HEALTHCARE THE WAY YOU DESERVE IT!

America's Choice

2024 Plan Year

WHAT WE DO

America's Choice offers $0 deductible plans with low monthly premiums that won't break your bank.

We provide a custom-tailored mix of health benefit plans with additional no cost benefits to support your overall health and well-being.

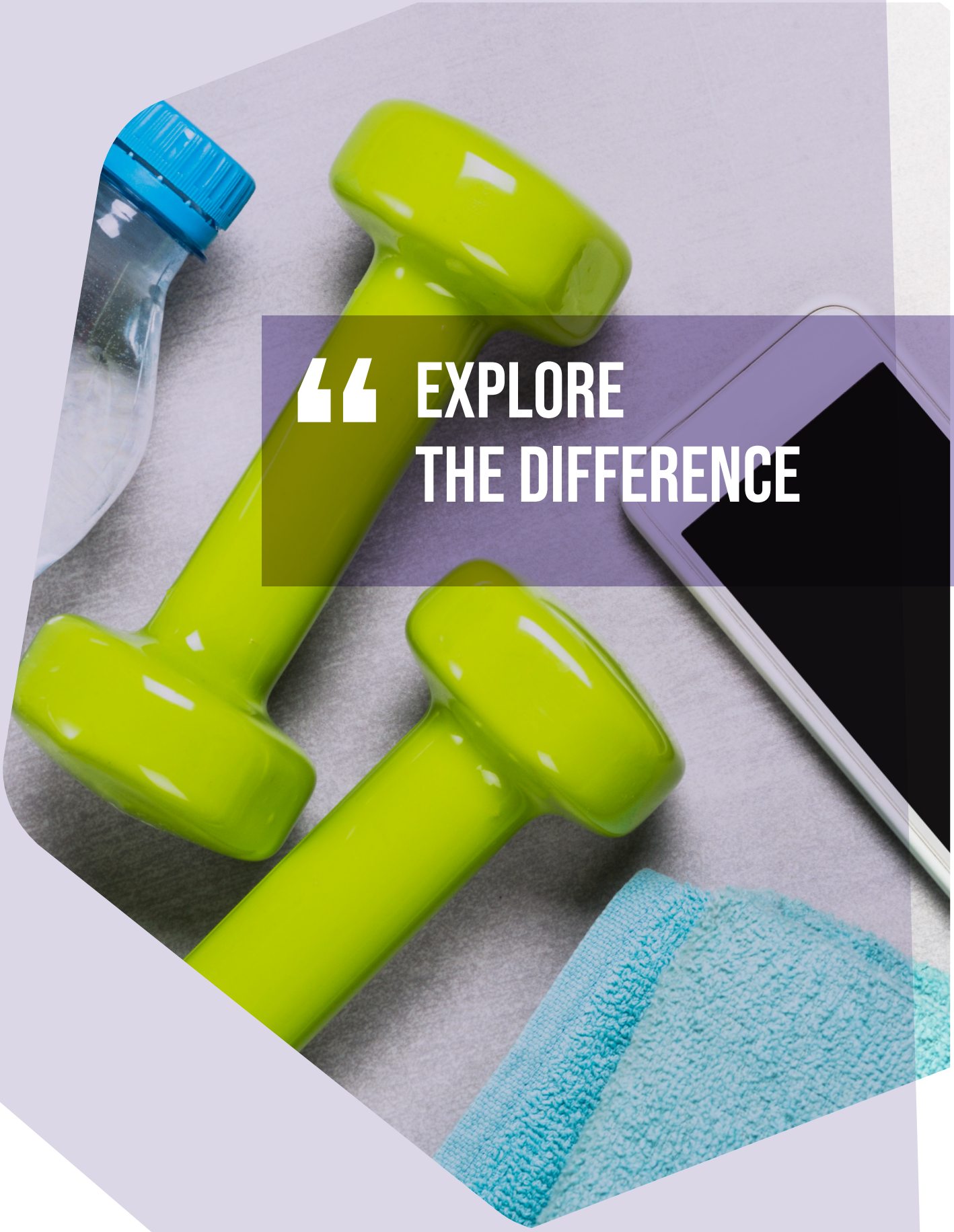
America's Choice plan is designed to:

Save you money

Save you time

Guide you on your journey of well-being

America's Choice offers an unparalleled solution aimed at surpassing your expectations. Our comprehensive suite of services encompasses a diverse range of physician and ancillary networks, cutting-edge pharmacy benefit management, innovative telehealth solutions, and convenient in-home services. With a dedicated commitment to cost-effectiveness, we diligently manage healthcare expenses while offering top-tier coverage options tailored to your needs. Trust America's Choice to elevate your healthcare experience to new heights.



“ EXPLORE THE DIFFERENCE

PERSONAL PORTAL

The Personal Health Dashboard™ (PHD) is a secure online personalized web portal which can be accessed at any time from any device. Once activated through the URL, you can download and utilize our free app.

