MANDATORY NOTICES

IMPORTANT NOTICE ABOUT THIS GUIDE AND THE LEGISLATIVE NOTICES INCLUDED:

A Plan Sponsor's responsibilities include making sure the health plan complies with ERISA, ACA and other federal and state regulations. Various federal notices are set forth below. Even if employers use third-party service providers to manage the plan, there are still certain functions that may make the employer responsible as a fiduciary. Plan Sponsors are recommended to maintain comprehensive record-keeping documents for up to seven years.

Insurance Office of America does not intend for you to use this guide as a substitute for legal counsel. Should you have any questions or concerns, you should contact your legal counsel for further guidance on all matters pertaining to compliance. Importantly, since this information is intended as a brief overview, please refer to the applicable federal regulations for more specific and detailed information. In addition, please note that States may have additional laws, restrictions and benefits that are more protective of individuals. You should always consult your State's benefits and insurance laws for further guidance.

Onin Staffing | 2027 Benefit Guide

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SECTION 1: ERISA

Your Rights Under ERISA (Statement of ERISA Rights)

As a participant in Onin Staffing's employee benefit plan(s), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

SECTION 2: HIPAA

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment 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 after your or your dependents other coverage ends.

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 after the marriage, birth, adoption, or placement for adoption.

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

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To request special enrollment or obtain more information, please contact Human Resources.

Health Insurance Portability and Accountability Act (HIPAA) – Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the HITECH Act, requires that Onin Staffing's group health plan maintain the privacy of your protected health information, ("PHI"), provide you with notice of our legal duties and privacy with respect to PHI, and follow the terms of the notice currently in effect. 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.

Uses and Disclosures of Protected Health Information

Onin Staffing's group health plan may use and disclose your PHI for purposes of treatment, payment, and health care operations without your written authorization. For example:

- **Treatment:** The plan may disclose your PHI to a health care provider who requests it in connection with your treatment.
- **Payment:** The plan may use and disclose your PHI to pay claims from health care providers for services rendered to you, to determine your eligibility for benefits, to coordinate benefits with other plans, or to determine your responsibility for plan premiums.
- **Health Care Operations:** The plan may use and disclose your PHI for plan operations such as quality improvement activities, auditing functions, cost-management analysis, plan administration, and customer service.

Other Permitted Uses and Disclosures Without Your Authorization

The plan may also use or disclose your PHI without your written authorization for the following purposes, to the extent permitted or required by law:

As required by law; for public health activities; to report victims of abuse, neglect, or domestic violence; for health oversight activities; for judicial and administrative proceedings; for law enforcement purposes; for purposes related to decedents (coroners, funeral directors); for cadaveric organ, eye, or tissue donation; for research purposes under specific conditions; to avert a serious threat to health or safety; for specialized government functions (military, national security, protective services); and for workers' compensation purposes.

Uses and Disclosures Requiring Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization. You may revoke an authorization at any time, in writing, except to the extent that the plan has already taken action in reliance on the authorization. Without your written authorization, the plan will not use or disclose your PHI for: marketing purposes; sale of PHI; psychotherapy notes (except as otherwise permitted); or any purpose not described in this notice.

Prohibition on Conditioning Authorization

The plan may not condition your enrollment in the health plan, eligibility for benefits, or payment of a claim on your providing an authorization for the use or disclosure of your PHI, except in limited circumstances involving research-related treatment or to determine enrollment or eligibility in the plan when disclosure of PHI is necessary for underwriting purposes (and such PHI will not be used for any other purpose).

Your Rights Regarding Your PHI

You have the following rights with respect to your PHI:

- **Right to Inspect and Copy.** You have the right to inspect and obtain a copy of your PHI contained in a "designated record set" for as long as the plan maintains the information. You may request your information in an electronic format if readily producible. The plan may charge a reasonable, cost-based fee. You also have the right to direct the plan to transmit a copy of your PHI in a designated record set directly to another person you designate in writing. Your written, signed request must clearly identify the designated person and where to send the copy of PHI.
- **Right to Amend.** You have the right to request that the plan amend your PHI or a record about you in a designated record set for as long as the information is maintained. The plan may deny your request if the plan did not create the information or if the plan determines the information is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to receive an accounting of certain disclosures of your PHI made by the plan during the six years prior to your request. The accounting will not include disclosures made for treatment, payment, or health care operations; disclosures made to you; disclosures authorized by you; or certain other disclosures.
- **Right to Request Restrictions.** You have the right to request a restriction on certain uses and disclosures of your PHI. The plan is not required to agree to a requested restriction, except that the plan must agree to restrict disclosures to a health plan for payment or health care operations when you have paid out of pocket in full for a health care item or service.
- **Right to Request Confidential Communications.** You have the right to request that the plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the plan only contact you by mail or at work. The plan will accommodate all reasonable requests.
- **Right to Receive Notice of a Breach.** You have the right to be notified if there is a breach of your unsecured PHI. See the "HIPAA Breach Notification Rights" section below for details.
- **Right to a Paper Copy of This Notice.** You have the right to obtain a paper copy of this notice upon request, even if you have agreed to accept the notice electronically.

Mandatory Notices

- **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with the plan administrator or with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint. To file a complaint with the plan, contact Human Resources. To file a complaint with HHS, write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201, or call 1-877-696-6775, or visit www.hhs.gov/ocr/privacy/hipaa/complaints.
- **Personal Representatives.** The plan will treat a personal representative as the individual for purposes of this notice and the HIPAA Privacy Rule. A personal representative is a person who has authority under applicable law to make health care decisions on your behalf (such as a parent for a minor child, a legal guardian, or a person with a valid health care power of attorney). If you are an adult or emancipated minor, your personal representative may exercise your rights under this notice. In certain cases involving abuse, neglect, or endangerment, the plan may choose not to treat a person as your personal representative if it reasonably believes doing so would not be in your best interest.

Plan's Duties

The plan is required by law to maintain the privacy of your PHI; provide you with this notice of its legal duties and privacy practices with respect to PHI; notify you following a breach of unsecured PHI; abide by the terms of this notice; and promptly notify you if a breach of your unsecured PHI is committed by one of the plan's business associates. The plan reserves the right to change the terms of this notice and to make the new provisions effective for all PHI that it maintains. If the plan changes this notice materially, a revised notice will be provided to you.

Fundraising Communications

If the plan or a related foundation uses or discloses your PHI for the purpose of raising funds for its own benefit, you have the right to opt out of receiving future fundraising communications. Each fundraising communication you receive will include a clear and conspicuous opportunity to elect not to receive further fundraising communications. If you opt out, the plan may not condition treatment or payment on your choice regarding fundraising communications. [Note: If the plan does not engage in fundraising activities, this provision does not apply.]

Contact Information

If you have questions about this notice or want to exercise any of your rights, contact:

Onin Staffing

3800 Colonnade Parkway Suite 300
Birmingham, AL 35243

205-298-7233

HIPAA Breach Notification Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), and under 42 CFR Part 2 (as amended effective February 16, 2024), you have the right to be notified following a breach of your unsecured protected health information (PHI), including substance use disorder (SUD) patient records that are subject to 42 CFR Part 2 protections.

What Is a Breach?

A breach is the acquisition, access, use, or disclosure of unsecured protected health information in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of such information. This includes unauthorized access, use, or disclosure of substance use disorder records protected under 42 CFR Part 2. Unsecured PHI is protected health information that has not been rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of approved technologies or methodologies (such as encryption or destruction).

Notification Requirements

In the event of a breach of your unsecured protected health information, Onin Staffing's group health plan (or its business associate, if applicable) will notify you without unreasonable delay and in no case later than 60 calendar days after the discovery of the breach.

Content of Breach Notification

The breach notification you receive will include, to the extent possible:

- A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;
- A description of the types of unsecured protected health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, diagnosis, disability code, or other types of information);
- Any steps you should take to protect yourself from potential harm resulting from the breach;
- A brief description of what the covered entity is doing to investigate the breach, mitigate harm to individuals, and protect against any further breaches; and
- Contact procedures for you to ask questions or learn additional information, which will include a toll-free telephone number, an e-mail address, website, or postal address.

