2022 Employee Benefits Guide

PROFESSIONAL
EMPLOYMENT
GROUP
OF COLORADO

This guide highlights the main features of many of the benefit plans sponsored by Professional Employment Group of Colorado. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. Professional Employment Group of Colorado reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

CHIP NOTICE

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 Professional Employment Group of Colorado, 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 on the following page, 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, dial 1-877-KIDS NOW, or visit 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 a state listed below, you may be eligible for assistance paying your employer health plan premiums. The list of states is current as of October 15, 2021. Contact your State for further information on eligibility.

To see if any other states have added a premium assistance program since October 15, 2021, 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

State	Website/Email	Phone
Alabama (Medicaid)	http://www.myalhipp.com	1-855-692-5447
Alaska (Medicaid)	Premium Payment Program: http://myakhipp.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx E-mail: CustomerService@MyAKHIPP.com	1-866-251-4861
Arkansas (Medicaid)	http://myarhipp.com/	1-855-692-7447
California (Medicaid)	http://dhcs.ca.gov/hipp hipp@dhcs.ca.gov	1-916-445-8322
Colorado (Medicaid and CHIP)	Medicaid: https://www.healthfirstcolorado.com/ CHIP: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus HIBI: https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program	1-800-221-3943 1-800-359-1991 1-855-692-6442 State relay 711
Florida (Medicaid)	https://www.flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268
Georgia (Medicaid)	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp	1-678-564-1162 ext. 2131
Indiana (Medicaid)	Healthy Indiana Plan for low-income adults 19-64: http://www.in.gov/fssa/hip/ All other Medicaid: https://www.in.gov/medicaid	1-877-438-4479 1-800-457-4584
Iowa (Medicaid and CHIP)	Medicaid: https://dhs.iowa.gov/ime/members CHIP: http://dhs.iowa.gov/Hawki HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas (Medicaid)	https://www.kancare.ks.gov/	1-800-792-4884
Kentucky (Medicaid and CHIP)	Medicaid: https://chfs.ky.gov KI-HIPP:https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KI-HIPP E-mail: KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx	1-855-459-6328 1-877-524-4718

State	Website/Email	Phone
Louisiana (Medicaid)	www.medicaid.la.gov www.ldh.la.goc/lahipp	1-888-342-6207 1-855-618-5488
Maine (Medicaid)	https://www.maine.gov/dhhs/ofi/applications-forms	Enroll: 1-800-442-6003 Private HIP: 1-800-977-6740 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	https://www.mass.gov/info-details/masshealth-premium-assistance-pa	1-800-862-4840
Minnesota (Medicaid)	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1-800-657-3739
Missouri (Medicaid)	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana (Medicaid)	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-800-694-3084
Nebraska (Medicaid)	http://www.ACCESSNebraska.ne.gov	1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada (Medicaid)	http://dhcfp.nv.gov	1-800-992-0900
New Hampshire (Medicaid)	https://www.dhhs.nh.gov/oii/hipp.htm	1-603-271-5218 1-800-852-3345 ext. 5218
New Jersey (Medicaid and CHIP)	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html	Medicaid: 609-631-2392 CHIP: 1-800-701-0710
New York (Medicaid)	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina (Medicaid)	https://medicaid.ncdhhs.gov/	1-919-855-4100
North Dakota (Medicaid)	http://www.nd.gov/dhs/services/medicalserv/medicaid/	1-844-854-4825
Oklahoma (Medicaid and CHIP)	http://www.insureoklahoma.org	1-888-365-3742
Oregon (Medicaid)	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	1-800-699-9075
Pennsylvania (Medicaid)	https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx	1-800-692-7462
Rhode Island (Medicaid and CHIP)	http://www.eohhs.ri.gov/	1-855-697-4347 1-401-462-0311
South Carolina (Medicaid)	https://www.scdhhs.gov	1-888-549-0820
South Dakota (Medicaid)	http://dss.sd.gov	1-888-828-0059
Texas (Medicaid)	http://gethipptexas.com/	1-800-440-0493
Utah (Medicaid and CHIP)	Medicaid Website: https://medicaid.utah.gov/CHIP Website: http://health.utah.gov/chip	1-877-543-7669
Vermont (Medicaid)	http://www.greenmountaincare.org/	1-800-250-8427
Virginia (Medicaid and CHIP)	https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp	1-800-432-5924
Washington (Medicaid)	https://www.hca.wa.gov/	1-800-562-3022
West Virginia (Medicaid)	http://mywvhipp.com/	1-855-699-8447
Wisconsin (Medicaid and CHIP)	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming (Medicaid)	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269

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As an employee of Professional Employment Group of Colorado, enjoying your work and making valuable contributions to business are equally vital. The health, satisfaction and security of you and your family are important, not only to your well-being, but ultimately, in terms of achieving the goals of our organization.

