Up to $37
Trifocal Lenses (One every 12 months)	$10 Copay	Up to $49
Lenticular Lenses (One every 12 months)	$10 Copay	Up to $64
Frames (One every 24 months)	$130 Allowance, then 20% off remaining balance	Up to $46
Contact Lenses (One every 12 months)		
Standard Contact Lens Fit & Follow-Up	15% off retail	Included in Contact Lens Allowance
Premium Contact Lens Fit & Follow-Up	15% off retail	Included in Contact Lens Allowance
Conventional	$130 allowance	Up to $100
Disposable	$130 allowance	Up to $100
Medically Necessary	Covered in Full after Copay	Up to $210
Semi-Monthly Payroll Contributions		
Employee Only	$0.77	
Employee + Spouse	$2.25	
Employee + Child(ren)	$1.86	
Employee + Family	$3.89	

NOTE: You can search for visions providers by visiting guardianlife.com, select "Resources" from the top menu bar, and click "**Find a Vision Provider**". Select VSP as your network and enter your search criteria to view your options.

Health Savings Account (HSA)

If you participate in our High-Deductible Health Plan (HDHP), you may be eligible to open a Health Savings Account (HSA). An HSA allows you to make tax-free contributions and earn tax-free growth of interest or investment earnings. You can use these contributions to pay for eligible expenses, such as medical and pharmacy expenses. Please refer to IRS publication 502 for a full list of eligible expenses.

According to treasury regulations, you are allowed to revoke or change your HSA contribution election throughout the year. Any unused funds in your HSA will roll over annually. Additionally, your account is portable, which allows you to take your funds with you from job to job or at retirement.

The IRS allows an annual maximum contribution to your HSA. The table to the right shows the annual maximum contributions for 2026 and 2027.

Annual Contribution Limit	2026	2027
Single	$4,400	$4,500
Family	$8,750	$9,000
Catch Up Provision if age 55 or older	$1,000	$1,000

Eligibility

To be eligible to contribute into an HSA account, you cannot:

- Be covered by any other non-HSA-compatible health coverage plan including, but not limited to, a Traditional Medical FSA or an HRA held by a spouse or partner.
- Be claimed as a dependent on another person's tax return (excluding spouses).
- Be "entitled" (enrolled in) to Medicare (A, B, C, or D).
    - Be aware – if you delay Medicare Part A enrollment after turning age 65, your Medicare Part A coverage will begin up to 6 months retroactively but not earlier than Medicare eligibility.
    - Receiving Social Security benefits causes automatic Medicare Part A enrollment when eligible
- Have prior year FSA dollars carryover / rollover into a current year general purpose FSA
- Have a positive general purpose FSA grace period balance

Frequently Asked Questions

How do I contribute to my HSA? You can contribute to your HSA through payroll deduction by requesting that your employer deduct a set amount from your paycheck.

When can I start to use the funds in my HSA? Once your account is open and you have available funds from a personal or company contribution, you can start using your HSA for eligible expenses. As soon as funds are deposited, you are 100 percent vested and in control of the funds.

What happens to my HSA if I leave my employer? You can keep your current HSA or transfer your funds to another qualifying HSA. If you choose to transfer your funds to a new HSA, you should complete the transfer within 60 days of withdrawing the funds in order to avoid taxes and an additional 20 percent penalty.

NOTE: you must be enrolled in an HDHP to continue to contribute to your HSA.
Please consult your tax professional for any personal tax advice

VOLUNTARY & ADDITIONAL BENEFITS

Life and AD&D
Disability
Worksite
Legal
Pet

Life and AD&D

At MYCROSCHOOL, INC, you have two options for Life and AD&D insurance through **Guardian**:

Basic Life & AD&D Insurance – Employer Paid

In the event of a death, life insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Group Life & AD&D Insurance: As a full-time, benefits-eligible employee, you are eligible for Group Life & AD&D Insurance that will cover $75,000. Beginning on and after your 65 birthday, your life insurance benefit decreases.