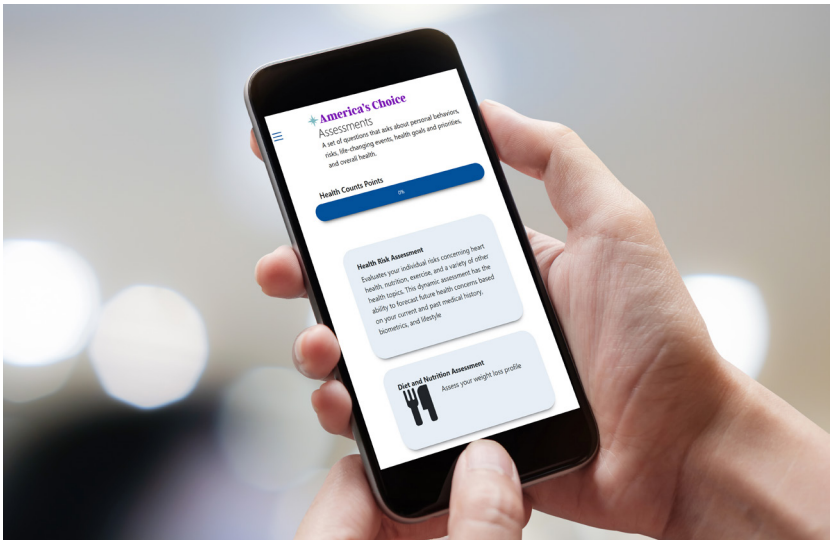
The PHD offers many resources including: Assessments, Medical Library, Road to Wellness online behavior change modules, Medical Records, Health Tracker, and much more.

Accessing your Personal Health Dashboard™ (PHD) Account

- Visit: **https://americaschoice.ushealthcenter.com/app** or scan the QR code.
- Select **Activate your Account**
- Select Activate by Demographics or by Email
- Enter your personal information and select **Activate**
- You will receive your username and be prompted to create a password.
- Enter your username and new password and select **Sign In**

America's Choice PHD

Remember your username and password for future logins!



Download the app

After you have activated your account, you can complete your health optimization activities right on the mobile app.

Search Personal Health Dashboard to download the app.

PHD PERSONAL HEALTH DASHBOARD

Available on the App Store

ANDROID APP ON Google Play

Where can I find information and links to all my benefits?

The Personal Health Dashboard™ (PHD) has information on all of your benefits under the My Benefits Tools tab. Simply log into your PHD and click on the tile you are interested in learning more about.

- Sign in to your Personal Health Dashboard™ at **https://americaschoice.ushealthcenter.com/app**
- Click on **Benefits**
- Click on the benefit you are interested in learning more about

EXPLORE YOUR PHD

Home

View your account information and update your personal info anytime. Use the language widget to translate the site into multiple languages. View Risk Resolution Guidelines to improve your health and Health Reminders for ongoing education.

Assessments

Take your Health Risk Assessment or find numerous mini-assessments to help you better understand your state of health and well-being.

Medical Records

View your Lab Results, Personal Health Assessment Report, Physician Report, and other health records such as a Health Maintenance Schedule.

Road to Wellness

This offers four behavior change modules designed to be completed over a couple months. Topics include Diet & Nutrition, Fitness, Tobacco Cessation, and Stress Management.

Library

View our extensive medical library or watch over 300 visually rich multimedia videos to help develop a deeper understanding of conditions and treatments. There is up-to-date medical information, tips for healthy living, and much more.

Health Tracker

Track your daily activity with the Fitness Tracker and food consumption with the Diet and Nutrition Tracker. Plus, connect your Fitbit, Garmin, Apple Watch, or mobile device directly to your PHD.

Benefits

Find all of your benefits in one spot. Access links and information on EAP, Telemedicine, Coaching, Identity Theft, and Living 2.0, here.

Mobile App

After you have activated your account, you can access your PHD on any device by downloading the app. Search Personal Health Dashboard on the Google Play Store or Apple App Store.

Need Assistance? 877-322-7398 X 2 | help@ushealthcenterinc.com

America's Choice

PREAUTHORIZATION & CASE MANAGEMENT

Preauthorization and case management are programs designed to help make sure you get the most appropriate medical care at the best cost to you. Our staff works closely with you and your doctor to get the maximum benefit from your health plan.

GuideCM

PREAUTHORIZATION

When and how do I get preauthorized?

Check your benefit plan to see which medical procedures require pre authorization. Whenever you have a major surgery or procedure planned, it is best to have your doctor call us to start the preauthorization process. Once we get all the needed information, we will review your request for medical necessity and notify you and your doctor of our decision.

Why do I have to be preauthorized?

Preauthorization helps identify patients that are at-risk for extensive health problems and possibly prevent or reduce future medical costs. We also want to ensure you receive the quality and appropriate care you need and deserve.

CASE MANAGEMENT

What is Case Management?

Case Management is a program designed to help you and your family cope with serious medical conditions. One of our nurses works closely with you, your family, and your physicians to ensure that you have the information and support that you need. Whether you need specialized equipment, referrals, or simply a sympathetic ear, the nurse assigned to you can help you get what you need, when you need it.

How do I know if I need Case Management?

We identify patients who may need case management through the preauthorization process. Once identified, one of our nurses will contact you to learn more about your needs.

Do I have to have a case manager?

Though our highest priority is to help you, we understand that some people are not comfortable sharing personal information, so the decision to use a case manager is entirely yours.

CONFIDENTIAL We respect the privacy of your personal health information. We are in full compliance with the current HIPAA regulations, and any information we receive from you or your physician will be kept strictly confidential.

FOR PREAUTHORIZATION: (866) 317-1714 I info@guidecm.com

America's Choice

TELEMEDICINE

MyLiveDoc
Your health, your time

TELEMEDICINE

CONNECT WITH BOARD-CERTIFIED PHYSICIANS
ANYWHERE IN THE UNITED STATES.

No Claims or Copay

Every State

Care Coordination

Exclusive Doctors

GETTING STARTED IS EASY!

You will receive an email to register. Once registered you can:

Call: **855-226-6567**

Email: **memberservices@mylivedoc.net**

Log in: **https://member.mylivedoc.net**

America's Choice

PRIMARY CARE

12 virtual primary care visits per member per year as well as, 12 care visits per covered child per year. Monday - Friday 8:00 am - 5:00 pm ET.