For the 2022 plan year, Professional Employment Group has worked hard to offer a competitive total rewards package that includes valuable and competitive benefits plans. These programs reflect our commitment to keeping our staff healthy and secure. We understand that your situation is unique, and PEG is offering an overall benefits package that can be shaped and molded by you to fit your needs.

This guide will outline all of the different benefits PEG offers, so you can identify which offerings are best for you and your family.

Elections you make during open enrollment will become effective on January 1. If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to Human Resources.

We hope this benefits booklet, along with our additional communication and decision-making tools, will help you make the best health care choices for you and your family.

Eligibility

All full-time employees who regularly work a minimum of 30 hours per week are eligible for benefits.

The plans offer coverage for eligible dependents, including:

- Your legal spouse or domestic partner
- Your children up to age 26. Dependent coverage terminates at the end of the month for medical, dental and vision, in which the dependent ceases to meet the definition of an eligible dependent
- “Children” are defined as your natural children, stepchildren, legally adopted children, and children for whom you are the court-appointed legal guardian and your domestic partner children
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested

You must notify the Human Resources Department within 30 days of a qualifying life event in order to make a change to your benefit elections

Documentation supporting the change will be required

Enrollment

Timing

PEG full-time employees are eligible for medical, dental, vision and accident coverage effective the first of the month following 30 days of employment.

The choices you make will remain the same through December 31, 2022. If you do not sign up for benefits during your initial eligibility period or during the Open Enrollment period, you will not be able to elect coverage until the following plan year, unless you have a qualifying life event.

Qualified Life Events

- Legal marital status, including marriage, death of a spouse, divorce, and annulment
- Number of covered dependents due to birth, death, adoption, granting of legal custodianship
- Employment for you, your spouse, or your dependent, including commencement of or return from leave of absence, or change in employment status
- Eligibility for other coverage, or loss thereof or loss or gain of benefit eligibility
- Medicare or Medicaid entitlement for you, your spouse, or dependent

When Coverage Ends

If your employment with PEG ends, your medical, dental, and vision coverage will end on the last day of the month following your date of separation. Other circumstances which may result in termination of coverage for you and/or your dependents include: reduction in regular hours, divorce/legal separation, and dependent children reaching age 26.

Enrollment Instructions

Log into Ease with your username and password, To begin, once you are on the Employee Dashboard click “Start Enrollment”. After you have completed your benefit elections, click “Submit”.

Need to Locate a Participating Provider?

The PEG medical plan allows you the flexibility to choose a health care provider when and where treatment is needed

When care is received inside Cigna's Open Access Plus service area you will experience the lowest out of pocket costs when you visit a Cigna provider

Visit www.mycigna.com, enter your search criteria and choose your medical plan to find a participating provider near you

Medical Plan

PEG offers three medical plan options - Cigna Open Access Plus HDHP, Open Access Plus Base and Open Access Plus Buy-Up Plans.

The Open Access Plus medical plans offer in-network and out-of-network benefits. When you need care, you decide whether to go to an in-network or an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network providers and facilities.

Plan Features	**Open Access Plus HDHP**	
	In-Network	Out-Of-Network
Calendar Year Deductible Amount you must pay before the plan begins to pay benefits unless otherwise noted	$6,350 Individual $12,700 Family	$12,700 Individual $25,400 Family
Out-Of-Pocket-Maximum Maximum amount you pay toward deductible, coinsurance, copays, and covered expenses per calendar year	$6,350 Individual $12,700 Family	$15,800 Individual $31,600 Family
Preventive Care Services	Covered at 100%	Not available
Office Visits, Labs, and Testing		
Office Visits	0% after deductible	50% after deductible
Telehealth Visits	0% after deductible	Not available
Mental Health/Substance Abuse Office Visits	0% after deductible	50% after deductible
Diagnostic X-ray and Lab Tests	0% after deductible	50% after deductible
Emergency / Urgent Care / Hospitalization		
Urgent Care	0% after deductible	50% after deductible
Hospital Emergency Room	0% after deductible	0% after deductible
Inpatient Facility Services	0% after deductible	50% after deductible
Outpatient Facility Services	0% after deductible	50% after deductible

Cigna

Preventive Care Covered at 100%

Cigna offers a wide range of preventive services to help you, and your family lead healthy, productive lives:

- Annual Routine Exams
- Well-Child Care Visits
- Immunizations
- Routine OB/GYN Visits
- Mammograms
- PAP Tests
- Prostate Screenings

Other services as required by the Affordable Care Act

Medical Plan

The Open Access Plus Base plan offers in-network and out-of-network benefits. When you need care, you decide whether to go to an in-network or an out-of-network provider. The OAP network is Cigna's largest nation network from coast to coast, with around 840,000 health care professionals and 15,000 facilities.