Be sure to keep your beneficiary designations up to date! You can change your beneficiary designation at any time, even outside of the Open Enrollment period. You are also able to designate full payment to a sole beneficiary or payment percentages to multiple beneficiaries.

Voluntary Life & AD&D Insurance

In addition to the company-paid Life & AD&D Insurance, you can purchase additional coverage by enrolling in Voluntary Life & AD&D for yourself and your eligible dependents through **Guardian**. To receive coverage for dependents, you must be enrolled in your own Voluntary Life and AD&D coverage. The Voluntary Life & AD&D insurance is convertible or portable for eligible individuals. Beginning on and after your 65 birthday, your life insurance benefit decreases.

Evidence of Insurability will be required if you previously waived or were declined coverage or if you are increasing your coverage amount above the GI. Employees currently enrolled can increase their coverage by up to $50,000 or the GI (whichever is less) with no EOI. All dependent increases are subject to EOI.

On the following page are some coverage highlights.

Life and AD&D

Employee Coverage*	Spouse Coverage**	Child(ren) Coverage**
$10,000 increments to a maximum of $500k *Guarantee Issue: $150,000*	$5,000 increments to a maximum of $200,000; cannot exceed 100% of Employee coverage *Guarantee Issue: $30,000*	**Birth to 14 days:** $1,000 **14 days to age 26**: $10,000; cannot exceed 100% of Employee coverage *All amounts are approved.*

Monthly Cost of Coverage	
Age[1]	**Rate per $1,000**
29 and under	$0.082
30–34	$0.102
35–39	$0.112
40–44	$0.152
45–49	$0.242
50–54	$0.392
55–59	$0.672
60–64	$1.032
65–69	$1.722
70+	$2.722
Child(ren)	$0.223

To calculate your semi-monthly premium, find your age group in the left column and its coordinating rate in the right column. The rates shown are for each $1,000 of coverage, so you will need to take the total coverage amount elected and divide by $1,000. Once you have that number you will multiply that by the rate.

Example:

Age 31

Rate is $ 0.102

Elects $50,000 life insurance coverage

$50,000 / $1,000 = 50

0.102 X 50 = $5.10 monthly cost

$5.10 *12 / 24 = $2.55 semi-monthly cost

NOTE: *Employee's rate is determined by the Employee's age. Spouse's rate is determined by the Employee's age.*

** Your benefit will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.*

***Your dependent's insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. (Totally disabled means that, as a result of an injury, a sickness or a disorder, your dependent spouse is confined in a hospital or similar institution or is confined at home for sickness or injury; or has a life threatening condition.)*

Disability

Disability insurance provides income protection in the event that you are unable to work due to a qualified disability. Below are the two types of disability insurance that we provide:

Short-Term Disability (STD) – Employee Paid*

Our short-term disability program with **Guardian** provides financial assistance for up to 13 weeks if you are unable to work. ** Below are the benefit highlights.

Plan Highlights	Level Of Coverage
Percentage of Wage Replacement	60% of covered weekly earnings
Maximum per Week	$1,500
Elimination Period	7 days
Maximum Benefit Period	13 weeks

Long-Term Disability (LTD) – Employee Paid*

Long-Term Disability Insurance with **Guardian** provides extended financial coverage if you are unable to work. ** Below are the benefit highlights.

Plan Highlights	Level Of Coverage
Percentage of Wage Replacement	60% of covered monthly earnings
Maximum per Month	$7,500
Elimination Period	90 days
Maximum Benefit Period	To Age 67/ADEA

Note: Evidence of Insurability will be required if you previously waived or were declined coverage.

This information is not intended to be tax or legal advice. Specific questions about tax-related matters should be referred to your tax accountant, legal counsel and the IRS.