How You Will Be Notified

Notification will be provided to you in written form by first-class mail at your last known address. If you have agreed to receive communications electronically, notification may be provided by e-mail. If the covered entity has insufficient or out-of-date contact information for you, substitute notice may be provided.

Mandatory Notices

Additional Information

If a breach affects 500 or more individuals, notice will also be provided to prominent media outlets serving the state or jurisdiction. The Secretary of the U.S. Department of Health and Human Services will also be notified. These requirements apply equally to breaches of substance use disorder patient records maintained under 42 CFR Part 2.

For more information about your privacy rights under HIPAA, contact Human Resources at Onin Staffing or visit the U.S. Department of Health and Human Services website at www.hhs.gov/hipaa.

Confidentiality of Substance Use Disorder Records – 42 CFR Part 2 Notice

Effective February 16, 2024, the U.S. Department of Health and Human Services issued a final rule aligning the confidentiality requirements for substance use disorder (SUD) patient records under 42 CFR Part 2 with the HIPAA Privacy Rule. This notice informs you of your rights regarding SUD records and the protections that apply.

Substance Use Disorder Records

If the Plan receives records protected by 42 CFR Part 2 from a covered substance use disorder treatment program, additional federal privacy protections apply to those records. This section describes those protections; it does not describe or change the benefits covered under the Plan.

What Are Part 2 Records?

Part 2 records are records of the identity, diagnosis, prognosis, or treatment of any patient that are created or maintained by a federally assisted program or activity relating to substance use disorder education, prevention, training, treatment, rehabilitation, or research. These records receive heightened confidentiality protections under federal law.

Single Consent for Treatment, Payment, and Health Care Operations

Under the updated regulations, if you provide a single written consent, your SUD treatment records may be used and disclosed for purposes of treatment, payment, and health care operations by Onin Staffing's group health plan and its covered entities and business associates. You are not required to provide consent, and your consent may be revoked at any time in writing (except to the extent that action has already been taken in reliance on your consent). If you choose not to consent, your SUD records will not be shared with the plan for treatment, payment, or health care operations purposes.

Prohibition on Use in Legal Proceedings

Your SUD treatment records protected under Part 2 may not be used in any civil, criminal, administrative, or legislative proceeding conducted by any federal, state, or local authority against you, without your written consent or a court order that meets specific requirements under 42 CFR Part 2. This is true even if you have consented to disclosure of your records for treatment, payment, or health care operations.

Anti-Discrimination Protections

No recipient of Part 2 records may discriminate against you in connection with admissions, access to services, employment, housing, insurance, education, or any other benefit based on information received from Part 2 records. This prohibition applies to Onin Staffing and all entities that receive your SUD records. Any violation of this anti-discrimination provision may result in criminal penalties and civil liability.

Restrictions on Redisclosure

Any person or entity that receives your SUD records pursuant to your written consent or as otherwise permitted under 42 CFR Part 2 is bound by the following restriction: This record that has been disclosed to you is protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of this information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR 2.12(c)(5) and 2.65.

Right to an Accounting of Disclosures of SUD Records

You have the right to request an accounting of disclosures of your SUD records. The accounting will include disclosures made for treatment, payment, and health care operations during the three years prior to your request. This right is in addition to, and broader than, the HIPAA accounting of disclosures right described above (which excludes TPO disclosures). To request an accounting, submit a written request to Human Resources or the Privacy Officer at Onin Staffing.

Right to Request Restrictions on SUD Records

You have the right to request restrictions on the use and disclosure of your SUD records. You may revoke or limit your consent at any time by providing a written revocation to the Part 2 program or to Onin Staffing. Revocation is not effective to the extent that action has already been taken in reliance on your prior consent.

Penalties for Violations

Any person who violates the federal confidentiality restrictions on substance use disorder patient records is subject to a criminal fine of not more than $500 for a first offense and not more than $5,000 for each subsequent offense. In addition, the HIPAA civil and criminal penalty structure now applies to breaches and violations involving Part 2 records, including penalties of up to $50,000 per violation (and up to $1.5 million annually for identical violations) and criminal penalties for knowing misuse.