Plan Features	Open Access Plus - Base Plan	
	In-Network	Out-Of-Network
Calendar Year Deductible Amount you must pay before the plan begins to pay benefits unless otherwise noted	$3,500 Individual $7,000 Family	$7,000 Individual $14,000 Family
Out-Of-Pocket-Maximum Maximum amount you pay toward deductible, coinsurance, copays, and covered expenses per calendar year	$7,900 Individual $15,800 Family	$15,800 Individual $31,600 Family
Preventive Care Services	Covered at 100%	Not available
Office Visits, Labs, and Testing		
Office Visits	PCP: $25 copay Specialist: $75 copay	50% after deductible
Telehealth Visits	$25 copay	Not available
Mental Health/Substance Abuse Office Visits	20% after deductible	50% after deductible
Diagnostic X-ray and Lab Tests	20% after deductible	50% after deductible
Emergency / Urgent Care / Hospitalization		
Urgent Care	$50 copay	50% after deductible
Hospital Emergency Room	$300 copay	$300 copay
Inpatient Facility Services	20% after deductible	50% after deductible
Outpatient Facility Services	20% after deductible	50% after deductible

Cigna®

Need to Locate a Participating Provider?

The PEG medical plan allows you the flexibility to choose a health care provider when and where treatment is needed

When care is received inside Cigna's Open Access Plus service area you will experience the lowest out of pocket costs when you visit a Cigna provider

Visit www.mycigna.com, enter your search criteria and choose your medical plan to find a participating provider near you

Medical Plan

The Open Access Plus Buy-Up plan offers in-network and out-of-network benefits. When you need care, you decide whether to go to an in-network or an out-of-network provider. The OAP network is Cigna's largest nation network from coast to coast, with around 840,000 health care professionals and 15,000 facilities.

Plan Features	Open Access Plus - Buy-Up Plan	
	In-Network	Out-of-Network
Calendar Year Deductible Amount you must pay before the plan begins to pay benefits unless otherwise noted	$1,000 Individual $2,000 Family	$2,000 Individual $4,000 Family
Out-Of-Pocket-Maximum Maximum amount you pay toward deductible, coinsurance, copays, and covered expenses per calendar year	$4,500 Individual $9,000 Family	$9,000 Individual $18,000 Family
Preventive Care Services	Covered at 100%	Not available
Office Visits, Labs, and Testing		
Office Visits	PCP: $25 copay Specialist: $75 copay	50% after deductible
Telehealth Visits	$25 copay	Not available
Mental Health/Substance Abuse Office Visits	20% after deductible	50% after deductible
Diagnostic X-ray and Lab Tests	20% after deductible	50% after deductible
Emergency / Urgent Care / Hospitalization		
Urgent Care	$50 copay	50% after deductible
Hospital Emergency Room	$300 copay	$300 copay
Inpatient Facility Services	20% after deductible	50% after deductible
Outpatient Facility Services	20% after deductible	50% after deductible

Cigna

Express Scripts

Express Scripts is the mail order pharmacy in-network on the Cigna pharmacy plans

Please call the Cigna Health Plan Pharmacy Department at 800-835-3784 for more information or visit your Cigna online member account at www.mycigna.com.

Pharmacy Highlights

Prescription Drug Coverage

If you enroll in the PEG medical plans, you will automatically receive prescription drug coverage through Cigna. When you need prescriptions, you can purchase them through a local retail pharmacy or, for medications you take on an ongoing basis, through the mail order program.

Mail Order Program

The mail order program offers a convenient and cost-effective way to fill prescriptions for medications you take on a regular basis (maintenance medications). When you use the mail order program, you receive a 90-day supply of medication. Your medications are mailed directly to your home. To order prescriptions through the mail order program, you must fill out a mail order form with a 90-day prescription from your doctor and your payment.

Specialty Prescription Program

If you have a chronic condition and take specialty medications, you must purchase these through a designated specialty pharmacy that provides the best available pricing and additional support.