** Your benefit will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.*

***Pre-existing conditions may be exempt from coverage*

Additional Benefits

Critical Illness

Guardian insures our Critical Illness coverage. If you are diagnosed with a covered critical illness, you will receive a cash benefit based on a specified percentage payable for the condition. At the time of your diagnosis, you will receive your benefits and can determine how to best use the cash benefit. This policy will also provide covered family members with cash benefits if they should fall critically ill. The benefit premium does not increase with age and your benefits do not decrease with age. The benefit premium is based on the plan option and benefit amount that you elect. This will be a True Open Enrollment, meaning no evidence of insurability will be required.

Hospital Indemnity

Unexpected hospital visits lead to unexpected costs – and research shows that most people aren't prepared to handle such surprise expenses. Hospital Indemnity Insurance can help cover some out-of-pocket medical costs associated with a hospital stay. This can be especially helpful if the major medical plan's deductible has not been met. Hospital Indemnity benefits are paid directly to the covered person, regardless of other coverage, and can be used for any purpose – there are no restrictions.

Accident Protection

You can opt in to **Guardian's** Accident Protection policy to cover accidents from motor vehicle collisions, sports injuries to everyday slips, and falls. **Guardian's** policy may pay cash (based on a schedule) to help families offset the expenses associated with these accidents or injuries. Benefits may be paid for:

- Hospital admission and confinement
- Ambulance
- Medical Equipment (crutches, leg braces, etc.)
- Emergency room and doctor visit
- Follow-up and physical therapy visits

Additional Benefits

Legal Plan/ID Theft Protection

LegalShield is a licensed legal expense organization that provides its members with full service and representation on all types of legal services. This plan covers services including, but not limited to, divorce, traffic tickets, buying or selling a home, foreclosures, will preparation, bankruptcy, lawsuits, child support, custody and visitation, and much more. Your cost varies depending on single or family coverage. You can bundle Legal and ID Theft for a discounted rate.

Pet Insurance

MYcroSchool, Inc. offers Spot pet insurance plans designed to help reimburse you for covered veterinary bills, with options to fit a range of budgets. Plans can help cover accidents and illnesses such as cancer and growths, hereditary conditions, dental illnesses, skin/eye/ear infections, vet exam fees and lab tests, surgery and hospitalization, and diagnostic imaging (MRIs, CT scans, X-rays). For added support, Spot also offers preventive care add-ons (Gold or Platinum) that may include services like spay/neuter, vaccinations, dental cleaning, and more. The claims process is simple: you can visit any licensed veterinarian in the U.S. or Canada, submit your claim online, and receive cash back for covered vet bills. Scan the QR code below to learn more and enroll.

LegalShield

Educational Services for All Employees

LegalShield's mission is to provide affordable and equal access to justice for all!

Member Resources Website

All employees have access to our [Member Resources Website.]