Same Day Appointments
Access a Virtual Primary Care appointment the same day of requesting it! Or, schedule when it's best for you.

Same Provider Each Visit
See the same provider each visit so that they can best understand your health needs and provide personalized care.

Annual wellness Check
An annual wellness check can help you get on a better health trajectory, get a personalized care plan, and learn more about your overall health!

URGENT CARE 24/7/365

Unlimited virtual urgent care visits per member per year.

Instant Access to Care
Virtual Urgent Care visits can be accessed as short as in 20 minutes! You can also schedule appointments when it best works for you.

In House Providers
See the same provider each visit so that they can best understand your health needs and provide personalized care.

Rx + PHARMACY CARE

70 urgent medications found on your member portal.

Prescriptions
If you have a virtual urgent care visit and your provider prescribes an urgent medication, you can pick it up at your local retail pharmacy at no added cost.

We treat over 50 routine medical conditions including:

- **Acne**
- **Allergies**
- **Cold / Flu**
- **Constipation**
- **Cough**
- **Diarrhea**
- **Ear Problems**
- **Fever**
- **Headache**
- **Insect Bites**
- **Nausea /Vomiting**
- **Pink Eye**
- **Rash**
- **Respiratory Problems**
- **Urinary Problems / UTI**

MENTAL HEALTH THERAPY

4 mental health therapy visits per member per year. Monday - Friday 8:00 am - 5:00 pm ET.

Convenient Scheduling
Easy access to a licensed, Master's level counselor within 1-3 days for adults and covered adolescents ages 12 and up.

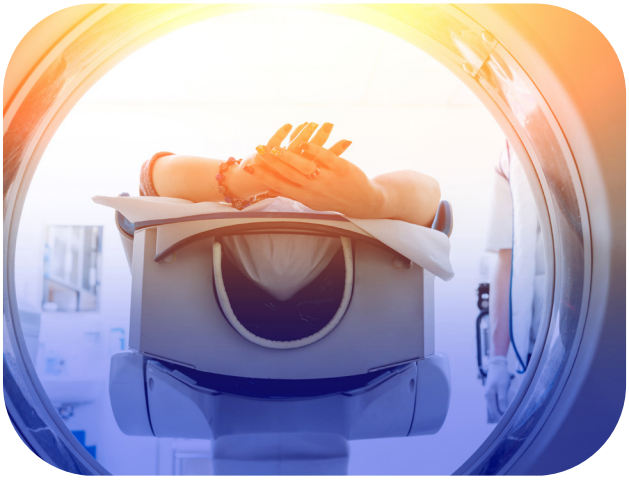
Same Therapist Each Visit
See the same therapist each visit so that they can best understand your personal needs. Our counselors are trained in clinical assessments and care coordination. Should you need in person care, our team is able to provide referrals when needed.

Why mental health therapy?

- **Work or personal conflicts**
- **Co-dependency**
- **Alcohol and drugs, reliance**
- **Tobacco reliance**
- **Eating disorders**
- **Stress and anxiety**
- **Relationship concerns**
- **Child or elder care matters**
- **Physical, sexual, or emotional abuse**

Additional Services:

If you have other challenges or need assistance and support accessing things like food, shelter, transportation, childcare, job training etc., call our Customer Care team at 855-226-6567 for help finding the resources and support that you need.



DIAGNOSTIC IMAGING

Green Imaging
Easy Affordable Medical Imaging

Your health is important to us and we've contracted with Green Imaging to provide medical imaging services at no cost to you. The process couldn't be easier!

Scheduling your appointment

At your appointment

After your appointment

STEP 1

Have your physician order ready and send to MemberServices@detegohealth.com or Call our Care Guides at 866-815-6001

Don't have your physician order?

Ask your doctor to fax us the order at 866.653.0882.

STEP 2

Call Our Care Guides: 866.815.6001

Please include or have ready:

- Your name
- Your zip code
- A picture of your physician order
- Your plan number

STEP 3

Your Green Imaging Medical Concierge will schedule your procedure and send you a voucher for service.

The Voucher Covers

The procedure fee

AND

The radiologist fee

STEP 4

At your appointment, show your Green Imaging voucher.

You will not have a co-pay, and do not need to show your insurance card.

Additionally, you will not be responsible for any bills you may receive in the mail.

STEP 5

The report from your exam will be sent to your referring doctor.

Referring physician has not received your exam report?

CALL: 713.524.9190

No Deductible Services at Discounted Rates:

- MRI (OPEN & CLOSED)
- CT
- PET
- ULTRASOUND
- MAMMOGRAM
- X-RAY
- BONE DENSITY (DXA)
- NUCLEAR MEDICINE
- ARTHOGRAM
- ECHOCARDIOGRAM

Call or email to get started at 866-837-1714 I info@guidecm.com

America's Choice

PHARMACY BENEFIT MANAGER

We have partnered with MetalistRx to offer you premium pharmacy Benefits. Whether its retail pharmacy, mail order or specialty pharma, MedalistRx has you covered for all your Rx needs 24/7.

For assistance, call our toll-free Member Services help desk at 855.633.2579 Option #1.

Concierge Call Service

Our specialists are waiting to handle all benefit coverage questions as well as pharmacy processing challenges. Visit the **MedalistRx Member Portal** or call 855-633-2579 option #1 for direct assistance. Our specialists would be pleased to help you:

- Find a pharmacy
- Understand your coverage
- Determine your copay
- Help you enroll in mail order
- Order a specialty medicine
- Understand your formulary
- Assist with overrides and the prior authorization process
- And much more ...

