

2026-2027 OPT OUT WAIVER

Rebecca School & Aaron School

Waiving Coverage in the Company's Medical Insurance

The Company provides employees regularly scheduled 30 or more hours per week the option of electing or waiving participation in an affordable medical plan. If enrollment in the Company's medical plan is declined AND the employee is enrolled in a medical plan providing minimum essential coverage outside of the Company, the employee is eligible for the Opt-Out Waiver. It is necessary to provide evidence of current insurance through another health care provider. The evidence must accompany this signed form when returned.

This waiver must be elected within the initial eligibility period for medical benefits. If the Opt-Out Waiver is not elected during the initial eligibility period, employees must wait until the next Open Enrollment unless experiencing a qualifying life event. Employees must notify the Benefits Department within 30 days of a qualifying life event.

This waiver is effective for the 2026-2027 plan year and not payable: when there are no wages being paid (i.e. leave of absence, termination of employment), when hours are reduced below 30 per week, or the employee loses coverage in a medical plan providing minimum essential coverage. The employee must notify the Plan Administrator at the time minimum essential coverage is lost. The Opt-Out is not paid retroactively for any reason.

I choose to receive the Opt-Out Waiver and accept \$25.00 as part of my taxable per pay compensation. I understand the Company is offering me an opportunity to enroll in affordable medical coverage and I have freely made the decision to waive participation in this coverage. I understand by waiving participation in the medical plan, I cannot elect to participate in the Company's medical plan until the next open enrollment or unless I experience a qualifying life event. I understand by signing this Opt-Out Waiver I am agreeing that I am enrolled in a plan providing minimum essential coverage and intend to be enrolled in this coverage for the 2026-2027 plan year (July 1, 2026-June 30, 2027).

I understand that I can enroll in the dental and/or vision plan and still receive the opt-out waiver. I must re-elect this waiver on an annual basis during the open enrollment/re-enrollment period.

Proof of my coverage through _____ is attached.
(Name of Provider)

Print Name

Employee Signature

Date

*Please submit all paperwork to the attention of the New Story Benefits Department at: fax 888.714.4428; or by email HRSupport@newstory.com.

The Company reserves the right to modify or end this program at its discretion.