Plan Features	OAP HDHP	OAP Base	OAP Buy-Up
	In-Network	In-Network	In-Network
Calendar Year Deductible	After Medical Deductible	After Medical Deductible	After Medical Deductible
Out-Of-Pocket -Maximum	Integrated with the Medical Out-of-Pocket-Max	Integrated with the Medical Out-of-Pocket-Max	Integrated with the Medical Out-of-Pocket-Max
Retail 30-Day Supply			
Tier 1	0% after deductible	$15 copay	$15 copay
Tier 2	0% after deductible	$35 copay	$35 copay
Tier 3	0% after deductible	$75 copay	$75 copay
Tier 4 / Tier 5	0% after deductible	$250 copay	$250 copay
Mail Order 90-Day Supply			
Tiers 1- 3	2.5 times the 30-day copay	2.5 times the 30-day copay	2.5 times the 30-day copay

Prevention First

Your dental health is an important part of your overall health. Make sure you take advantage of your preventive dental visits

Regular dentist visits tell your dentist a lot about your overall health, including if you may be developing diabetes, heart disease and some forms of cancer

Need to Locate a Participating Provider?

Visit www.mycigna.com and select Find a Dentist and choose the DPPO Advantage plan

Enter your zip code to find a participating dentist near you

Dental Plan

PEG's dental plan is administered through Cigna and provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, fillings and crowns.

If you receive care from one of Cigna's preferred PPO dentists, you'll pay less for your care. If you choose a out-of-network dentist, your share of costs will generally be higher, and you may need to file your own claims.

For a list of Cigna preferred dentists, go to **www.mycigna.com**.

Plan Features	**Cigna DPPO Advantage**	
	In-Network	Out-Of-Network
Calendar Year Deductible Amount you must pay before the plan begins to pay benefits unless otherwise noted	$50 Individual $150 Family	$50 Individual $150 Family
Annual Benefit Maximum	$2,000 per Person	
Preventive Care Services Exams, routine cleanings, flouride treatments, space maintainers	Covered at 100%	Covered at 90%
Basic Services Filings, simple extractions, oral surgery, periodontics, endodontic	20%* after deductible	20%* after deductible
Major Services Dentures, crowns, bridges	50%* after deductible	50%* after deductible

Cigna

Health Rewards - Vision Network Savings Program

Minimum 20% savings on additional purchases of frames and/or lenses, including lens options, with a valid prescription; offered savings does not apply to contact lens materials. Check with your Cigna Vision Network Provider for details

Need to Locate a Participating Provider?

To find a provider near you, visit www.mycigna.com, select "Coverage", then select the Vision page. Click on "Visit Cigna Vision". Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision Directory

Vision Plan

PEG's vision plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. The vision plan is administered through Cigna.

If you enroll in vision coverage, you can go to any eye care provider you choose. However, if you choose providers who are part of the Cigna network, you will receive a discount on services.

The vision plan is designed to cover eye care needs that are visually necessary. You must pay extra if you choose certain cosmetic or elective eyewear, so be sure to ask your eye doctor what items are covered by the plan before you purchase materials.

Plan Features	Cigna PPO	
	In-Network	Out-Of-Network Reimbursement
Exam Once every 12 months	$10 Copay	Up to $45
Frames Once every 12 months	$180 Allowance You will receive an additional 20% savings on the amount that you pay over your allowance	Up to $100
Lenses Once every 12 months **Single** **Bifocal** **Trifocal** **Lenticular**	 $25 Copay $25 Copay $25 Copay $25 Copay	Reimbursement up to approved amount based on lens type less $25 copay (member responsible for any difference)
Contact Lenses - In lieu of frames (once every 12 months)		
Contact Lenses	$180 Allowance Includes fitting & evaluation	Up to $144 Includes fitting & evaluation

Allstate BENEFITS

Wellness Rider

$50 per visit - 2 max per member, 4 max per family

Wellness Rider pays benefit when you receive treatment by a physician outside of a hospital due to preventive or accident treatment (Ex. Doctor Visit, Dental Visit, Eye Exam)

Don't Forget to Designate a Beneficiary

Choosing who will receive your life insurance benefit is an important decision. Please make sure your beneficiary information is up to date

Accident Insurance

Accident and AD&D Insurance

The Allstate Accident plan pays cash to you and/or your family for treatment of an injury. Accidents happen every hour of every day and they can be as minor as a sprained ankle or can unfortunately be life changing. Stitches, broken bones, slips and falls, auto accidents, motorcycles, skiing/snowboarding, and sports injuries are all covered accidents.