Prescription Benefits

Retail Pharmacy Prescriptions

Simply present your new ID Card to your pharmacist with your prescription. Your pharmacist may make you aware of generic options available to you. The pharmacist will then inform you of your appropriate cost. **Click here** to view the 2024 MedalistRx Premium Standard Formulary.

Mail-Order Pharmacy Prescriptions

There are three options available to you to get your medications delivered to your home.

1. Order online at **www.optumrx.com**
2. Send in your completed mail-order form found on our website
3. Call our mail-order pharmacy, OptumRx, Member Services toll free at 800.797.9791.

Script Aide Specialty Pharmacy - Call 866-837-1515 or email info@scriptaide.com

Script Aide Specialty Pharmacy is your full-service specialty pharmacy. A dedicated team of specialty pharmacists and staff are able to help you get your specialty medication at the best price with the fastest and safest delivery. Every patient has access to benefit consulting and comprehensive clinical support.

DIABETES MANAGEMENT

America's Choice has partnered with Diathrive to get you diabetes supplies and coaching at no cost to you.

Diabetes Testing Supplies Covered at 100%

Diathrive

- ✓ Quality glucose testing supplies
- ✓ FDA approved supplies
- ✓ Accurate and FDA approved
- ✓ Delivered every 3 months
- ✓ Insulin pen needles also available
- ✓ Share your results from your phone

Personal Health Coaching For Employees Covered 100%

- One on one (phone or web chat)
- Diabetes education
- Proven smoking cessation program
- Nutrition and personal training
- Personalized goals
- Certified coaches

CALL OR EMAIL TO LEARN MORE.

866-837-1714 I info@guidecm.com

MEDICAL EQUIPMENT AND SERVICES

Connect DME

America's Choice has partnered with Connect DME to offer you home medical equipment and services at dramatically lower costs. Connect DME also offers in-home or in-facility sleep studies. The Home Sleep Study is performed by a respiratory therapist and interpreted by a board certified sleep physician.









Medical Equipment & Services

Connect DME offers over 6,000 products including:

- Joint Bracing such as knee, ankle, shoulder
- Respiratory Supports such as CPAPs, Bi-PAPs and Nebulizers
- Breast Pumps and accessories
- Therapy equipment including: DVT Prevention, Cold/Heat Therapy, CPM Machines, and TENS Units
- Supports such as Knee-Wheelers, Crutches, Wheel Chairs and Walkers

For more information: Call 866-837-1714 or email : info@guidecm.com

BALANCE BILLING

Don’t break the bank. Break the cycle.

You work hard for your money. The last thing you desire is to settle a medical bill without certainty about overpayment. As your health plan's ally, we meticulously review medical claims to avoid errors and ensure charges stay within your plan's limits.

While most providers accept fair payments from your plan, some may issue a bill for the balance between what your plan covers and their charges. In such cases, we're here to assist you!

YOUR PART: Identify Balance Bills

Compare the EOB & Provider Bill

After receiving medical care, keep an eye out for the Explanation of Benefits (EOB) from your health plan and a Provider Bill sent by the doctor or facility.

Compare the “amount you owe” on the EOB and bill. If they don’t match, this is a balance bill and we will help!

Send Bills to our Care Guides

Send any balance bills you receive to our care guides right away so we can get to work! You can rely on us to address any billing issues with the provider.

OUR PART: Advocate on Your Behalf

Pay Confidently with our Support

Once we have your written permission, we will work to resolve the bill with the provider on your behalf. We will:

- Assign a dedicated Member Services Advocate to support you and provide regular updates
- Arrange for comprehensive legal support at no extra cost, if necessary
- Provide access to live and online support

Send your balance bill to us. It’s easy!

Email a clear snapshot from your phone or computer to:

MemberServices@DetegoHealth.com

Fax a copy

866-437-0688

Mail a copy to Detego Health:

759 N 114th #300
Omaha, NE 68154

QUESTIONS? We’re here for you.

Phone: 866-815-6001 | **Email:** MemberServices@detegohealth.com

America’s Choice

IDENTITY THEFT PROTECTION

Register Today!

1. Log on to your Personal Health Dashboard™: https://americaschoice.ushealthcenter.com/app
2. Take note of your Member ID located in the upper right corner. This will be used as your customer account number.
3. Your Customer Account = USHC-(Member ID Number). For example, USHC-USH0205172
4. Click on the Benefits.
5. Click on the Identity Theft Protection - Register tile.
6. Complete the required information and click Register.

Required to enroll: name, date of birth, street, city, state, zip, email, and phone number. If there are questions about enrollment, call US HealthCenter at 877-322-1798.

No one can prevent a data breach!
This service can protect your online footprint with digital safety plans for you, your family, and your home.

The Facts

Six Months to Restore Identity

On average, it can take between 100 and 200 hours and six months to restore a stolen identity.

14.4 Million Victims in America

Last year, 14.4 million Americans became victims of identity fraud; that's nearly 1 in 15 people.

$5,000 in Losses

Losses for Identity theft average $5,000 or more per incident.

33% of U.S. Adults

Overall, 33 percent of adults in the United States have experienced identity theft.

Your Identity Theft Protection Includes:

- $25,000 Insurance policy
- Internet monitoring and dark web surveillance
- 24/7/365 Toll-Free Victim Response Center
- Full restoration and recovery services
- Banking and account monitoring
- ID risk score

HEALTH COACHING

US HealthCenter
PERSONAL • PREDICTIVE • HEALTH

What is Wholeistic™ Coaching?