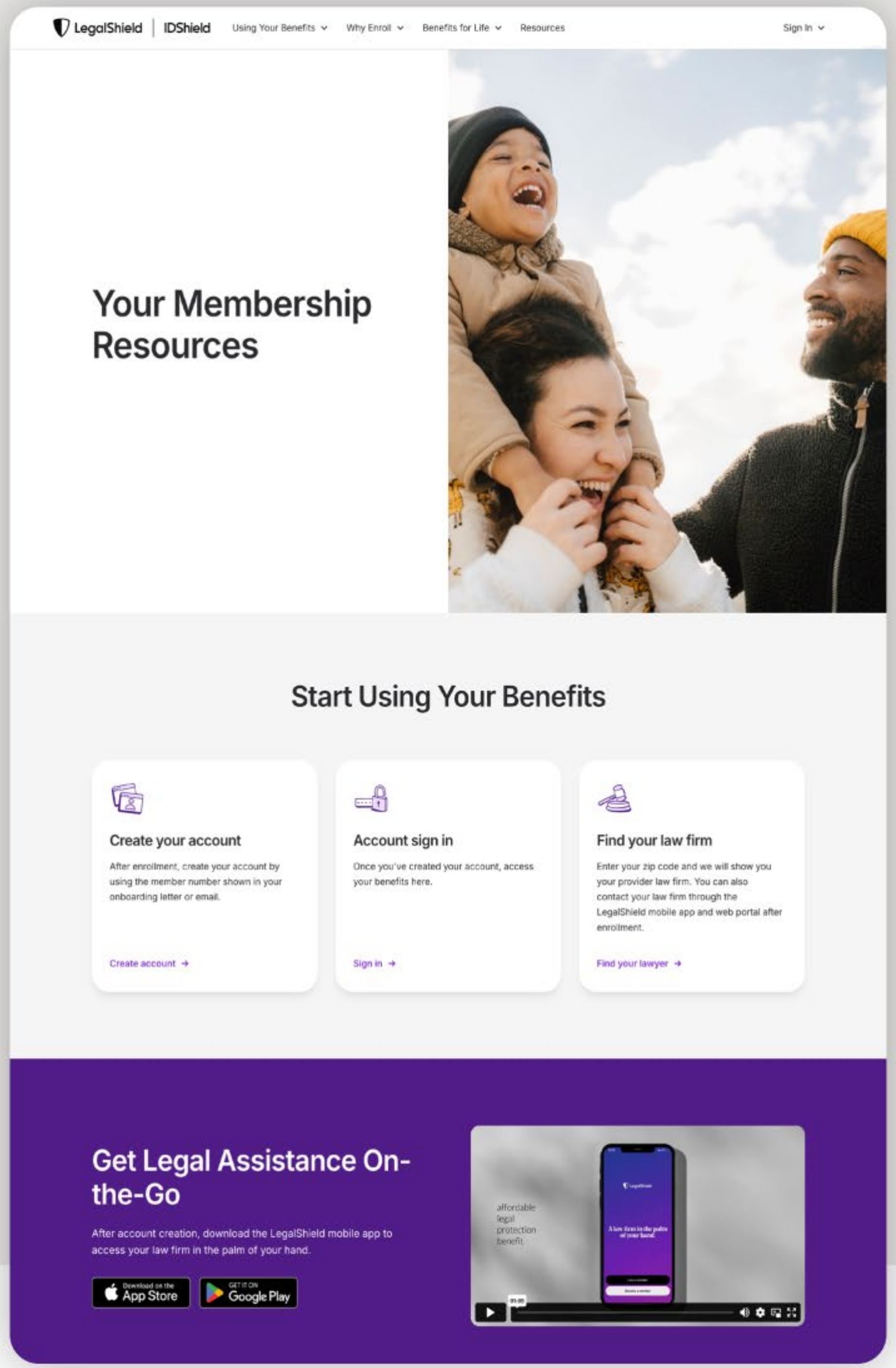
The website helps employees maximize plan usage by offering:

Guides

Articles

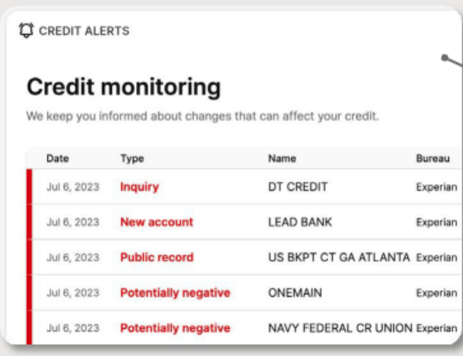
Videos

All employees can access our library of **[Legal Forms and download them for free]**. Once filled out, enrolled participants can ask their provider lawyer to review.



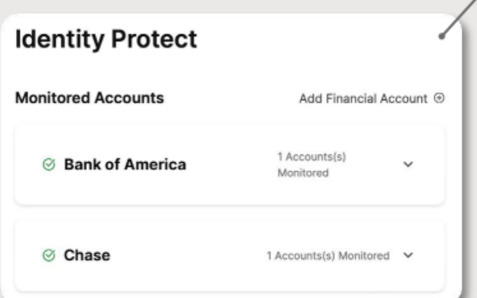
IDShield's Member Portal

Participants can access their identity protection portal and other resources, including IDShield's online privacy and reputation management services.