Plan Features	Off-Job Accident with AD&D
Accidental Death	$100,000
Common Carrier	$250,000
Dismemberment	$100,000
Emergency Room	$400
Accident Physician	$200
X-ray	$400
CT/MRI	$200
Hospital Admission	$2,000
Daily Hospital Confinement / ICU	$400 / $800
Ambulance / Air Ambulance	$400 / $1,200
Lacerations	$200
Burns	$400-$2,000 (skin graft 50% of burn benefit)
Blood	$1,200
Prosthesis	$2,000-$4,000
Physical Therapy	$120
Lodging	$400
Follow-up Treatment	$200
Loss of eye/hand/foot/finger/toe	Up to $100,000
Dislocations / Fractures	
Hip/Thigh, Knee, Ankle, Wrist, Elbow, Shoulder, Hand, Collarbone, Two fingers/toes, One finger/toe	Up to $8,000 Varies due to Injury and Benefit Schedule

OPTUM

Health Savings Account

A Health Savings Account (HSA) is a personal health care savings account that you can use to pay out-of-pocket health care expenses with pre-tax dollars.

Contributions to an HSA cannot exceed the 2022 IRS contribution maximums of $3,650 for employee-only coverage and $7,300 for all other tiers. Employees age 55 and older may contribute additional funds to their HSA (up to $1,000 in 2022).

HSA Eligibility

You are eligible to fund an HSA if you are enrolled in PEG's Choice Plus high-deductible health plan (HDHP). You are not eligible to fund an HSA if:

- You are covered by a non-HSA plan, healthcare FSA, or health reimbursement arrangement
- You are claimed as a dependent on someone else's tax return
- You are enrolled in Medicare, TRICARE or TRICARE for Life
- You have received Veterans Administration Benefits in the last three months (unless the condition for which treatment was service related)

Use your HSA to pay for Qualified Medical Expenses:

- You can use your HSA money to pay for eligible expenses now or in the future
- Funds in your HSA can be used for your expenses and those of your spouse and eligible dependents, even if they are not covered by the PEG plan
- Eligible expenses include deductibles, doctor's office visits, dental expenses, eye exams, prescription expenses and LASIK eye surgery

A complete list of eligible expenses can be found at www.irs.gov/pub/irs-pdf/p502.pdf.

Maximize your Tax Savings:

- Contributions to an HSA are tax free and are made through payroll deductions on a pre-tax basis
- The money in your HSA (including interest and investment earnings) grows tax free
- As long as you use the funds to pay for Qualified Medical Expenses, the money is spent tax free

Your HSA is an Individually Owned Account:

- You own and administer your HSA. You determine how much you will contribute to your account and when to use the money to pay for eligible health care expenses
- You can change your contribution at any time during the plan year without a qualifying event
- Like a bank account, you must have a balance in order to pay for eligible healthcare expenses
- Keep all receipts for tax documentation
- An HSA allows you to save and "rollover" money from year to year
- The money in the account is always yours, even if you change health plans or jobs
- There are no vesting requirements or forfeiture provisions

24-Hour Nurseline

Not sure if you need care? Just want advice about what to do next? Talk to a registered nurse free, 24/7. Call: (855) 673-306

They'll ask a few questions about your symptoms, then help you decide whether to go to urgent care, see your doctor, go to the emergency room, or care for yourself at home. They're here with support and guidance for any non-emergency situation

Additional Benefits

Virtual Care - MDLIVE

PEG employees enrolled in one of Cigna's medical plans can connect with board-certified medical providers and licensed therapists online using a phone, tablet, or computer:

- Connect 24/7 with board-certified providers for more than 80 minor medical conditions.
- Schedule online appointments with licensed counselors or psychiatrists for behavioral or mental health conditions.
- Schedule an appointment for a virtual wellness screening
- Have a prescription sent directly to your pharmacy, if appropriate

Medical virtual care for minor conditions costs less than ER or urgent care center visits, and may be even less than an in-office Primary Care Provider (PCP) visit.

Connect with virtual care your way.