We have partnered with US HealthCenter to offer free Wholeistic™ Health Coaching. Wholeistic™ Health Coaching is a telephonic health management and improvement program that provides you with a personal health coach. Your coach will work with you on an appointment basis to help you understand and manage your health as well as your family's health. Rest assured, your sessions are entirely confidential and come at no expense to you.

As well as managing your health, these one-on-one appointments can also help you lower your health risk(s) and improve your overall well-being. You can discuss a wide range of health conditions or topics such as stress management, high blood pressure, cholesterol, diabetes, weight, smoking cessation, allergies, asthma, heart disease, or cancer.

Getting started is easy!

- Contact us toll free at **877-322-7398 x 3** at any time.
  This line goes directly to a voice mailbox. Please leave the name of your employer, your phone number, and the best time to reach you. A health coach will contact you within 24 hours of your request.
- Send an email to **healthcoach@ushealthcenterinc.com**.
  Please provide the name of your employer, your phone number, and the best time to reach you.

OVER 800,000 PROVIDERS

PHCS

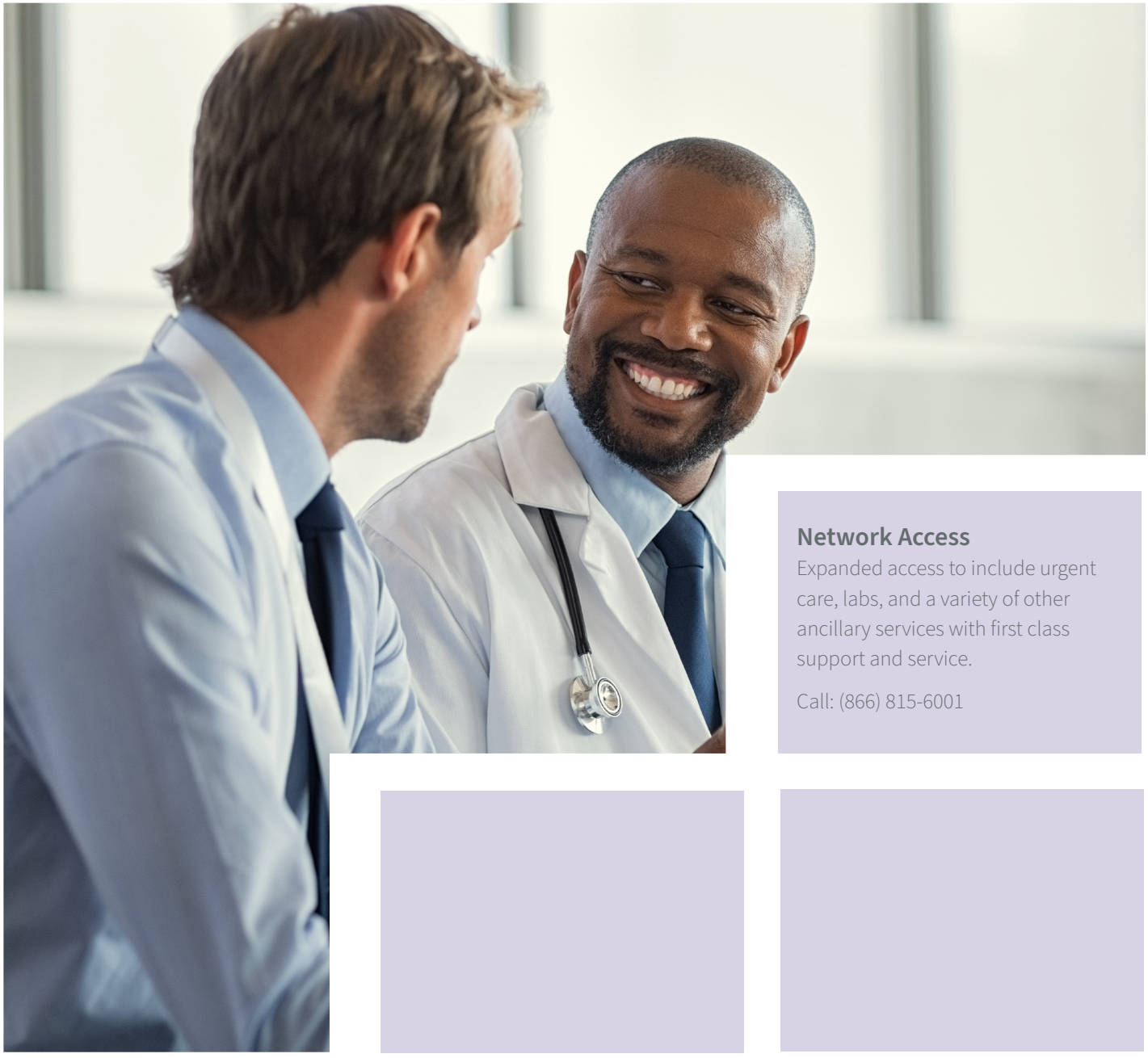
Find your Physician

Expanded access to include Urgent Care, labs, and a variety of other ancillary services with first class support and service. To locate providers participating in the MultiPlan® PHCS network call (888) 263-7543 or Log on to: **www.multiplan.com** and click "***Find a Provider***" located in the top right-hand corner and follow the steps below:

1. Acknowledge you have read the disclaimer at the that pops up on the bottom of the screen
2. Click on the green "**Select Network**" button
3. Choose "**PHCS**" as your network
4. Choose "**Practitioner and Ancillary**" from the list
5. Enter one of the search criteria suggested in the search box to begin your search
6. If your browser settings don't allow your location to be detected, enter your zip code

If your physician is not in network, please call our care guides at 866.815.6001. Our team will contact your provider on your behalf and request they continue to provide you services under our plan.