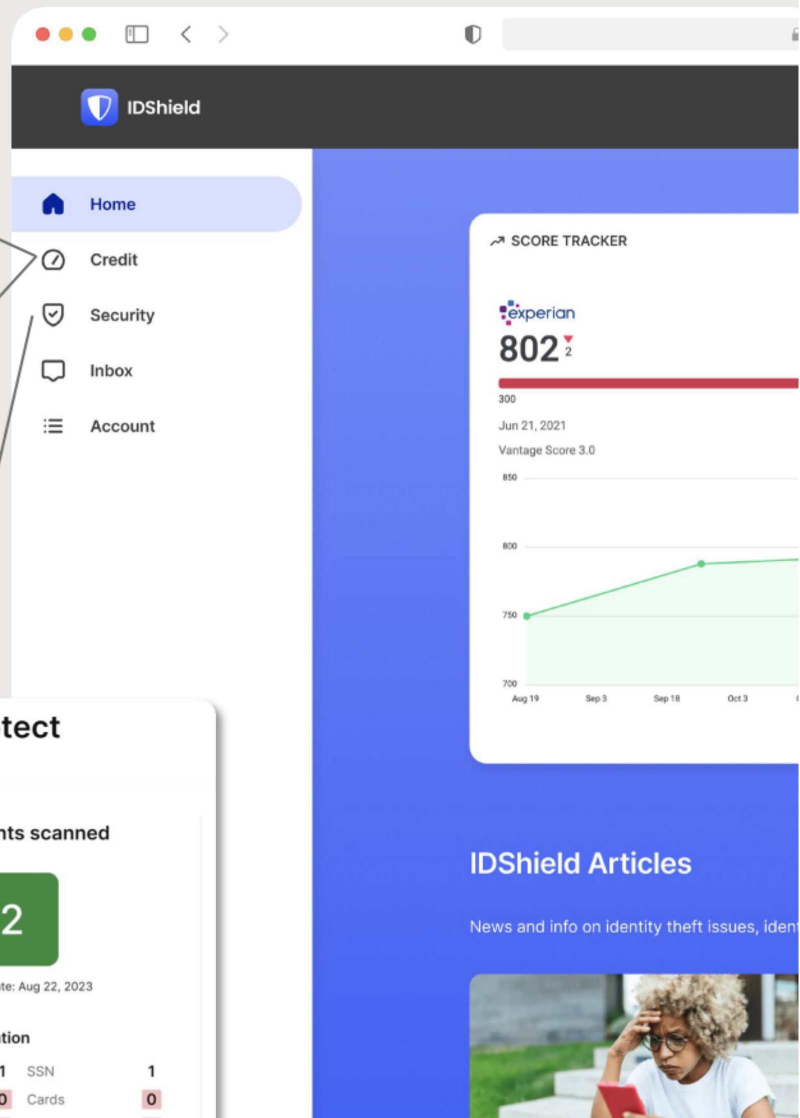
Credit Score Tracking

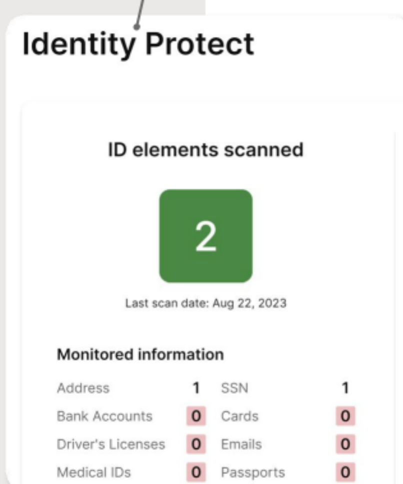
Not just the "what" of a credit score, but also the "why". Credit scores are updated monthly.



Financial Threshold Monitoring

Search by bank and add financial accounts for monitoring. A separate threshold limit can be set on each account.