Complaints

If you believe that your rights under 42 CFR Part 2 have been violated, you may file a complaint with: (1) Onin Staffing's Privacy Officer or Human Resources; (2) the U.S. Department of Health and Human Services, Office for Civil Rights, at www.hhs.gov/ocr/complaints or 1-800-368-1019; or (3) any appropriate state authority. You will not be penalized or retaliated against for filing a complaint.

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For more information about your rights under 42 CFR Part 2 and HIPAA, contact Human Resources or the Privacy Officer at Onin Staffing, or visit the Substance Abuse and Mental Health Services Administration (SAMHSA) website at www.samhsa.gov.

SECTION 3: ACA / AFFORDABLE CARE ACT

Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Important Notice: Medicare Part D Creditable Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Onin Staffing 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.

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. Onin Staffing has determined that the prescription drug coverage offered by the UMR Bronze medical 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.

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 under the group plan and don't join a Medicare

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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 More Information About This Notice Or Your Current Prescription Drug Coverage

Contact your Human Resources 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 the group plan coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

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

Contact Human Resources for more information:

Onin Staffing

3800 Colonnade Parkway Suite 300
Birmingham, AL 35243

205-298-7233

Important Notice: Medicare Part D Non-Creditable Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your Onin Staffing 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.

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. Onin Staffing has determined that the prescription drug coverage offered by the **UMR Blue Medical Plan**, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage.

3. You can keep your current coverage from the group plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you decide to drop your current coverage under the group plan, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

Since the prescription drug coverage under the group plan is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. If you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

Contact Human Resources for more information:

Onin Staffing

3800 Colonnade Parkway Suite 300
Birmingham, AL 35243

205-298-7233

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

State Contacts

ALABAMA Medicaid

Website: myalhipp.com | Phone: 1-855-692-5447

ALASKA Medicaid

The AK Health Insurance Premium Payment Program
Website: myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS Medicaid

Website: myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA Medicaid

Health Insurance Premium Payment (HIPP) Program
Website: dhcs.ca.gov/hipp
Phone: 916-445-8322 | Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: www.healthfirstcolorado.com
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): www.mycohibi.com
HIBI Customer Service: 1-855-692-6442

FLORIDA Medicaid

Website: www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA Medicaid

GA HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

ILLINOIS Medicaid

Illinois Medicaid Premium Assistance Information Medicaid application website: abe.illinois.gov
HIPP Hotline Number: 217-524-8268
HIPP Email: hfs.boc.hipp@illinois.gov

INDIANA Medicaid

Health Insurance Premium Payment Program.
All other Medicaid
Website: www.in.gov/medicaid
www.in.gov/fssa/dfr
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA Medicaid and CHIP (Hawki)

Medicaid Website: hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

State Contacts

KANSAS Medicaid

Website: www.kancare.ks.gov
Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660

KENTUCKY Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: chfs.ky.gov/agencies/dms

LOUISIANA Medicaid

Louisiana Medicaid Website: www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website:
www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE Medicaid

Enrollment Website:
www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS Medicaid and CHIP

Website: www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA Medicaid

Website: mn.gov/dhs/health-care-coverage
Phone: 1-800-657-3672

MISSOURI Medicaid

Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA Medicaid

Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA Medicaid

Medicaid Website: dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE Medicaid

Website: 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

NEW JERSEY Medicaid and CHIP

Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid
Phone: 1-800-356-1561 | CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK Medicaid

Website: www.health.ny.gov/health_care/medicaid
Phone: 1-800-541-2831

NORTH CAROLINA Medicaid

Website: medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA Medicaid

Website: www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA Medicaid and CHIP

Website: www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON Medicaid and CHIP

Website: healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA Medicaid and CHIP

Website: www.pa.gov/en/services/dhs/apply-for-medic-aid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND Medicaid and CHIP

Website: www.eohhs.ri.gov
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA Medicaid

Website: www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA Medicaid

Website: dss.sd.gov
Phone: 1-888-828-0059

TEXAS Medicaid

Website: www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)
Website: medicaid.utah.gov/upp
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: medicaid.utah.gov/expansion
Utah Medicaid Buyout Program Website: medicaid.utah.gov/buy-out-program
CHIP Website: chip.utah.gov

VERMONT– Medicaid

Website: dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

State Contacts

VIRGINIA Medicaid and CHIP

Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON Medicaid

Website: www.hca.wa.gov
Phone: 1-800-562-3022

WEST VIRGINIA Medicaid and CHIP

Website: dhhr.wv.gov/bms
mywvhipp.com
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN Medicaid and CHIP

Website: www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING Medicaid

Website: 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 July 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 5/31/2029)

Mandatory Notices

Mandatory Notices

SECTION 4: COBRA

Model General Notice of COBRA Continuation of Coverage Rights

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;
- 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 after the qualifying event occurs. **You must provide this notice to:** Human Resources.