NO ADDED COST



Network Access

Expanded access to include urgent care, labs, and a variety of other ancillary services with first class support and service.

Call: (866) 815-6001

Patient Assistance Program

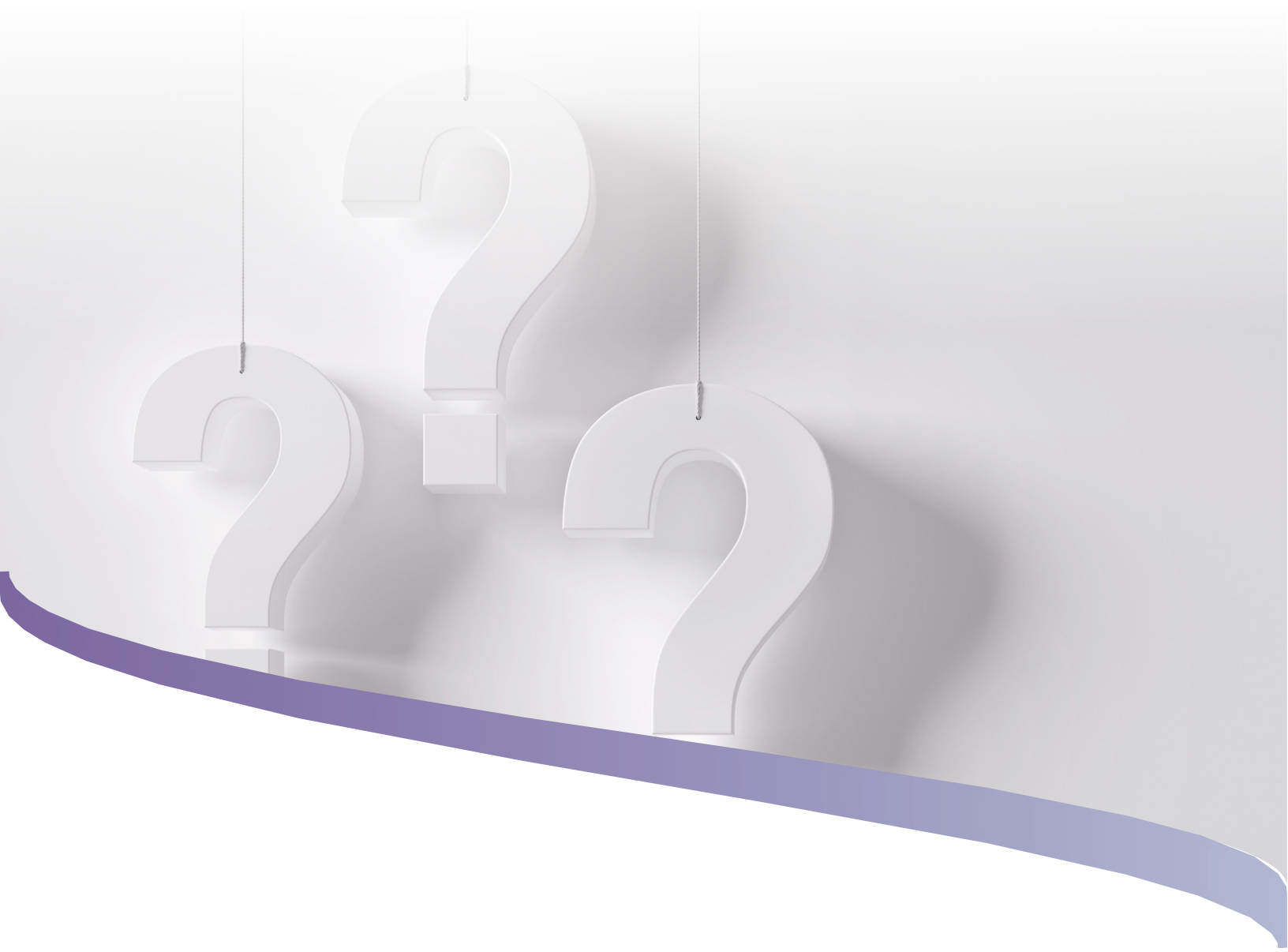
Intended for members that live in the United States and demonstrate qualifying financial need. Those who qualify, will receive their medicine for free — no co-pays or shipping costs.

Call: 866-837-1515

Prescription Importation Programs

Compare pricing and import prescriptions from our Canadian pharmacies allowing your members to save up to 70% on their prescriptions.

Call: 866-837-1515



AMERICA'S CHOICE FAQ'S

America's Choice

Answers to Frequently Asked Questions about your health benefits.

The following are answers to Frequently Asked Questions (FAQs) about America's Choice powered by Detego Health and the health benefits provided under your Plan. If you need additional assistance, please call the Detego Health Care Guides team toll-free at (866) 815-6001.

About Detego Health

Who is Detego Health?

Detego Health is a Third-Party Administrator for small to midsize companies. We are not an insurance company. We coordinate all the services needed to administer self-insured and level funded plans for employers.

Doctors, Urgent Care & Other Providers

How do I find a physician or Urgent Care Provider?

Keep in mind that your benefits are not like traditional insurance. Staying within the defined benefit network (PHCS, Green Imaging, etc.) and utilizing the established protocols for non-emergency medical needs will ensure cost savings. Please call or email our Care Guides team prior to accessing care outside of these defined protocols in order to avoid balance billing and/or denial of claims.

You can view the most current list of providers online by selecting **www.multiplan.com/webcenter/portal/providersearch** and visiting the PHCS Physicians & Ancillary network and selecting "Find a Provider."

Outpatient Care

How do I find providers for blood work, imaging, and surgery centers?