Dark Web Monitoring Services

IDShield continually scans the dark web for **Personally Identifiable Information (PII)**. to spot ID theft at the earliest stages.

MYcroSchool, Inc. Employees Get Up To 20% Off*

Scan Below to Get Your Discount

Top-Rated Pet Plans Options for Less than $1/Day[1]

Every pet is welcome, any breed, any age, even pets with pre-existing conditions. If a condition remains symptom-free for some time, it may also qualify for future coverage!

Customizable Vet Bill Coverage for Every Pet

Accident Plans
for when they get hurt

Illness Plans
for when they get sick

Wellness Plans
to keep them healthy

How does pet insurance work?

1. Visit Any Vet in the U.S or Canada
2. Submit Your Claim Online or our App
3. Get Cash Back for Covered Vet Bills

Did you know?

Every 6 seconds, a pet owner faces an unexpected vet bill of $1,000 or more.[2]

Get Your Special Offer Today: spotpet.link/mycroschool

1 Based on the average premium of current accident-and-illness policyholders with a $2,500 annual limit, 70% reimbursement rate, and $1,000 deductible as of 7/1/2026. Actual premiums may vary. Premiums are based on and may increase or decrease due to the age of your pet, the species or breed of your pet, and your home address. 2 Forbes Advisor, Jan. 2, 2025, 2 Source: Forbes Advisor, "Pet Insurance Statistics. *Includes up to 10% group discount plus up to 10% multi-pet discount on 2nd+ pets. Discounts vary by state and are subject to change. Not available in all states. Waiting periods, annual deductible, co-insurance, benefit limits and exclusions may apply. For all terms visit spotpetins.com/sample-policy. Products, schedules, discounts, and rates may vary and are subject to change. More information available at checkout. Insurance plans are underwritten by eitherIndependence American Insurance Company (NAIC #26581. A Delaware insurance company located at 11333 N. Scottsdale Rd, Ste. 160, Scottsdale, AZ 85254) or United States Fire Insurance Company (NAIC #21113. Morristown, NJ), and are produced by Spot Pet Insurance Services, LLC. (NPN # 19246385. 990 Biscayne Blvd Suite 603, Miami, FL 33132. CA License #6000188).

ANNUAL NOTICES

Medicare Part D
Creditable Coverage Notice

Important Notice from MYcroSchool, Inc
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 MYcroSchool, Inc 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. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two 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. **MYcroSchool, Inc has determined that the prescription drug coverage offered by the plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

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 lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan while enrolled in MYcroSchool, Inc coverage as an active employee, please note that your MYcroSchool, Inc coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in MYcroSchool, Inc coverage as a former employee.

You may also choose to drop your MYcroSchool, Inc coverage. If you do decide to join a Medicare drug plan and drop your current MYcroSchool, Inc coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with MYcroSchool, Inc and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, 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 (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 MYcroSchool, Inc changes. You also may request a copy of this notice at any time.

Annual Notices

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).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 08/05/2026
Name of Entity/Sender: MYcroSchool, Inc
Contact-Position/Office: Denise Castro
Address: 7054 NW 10th Pl, Gainesville, FL 32605
Phone Number: 352-586-1364

Annual Notices

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in MYcroSchool, Inc group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days or any longer period that applies under the plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within "30 days" or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan. To request special enrollment or obtain more information, contact

Denise Castro
352-586-1364
Denise.Castro@newmycro.org

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

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 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

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 and health coverage offered through your employment

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 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.

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.

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1 Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
2 An employer-sponsored or other employment-based 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 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the “minimum value standard,” the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Annual Notices

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.

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?
For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your plan administrator.

