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

Member Responsibilities:

- Supply information to Detego Health as needed to access health benefits.
- Learn how to use health benefits and access member assistance to ask questions about benefits.
- Supply information to Detego Health's network providers so that they can provide health services.
- Understand their own health and work with providers to develop and follow an agreed-upon plan.

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.

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:

- 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.

- 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	INDIANA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ALASKA – Medicaid	IOWA – Medicaid & CHIP (Hawki)
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.aspx	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
ARKANSAS – Medicaid	KANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://www.kancare.ks.gov Phone: 1-800-792-4884
CALIFORNIA - Medicaid	KENTUCKY – Medicaid
Websites: Health Insurance Premium Payment (HIPP) Program http:dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	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
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	LOUISIANA – 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: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-695-2447
FLORIDA – Medicaid	MAINE – Medicaid
Website: https//www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hippindex.html Phone: 1-877-357-3268	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 Phone:
GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurancepremium-payment-program-hipp Phone: 678-564-1162 ext. 2131	Website: https//www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840

MINNESOTA – Medicaid	PENNSYLVANIA – Medicaid
Website: https//mn.gov/dhs/people-we-serve/children-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462
MISSOURI – Medicaid	RHODE ISLAND – Medicaid
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347 or 401-462-0311 (Direct Rite Share Line)
MONTANA – Medicaid	SOUTH CAROLINA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEBRASKA – Medicaid	SOUTH DAKOTA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEVADA – Medicaid	TEXAS – Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW HAMPSHIRE – Medicaid	UTAH – Medicaid and 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: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NEW JERSEY Medicaid & CHIP	VERMONT– Medicaid
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	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NEW YORK – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	http://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
NORTH CAROLINA – Medicaid	WASHINGTON – Medicaid
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.hca.wa.gov/ Phone: 1-800-562-3022
NORTH DAKOTA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
OKLAHOMA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
OREGON – Medicaid	WYOMING – Medicaid
Website: http/healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	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.

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. Your hours of employment are reduced, or

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 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 COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent in accordance with the outlined COBRA continuation procedures of the Plan Document.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, 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 Street #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 Street #300
Omaha, NE 68154

866-815-6001