- For Emergency Room Visits- In an emergency, you may visit ANY ER you can access. Just give us a call the next day to inform us.
- For Imaging Services (MRI, CT Scans, PET Scan, or X-ray) - These services must be pre-certified.
- For Labs and Blood Work - The PHCS Physician and Ancillary network is available for blood work.
- For any and all questions on your plan, call our Care Guides at (866) 815-6001.

Do I need to select a primary care physician or obtain a referral to see a specialist?

No! America's Choice Health plans do not require you to select a primary care physician or obtain a referral to see a specialist. However, an ongoing relationship with a primary care physician can help you manage your health and address any concerns you have early on.

You can use the PHCS Physician & Ancillary Network Provider Finder from your computer or mobile phone Web browser to search for primary care physicians for you and your covered family members in specialties such as internal medicine, family practice and pediatrics.

Will I receive a provider directory?

Provider directories are not printed, as they are updated so frequently. You may view the most current list of providers online by visiting **www.multiplan.com/webcenter/portal/providersearch**.

Where can I get a Summary of my Benefits & Coverage (SBC)?

A Summary of Benefits can be provided by calling our Care Guides at (866) 815-6001.

Why do the ID cards only have the employee's name and not all family members' names?

The ID cards display only the subscriber (employee) name and Employee Coverage Tier. The cards are to be used for all eligible family members even though their names are not printed on the card. If you need an additional card, you can request one by contacting our Care Guides at (866) 815-6001.

How do I submit a claim?

If you need to submit a claim, please call 866-837-1436 or email member services at **info@naviclaim.com**.

How and when can I call Detego Health Care Guides?

You can reach our Care Guides Monday through Friday, from 8 a.m. to 6 p.m. Eastern Time. Our Care Guides are available to explain your benefits.

Please call (866) 815-6001 or visit us at www.detegohealth.com.

Can I email questions directly to Detego Health?

Yes! Once you receive your welcome packet you can email us directly at **MemberServices@detegohealth.com.**

Do you have videos that can help me better understand how to use your services?

Yes! Click on the QR code below to be taken to the “How To” video library.

REQUIRED NOTICES

America's Choice

**** The following notices are to provide you with information regarding your rights. Please review the information carefully and contact our office with any questions.**

Privacy Notice

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.

Your Privacy Is Important To Us: Detego Health is committed to protecting the information that we receive from you or about you, and in turn, respecting your privacy. To effectively administer the health care Plan that covers you, Detego Health must collect and disclose Protected Health Information. This information is considered private and confidential. We have policies and procedures in place to protect the information against unlawful use and disclosure. This Privacy Notice will explain the type of information we collect; how we use that information; and how we protect that information. Detego Health is operating under the conditions of this notice. If any of the elements change, you are entitled to a revised copy of this notice.

What Is "Protected Health Information"?

Protected Health Information includes your name, address, social security number, date of birth, marital status, dependent information, employment information, present or future, physical or mental health conditions, the provision of health care, or the past, present, or future for the provision of health care. This information is collected from applications and claim forms submitted by you and/or your health care provider. For example, whenever a doctor treats you, we will receive a bill from that doctor. The information with that bill may include identifying information about you such as your name, social security number, as well as your diagnosis, procedures, and supplies used. We will use the information on the claim form to pay your provider in accordance with the terms of your Benefits Plan.

Why Does Detego Health Collect This Information?

We collect Protected Health Information to accurately identify you, process your claims, perform health care operations, and administer your employer's health plan.

How Is The Information Protected?

At Detego Health, we restrict the access of the Protected Health Information only to those employees who need it in order to provide services to you. All information accessed by employees of Detego Health, is used on a "minimum necessary" basis. We maintain physical, electronic and procedural safeguards to protect Protected Health Information against unauthorized access and uses. Access to our facilities and files is limited to authorized personnel. Electronic information that we receive and maintain is protected through the use of a variety of technical tools. Detego Health has designated a Privacy Officer who has the responsibility for overseeing the implementation and enforcement of policies and procedures to safeguard Protected Health Information against inappropriate access, use, and disclosure, consistent with applicable law.

What Information We May Disclose:

We do not disclose any Protected Health Information to anyone, except with member authorization or as otherwise permitted by law. An authorization is required, from you, for the use or disclosure of psychotherapy notes, for marketing purposes, and for the sale of your Protected Health Information. You are also permitted to revoke authorization at any time. Disclosures by law typically include those described below. When it is necessary for a person's care or treatment, payment of your medical bills, or the operation of the Health Plan or related activities, the Protected Health Information may be used internally, shared with our affiliates, or disclosed to other health care providers, insurers, payers, the Plan Sponsor, and others who may be financially responsible for payment of services or benefits under the Plan. Protected Health Information may also be disclosed when performing basic Health Care Operations functions necessary to operate a group health plan. Examples of uses and disclosures include conducting plan performance assessments; network or vendor performance assessments; review of the cost impact of benefits design changes; disclosure to underwriters for marketing and underwriting of the plan to obtain reinsurance quotes (genetic information will not be included in the disclosed information); disclosure to stop-loss or reinsurance carriers to obtain claim reimbursements for the Plan; and disclosure to plan consultants who provide legal, actuarial and auditing services to the Plan. These parties are required to keep Protected Health Information confidential as provided by applicable law.

Other Disclosures: If you would like us to disclose your Protected Health Information to yourself or another party, please contact the Privacy officer at Detego Health and request an authorization form. If you would like to access your medical records, you should contact the provider that generated the original records, which are more complete than any we may maintain.