Annual Notices

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.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	**4. Employer Identification Number (EIN)**	
MYcroSchool, Inc	86-3905921	
5. Employer address	**6. Employer phone number**	
7054 NW 10th Pl	352-586-1364	
7. City	**8. State**	**9. Zip code**
Gainesville	FL	32605
10. Who can we contact about employee health coverage at this job?		
Denise Castro		
11. Phone number (if different from above)	**12. Email address**	
	Denise.Castro@newmycro.org	

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. Eligible employees are:
    - Employees working 30 or more hours per week
- With respect to dependents:
  ☑ We do offer coverage. Eligible dependents are:
    - Spouse or domestic partner and children up to age 26 or 30, if they qualify
  ☐ 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, **www.Healthcare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **www.Healthcare.gov** to find out if you can get a tax credit to lower your monthly premiums.

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 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)**.

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 January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid	ARKANSAS – 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	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**	**FLORIDA – Medicaid**
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	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	Website:https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**	**IOWA – Medicaid and CHIP (Hawki)**
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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562

KANSAS – Medicaid	**KENTUCKY – Medicaid**	**LOUISIANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	LA Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP Phone: 877-697-6703 Email: La.HIPP@la.gov fax: 1-888-716-9787 Address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**	**MINNESOTA – Medicaid**
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-forms Phone: 800-977-6740 / TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA - Medicaid**	**NEBRASKA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website:http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website:https://dhhs.ne.gov/Pages/ACCESSNebraska.aspx Phone: 1-855-632-7633 Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**	**NEW JERSEY – Medicaid and CHIP**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**	**NORTH DAKOTA – Medicaid**
Website:https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website:http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	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: pa.gov | Phone: 1-800-986-5437
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**	**SOUTH DAKOTA - Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311	Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**	**VERMONT– Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**	**WEST VIRGINIA – Medicaid and CHIP**
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	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid	
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since January 31, 2026, 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

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MYcroSchool,, Inc. (“MYcroSchool, Inc”) sponsors certain group health plan(s) (collectively, the “Plan” or “We”) to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the “Notice”) describes the legal obligations of MYcroSchool, Inc, the Plan, and your legal rights regarding your protected health information, including certain substance use disorder (SUD) records covered by 42 CFR part 2 (Part 2), held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as “protected health information.” Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully insured group health plans offered by MYcroSchool, Inc, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the MYcroSchool, Inc HIPAA Privacy Officer:

MYcroSchool, Inc,
Attention: HIPAA Privacy Officer
7054 NW 10th Pl, Gainesville, FL 32605
352-586-1364
Denise.Castro@newmycro.org

Effective Date

This Notice, as revised, is effective August 5, 2026.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

Annual Notices

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories. Note: Any protected information we may use or disclose under this Notice may be shared again by the person or organization who receives it. Once your protected health information is shared with others, it may no longer be protected.

For Treatment
We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment
We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations
We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information, including SUD treatment records, to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

Annual Notices

To Avert a Serious Threat to Health or Safety

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations
In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

SUD treatment records received from programs subject to 42 CFR part 2, or testimony relaying the content of such records, shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless based on your written consent, or a court order after notice and an opportunity to be heard is provided to you or the holder of the record, as provided in 42 CFR part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

1. the individual identifiers have been removed; or
2. when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of SUD Part 2 treatment records, psychotherapy notes, and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights
You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Annual Notices

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period MYcroSchool, Inc has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.For more information, please see Your Rights Under HIPAA**.**

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

Model General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get 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 more 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 Plan Administrator.

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 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're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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 of the following qualifying events:

- 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 continuation 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 qualifying 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 all 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 *or enter longer period permitted under the terms of the Plan* after the qualifying event occurs. You must provide this notice to the Plan Administrator.

How is COBRA continuation 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 that generally lasts for 18 months due to employment termination or reduction of hours of 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.

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

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying 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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

Annual Notices

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

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/agencies/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
To protect your family's rights, let the Plan Administrator know about 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
Name of Entity/Sender: MYcroSchool, Inc
Contact-Position/Office: Denise Castro
Address: 7054 NW 10th Pl, Gainesville, FL 32605
Phone Number: 352-586-1364

Fixed Indemnity Policy Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

MYcroSchool

my school, my way