- Contact your in-network provider or counselor
- Talk to an MDLIVE medical provider on demand or schedule an appointment at www.mycigna.com
- Call MDLIVE 24/7 at 888-726-3171

Cigna One Guide - Enrollment Support

Call a Cigna One Guide representative during pre-enrollment to get personalized, useful guidance.Your personal guide will help you:

- Easily understand the basics of health coverage
- Identify the types of health plans available to you
- Check if your doctors are in-network to help you avoid unnecessary costs
- Get answers to any other questions you may have about the plans or provider networks available to you

After enrollment, the support continues for Cigna customers. Cigna One Guide service will be there to guide you through the complexities of the health care system, and help you avoid costly missteps. Our goal is a simpler healthcare journey for you and your family. Cigna One Guide service provides personalized assistance to help you:

- Resolve health care issues
- Save time and money
- Get the most out of your plan
- Find hospitals and health care providers in your plan's network
- Get cost estimates and avoid surprise expenses
- Understand your bills

Your personal guide is just a call away. Call 888-806-5094 to speak with a Cigna One Guide representative today.

WorkLife is always 100% Free and Confidential.

Whether you're looking for a doctor or trying to predict your out-of-pocket costs, health care can be frustrating and overwhelming. WorkLife Partnership can help you make good health care decisions for yourself and your family.

WorkLife can walk you through:
- Choosing the right benefits
- Getting care covered
- Medical bills and debt

Se habla Español.

Additional Benefits

WorkLife Navigators connect people to *thousands of resources and services* each year.

Whether you're experiencing a stressful situation, pursuing a goal, or managing change, it can be hard to know **where to start** or **who can help**. Plus, there are so many resources and programs out there; how do you navigate them all? WorkLife Resource Navigators are here to help you do just that. They are experts in the resources in your community and can help you connect to the right support—no matter your situation.

Here are a few examples of the resources & services WorkLife Navigators can connect you to:

A
Attorney Search
After School Programs
Addiction & Recovery Services
Affordable Housing Search

B
Baby Supplies
Back to School Supplies
Budgeting Guidance
Bankruptcy Services

C
Childcare Search
Carpooling Resources
Citizenship Services

D
Divorce or Family Legal Support
Disability Services
Diapers & Formula Resources

E
Elder Care Services/Resources
EAP Referral
Emergency Food Assistance

F
Financial Guidance
Food Pantry Services
Free/Reduced Lunch Programs

G
Goal Setting
Government Benefit Assistance

H
Housing Resources
Health Exchange Enrollment
Home Repair Resources & Services

I
Insurance/Benefits Support
Internal Conflict Resolution

J
Job Training & Education

K
Kids Clothing

L
Low-Cost Internet Services
Legal Resources & Education

M
Mental Health Resources
Mechanic Referrals
Medical Bill Coaching

N
Nutrition Education

O
Obtaining Transportation
Online Education Resources

P
Peer Support Groups
Parenting Resources
Pet Food Assistance

R
Retirement Plan Resources

S
Student Loan Counseling
Stress Management

T
Therapist Search
Tax Prep Services & Referrals

U
Utility Assistance
Upskilling Services

V
Vehicle Repair Services

W
Wellness Coaching
Work Supplies & Uniforms

Y
Youth Services (Mentoring & Coaching)

Get your questions answered by reaching out to WorkLife today.

Email: navigator@worklifepartnership.org
Phone: 888-219-8993
Go Online: askthenavigator.org

PEG contributes 50% of the monthly medical premium of the OAP Base Plan towards the cost of the employee only premium, which is reflected in the weekly rates included on this page.

The employee is 100% responsible for the cost of adding any dependents to the plan.

Dental, vision and accident plans are 100% voluntary.

2022 Weekly Rates

Medical	OAP HDHP w/ HSA	OAP Base	OAP Buy-Up
Employee Only	$41.46	$56.02	$72.20
Employee + Spouse	$133.43	$164.12	$198.24
Employee + Child(ren)	$102.75	$128.05	$156.19
Employee + Family	$210.05	$254.19	$303.26

Dental	Cigna DPPO Advantage
Employee Only	$9.37
Employee + Spouse	$18.00
Employee + Child(ren)	$18.99
Employee + Family	$31.12

Vision	Cigna PPO
Employee Only	$2.10
Employee + Spouse	$3.95
Employee + Child(ren)	$3.99
Employee + Family	$6.22

Accident	Allstate: Off-Job w/ AD&D
Employee Only	$2.68
Employee + Spouse	$6.08
Employee + Child(ren)	$7.49
Employee + Family	$9.56

Compliance Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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 of 1998 (WHCRA). WHCRA requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. 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.

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those established for other benefits under the plan.