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.

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.

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.

IF YOU HAVE QUESTIONS

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

PLAN CONTACT INFORMATION

Onin Staffing

3800 Colonnade Parkway Suite 300
Birmingham, AL 35243

205-298-7233

State Continuation of Coverage

Due to size, your group plan does not fall under Federal COBRA guidelines. However, you may have a state continuation option available to you. Contact your insurance carrier or Human Resources for more information. Additional information can be found on your state's department of insurance website.

SECTION 5: GINA

Genetic Information Nondiscrimination Act (GINA) Notice

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

SECTION 6: MHPAEA

Mental Health Parity and Addiction Equity Act (MHPAEA) Notice

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that group health plans and health insurance issuers ensure that financial requirements (such as copays, deductibles, and coinsurance) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits.

If Onin Staffing's group health plan provides mental health and/or substance use disorder benefits, those benefits must be provided in parity with medical and surgical benefits. This means:

- Financial requirements (such as copays, deductibles, coinsurance, and out-of-pocket maximums) applicable to MH/SUD benefits cannot be more restrictive than the predominant financial requirements applied to substantially all medical/surgical benefits in the same classification.
- Treatment limitations (such as visit limits, prior authorization requirements, and other utilization management tools) applicable to MH/SUD benefits cannot be more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits in the same classification.
- Non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits must be comparable to, and applied no more stringently than, those applied to medical/surgical benefits.

Your Rights Under MHPAEA

As a participant or beneficiary in Onin Staffing's group health plan, you have the right to:

- Request and receive the criteria for medical necessity determinations made with respect to mental health or substance use disorder benefits under the plan.
- Request and receive the reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits under the plan.
- Request a copy of the plan's comparative analysis demonstrating compliance with MHPAEA's non-quantitative treatment limitation (NQTL) requirements upon request, as required by the Consolidated Appropriations Act, 2021.

Mandatory Notices

To exercise these rights or for questions regarding mental health and substance use disorder parity, contact Human Resources at Onin Staffing or the plan administrator.

You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or www.dol.gov/ebsa for assistance.

SECTION 7: OTHER HEALTH PLAN PROTECTIONS

Women's Health and Cancer Rights Act of 1998

If you are enrolled in a health plan that covers the medical and surgical costs of a mastectomy, the WHCRA states that your plan must also cover the costs of certain reconstructive surgery and other post-mastectomy benefits.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the 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. Therefore, the deductibles and coinsurance of your enrolled plan will apply.

If you would like more information on WHCRA benefits, contact your plan administrator or Human Resources.

Newborns' and Mothers' Health Protection Act

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

Michelle's Law Notice

Under Michelle's Law (29 U.S.C. § 1185c), if your dependent child is covered under Onin Staffing's group health plan as a student and loses student status due to a medically necessary leave of absence from a postsecondary educational institution, the plan is required to continue coverage for the dependent child.

Eligibility

This protection applies if:

- The dependent child is a covered dependent under the group health plan;
- The dependent child was enrolled as a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence; and
- The leave of absence is medically necessary due to a serious illness or injury of the dependent child.

Duration of Coverage

Coverage for the dependent child will continue for the earlier of:

- One (1) year after the first day of the medically necessary leave of absence; or
- The date on which coverage would otherwise terminate under the terms of the plan.

Written Certification Required

To invoke this right, a written certification from the dependent child's treating physician must be provided to the plan, stating that the dependent child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

Level of Coverage

During the continuation period, the plan must continue to provide the same level of benefits and coverage that would have been provided had the dependent child continued to be a student at the postsecondary educational institution.

For more information or to request continuation of coverage under Michelle's Law, contact Human Resources at Onin Staffing.