Providers are required to give members access to their medical records. If you think that the information in your medical records is wrong or incomplete, contact the provider that was responsible for the service or treatment in question. Where required by law, or if we are the source of the error, we will contact or amend the records we maintain (but not the records maintained by your provider or other third parties).

HIPAA Privacy Rule: The HIPAA Privacy Rule affords you the following rights:
The right to request restrictions on certain uses and disclosures of protected health information as provided by §164.522 (a) of the Privacy Rule; however, the Group Health Care Plan is not required to agree to your restriction.

- The right to receive confidential communication of your Protected Health Information.
- The right to inspect and copy your Protected Health Information.
- The right to request an amendment of your Protected Health Information
- The right to receive an accounting of all non-standard disclosures of your Protected Information
- Right to be notified of breaches of unsecured electronic Protected Health Information
- Right to opt out of fundraising communications, if applicable. If you have any questions or would like additional information, you may contact the Privacy Officer of Detego Health at 866-815-6001

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint. Detego Health's Privacy Practices are subject to updates as required by federal regulations.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The amount of benefits payable for this coverage is subject to the current Plan provisions, and also subject to applicable deductibles and coinsurance provisions under the current Plan.
If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

The Newborns' and Mothers' Health Protection Act (NMHPA) was signed into law on September 26, 1996. This law protects newborns and mothers by requiring that they be allowed to stay in a hospital for a certain length of time. Group healthcare plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires parity with respect to how annual and lifetime benefits are applied to mental health and substance abuse benefits. In general, the MHPAEA bars Group Healthcare Plans, insurance companies and HMOs offering mental and substance abuse benefits from setting annual or lifetime dollar limits on mental health benefits.

NOTICE OF EXTENDED COVERAGE TO PARTICIPANTS COVERED UNDER A GROUP HEALTH PLAN (MICHELLE'S LAW)

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

1. Dependent child means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his or her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.
2. Medically necessary leave of absence means a leave of absence or any other change in enrollment:
    - of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury
    - which is medically necessary and which causes the dependent child to lose student status under the terms of the Plan

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- One year after the first day of the leave of absence
- The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student)

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

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 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 5, 2022. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ P hone: 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: http://dhss.alaska.gov/dpa/Pages/medicaid/default.asp
ARKANSAS – Medicaid	CALIFORNIA - Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Websites: Health Insurance Premium Payment (HIPP) Program http:dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https:www.colorado.gov/pacific/hcpf/child-health-planplus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: https//www,flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hippindex.html Phone: 1-877-357-3268
GEORGIA – Medicaid	INDIANA – Medicaid
Website: https://medicaid.georgia.gov/health-insurancepremium-payment-program-hipp Phone: 678-564-1162 ext. 2131	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid & CHIP (Hawki)	KANSAS – Medicaid NEW
Medicaid Website: https//dhs.iowa.gov/ime/members Medicaid Phone: 800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 800-257-8563 HIPP Website: https//dhs.iowa.gov/ime/members/ Medicaid-a-to-z/hipp HIPP: 1-888-346-9562	Website: http://www.kancare.ks.gov Phone: 1-800-792-4884

KANSAS – Medicaid	KENTUCKY – Medicaid
Website: http://www.kancare.ks.gov Phone: 1-800-792-4884	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https//chfs.ky.gov
LOUISIANA – Medicaid	MAINE – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-695-2447	Website: http://www.maine.gov/dhhs/ofi/publicassistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https:www.maine.gov.dhhs/ofi/applications-forms
MASSACHUSETTS – Medicaid and CHIP	MINNESOTA – Medicaid
Website: https//www.mass.gov/info-details/masshealth- premium-assistance-pa Phone: 1-800-862-4840	Website: https//mn.gov/dhs/people-we-serve/children-and-services/ other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid	MONTANA – Medicaid
Website: https://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
NEBRASKA – Medicaid	NEVADA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	NEW JERSEY Medicaid & CHIP
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP Program: 800-852-3345 ext. 5218	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/Medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http:www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid	NORTH CAROLINA – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	PENNSYLVANIA – Medicaid
Website: http/healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.dhs.pa.gov/Services/Assistance/Pages/ HIPP-Program.aspx Phone: 1-800-692-7462

RHODE ISLAND – Medicaid	SOUTH CAROLINA – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347 or 401-462-0311 (Direct Rite Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid	TEXAS – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	VERMONT– Medicaid
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	WASHINGTON – Medicaid
Medicaid Website:http://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282	Website: http://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531	

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

For additional information regarding balance billing regulations please contact our office at 866-815-6001

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

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

For additional information regarding balance billing regulations please contact our office at 866-815-6001

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of- pocket limit.

If you believe you've been wrongly billed, you may contact our office at 866-815-6001.

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

** CONTINUATION COVERAGE RIGHTS UNDER COBRA**

Introduction

This notice contains 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 the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from 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 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 are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following 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 of the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

How is COBRA Coverage Provided?

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

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the Social Security Administration determination notice must be provided within 60 days of the date of the determination and prior to the end of the 18th month on continuation coverage and sent to: COBRA Administration, Detego Health, P.O. Box 701648, Tulsa, Oklahoma 74170.

- Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights can be addressed by our office at:

Detego Health LLC
759 N 114th #300,
Omaha, NE 68154
866-815-6001

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

Keep your Plan Administrator informed of changes of address and family or participant status

To protect you and your family's rights, you should keep the Plan Administrator informed of any changes regarding your address and the addresses of family members. Also remember, for 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 should also keep a copy of any notices you send to the Plan Administrator for your records.

Please contact our office, at the address or phone number below for any questions on these notices and/or your plan benefits and eligibility.

Detego Health LLC
759 N 114th #300,
Omaha, NE 68154
866-815-6001