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

This group health plan complies with the privacy requirement for Protected Health Information (PHI) under HIPAA. A copy of the Privacy Practices is available from the insurance carriers for medical, dental, and vision insurance.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself, or your dependents (including your spouse) in the medical plan because of other medical coverage, you may be able to enroll yourself and/or 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' coverage). However, you must request enrollment within 30 days after your previous coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in the medical plan, provided that you request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

If you or your dependent lose eligibility for coverage under Medicaid or a State child health plan or if you or your dependent become eligible for State-sponsored premium assistance for the medical plan, you may be able to enroll yourself and/or your dependents in this plan if you request enrollment within 60 days of the date of termination of Medicaid or State child health plan coverage or your eligibility for premium assistance.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

If you and your covered dependents are not currently covered by Medicare and will not become covered by Medicare within the next 12 months, this Notice is for informational purposes only. Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Professional Employment Group of Colorado and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage,
including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Professional Employment Group of Colorado has determined that the prescription drug coverage offered by Professional Employment Group of Colorado. 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.

Compliance Notices

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 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?
If you decide to join a Medicare drug plan, your current coverage with Professional Employment Group of Colorado will not be affected. You can keep this coverage if you join a Medicare drug plan and this plan will coordinate with your Medicare drug coverage. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your medical and prescription drug coverage through Professional Employment Group of Colorado, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with Professional Employment Group of Colorado. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…
Contact the person listed on this notice for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Professional Employment Group of Colorado. 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.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: January 1, 2022
Sender: Professional Employment Group
Contact: Attn: Human Resources
Address: 7000 E Belleview Ave Greenwood Village, CO 80111
Phone: 720-409-4965

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

Compliance Notices

NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS INTRODUCTION

You are receiving this notice because you have recently become covered under the a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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 coverage would otherwise end because of a life event known as 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.

WHAT IS A QUALIFYING EVENT?

If you are 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 hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct; or
- You retire.

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 happens:

- 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the 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 or the date on which health coverage would end under the Plan because of this event. If the employee eliminates the coverage of his or her spouse and/or dependents in anticipation of a divorce or legal separation, the spouse and/or dependents may still elect COBRA after the divorce or legal separation if the Plan Administrator is notified within 60 days of the divorce or legal separation. COBRA is not available for the period between the elimination of coverage and the divorce or legal separation.
You must provide this notice in writing to the Plan Administrator. You may be asked to supply supporting documentation. If you fail to provide timely notice, you will lose all rights to COBRA continuation coverage under the Plan.

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. The Plan Administrator will send you a COBRA election form. You may elect to continue your medical, dental, and visiont benefit coverage or, alternatively, only one or more of your health coverages. 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.

Compliance Notices

In order to elect COBRA continuation coverage, you must return the COBRA election form to the Plan Administrator within 60 days from the later of: (a) the date of the qualifying event; (b) the date notice of the right to continue health coverage is sent; or (c) the date group health coverage would otherwise cease. If you fail to meet this deadline, your right to COBRA continuation coverage will be lost.

You do not have to show that you are insurable to elect COBRA continuation coverage. However, COBRA continuation coverage is provided subject to your eligibility for that coverage; the Plan Administrator determines that you are ineligible. This cancellation right applies even if the Plan Administrator previously accepted one or more of your COBRA premium payments.

HOW LONG DOES COBRA COVERAGE LAST?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. When the employee is on a leave of absence for United States military service, COBRA continuation coverage lasts for up to a total of 24 months. There are two 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.

You must send notice (including proof of the Social Security determination) to the Plan Administrator within 60 days after you receive the determination (or, if the determination was received before the qualifying event, within the first 60 days of COBRA continuation), but no later than the end of the 18-month period. If you fail to provide timely notice, the right to the extension will be lost. If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days after the Social Security Administration's determination. The disability extension ends after the Social Security Administration determines that the qualified beneficiary is no longer disabled.

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. You must notify the Plan Administrator of the second qualifying event within 60 days of the second qualifying event. If you fail to provide timely notice, the right to the extension will be lost.

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.

EARLIER TERMINATION OF COBRA COVERAGE

COBRA continuation coverage will be terminated before the end of the maximum period if any required premium is not paid by the deadline, a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or the Employer ceases to provide any group health plan for its employees.

HOW MUCH DOES COBRA COVERAGE COST?

A qualified beneficiary is required to pay the cost of continuation coverage. The amount a qualified beneficiary is required to pay is 102% (or, in the case of an extension of continuation coverage due to a disability, 150%) of the cost to the group health plan (including both Employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact identified below.

Compliance Notices

For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at 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 INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members and/or any new Dependents. You may add a newborn or adopted child to your COBRA continuation coverage under the rules that apply to active employees. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

All notices to the Plan Administrator must be in writing and be addressed to:

Professional Employment Group of Colorado
7000 E Belleview Ave, Greenwood Village, CO 80111
720-409-4965

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be kept properly confidential. This Act gives you significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Professional Employment Group of Colorado Plan (the "Plan"), which is a covered entity, and your legal rights regarding your protected health information ("PHI") held by the Plan. This Notice was prepared in accordance with HIPAA and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") and their implementing regulations.
We may use and disclose your PHI for the following purposes:

REQUIRED PHI USES AND DISCLOSURES

Upon your request, the Plan is required to give you access to certain PHI in order, for example, to inspect and copy it. Use and disclosure of your PHI may also be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with HIPAA, the HITECH Act, and their implementing regulations.

USE AND DISCLOSURE TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The Plan and its business employees will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment, and health care operations. The Plan may also disclose PHI to the Plan Sponsor, Professional Employment Group of Colorado, for purposes related to treatment, payment, and health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include case management.
- Payment means activities such as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be adjudicating a claim and reimbursing a provider for an office visit.
- Health care operations include the business aspects of running our health plan, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and premium rating. An example would be an internal quality assessment review.

USES AND DISCLOSURES THAT REQUIRE THAT YOU BE GIVEN AN OPPORTUNITY TO AGREE OR DISAGREE PRIOR TO THE USE OR RELEASE

Disclosure of your PHI to family members, other relatives, your close personal friends, and anyone else you select is allowed if:
» the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
» you have either agreed to the disclosure or have been given an opportunity to object and have not objected.
The Plan also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.
If you are not present or able to agree to these disclosures of your PHI, then, using its professional judgment, the Plan may determine whether the disclosure is in your best interest.

USES AND DISCLOSURES FOR WHICH CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT IS NOT REQUIRED

Use and disclosure of your PHI is allowed without your consent, authorization or opportunity to object under the following circumstances:

- When required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.
- When permitted for purposes of public health activities, including (but not limited to) disclosures to public health or governmental entities authorized by law to collect or receive information for the purpose of preventing or controlling disease; disclosures to public health authorities or governmental agencies authorized by law to receive reports of child abuse or neglect; disclosures to persons subject to the Food and Drug Administration oversight, to report adverse events or product defects; and to facilitate product recalls.
- When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect, or domestic violence. In such case, the Plan will

promptly inform you that such a disclosure has been or will be made unless the Plan believes that such disclosure could place you at risk of serious harm or is not in your best interests. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

- The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes (but is not limited to) uses or disclosures in civil, administrative, or criminal investigations, proceedings, or actions; audits; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of the health care system, compliance with civil rights laws, or government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena, discovery request, or court order provided certain conditions are met.
- When required for law enforcement purposes under certain circumstances. For instance, this permitted use or disclosure could include (but is not limited to) reporting certain types of wounds or suspicious conditions surrounding a death; disclosures pursuant to legal process; disclosures for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and/or disclosures relating to individuals suspected to be a victim of crime under certain circumstances.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. Further, the Plan may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.
- The Plan may use or disclose PHI for research purposes, subject to certain conditions.
- Consistent with applicable law and standards of ethical conduct the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan may use or disclose PHI to a person reasonably able to prevent or lessen the threat, including the target of the threat. Similarly, under certain circumstances, the Plan may use or disclose PHI if, in good faith, the Plan believes it is necessary for law enforcement authorities to identify or apprehend an individual.
- Under certain conditions, the Plan may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, the Plan may disclose, in certain circumstances, your information to the foreign military authority. The Plan also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.
- If you are an inmate of a correctional institution, the Plan may disclose your PHI to the correctional institution or to a law enforcement official for (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
- We will not use or disclose your genetic information for underwriting purposes.
- We may use and disclose your PHI to provide appointment reminders or send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.
- We may contract with individuals or entities known as Business Employees to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Employees will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI. For example, we may disclose your PHI to a Business Employee to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Employee enters into a Business Employee contract with us.
- We may also create and distribute de-identified health information by removing all references to individually identifiable Information.

USES AND DISCLOSURES FOR WHICH AN AUTHORIZATION IS REQUIRED

The following uses and disclosures will be made only with your authorization: (1) most uses and disclosures of psychotherapy notes, (2) uses and disclosures of PHI for marketing purposes, (3) disclosures that constitute a sale of PHI, and (4) other uses and disclosures not described in this Notice. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

YOUR RIGHTS

- **Right to Request Restrictions.** The right to request restrictions on certain uses and disclosures of PHI about you, including those related to uses and disclosures to carry out treatment, payment, or health care operations, and disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a requested restriction, unless the request is made to restrict disclosure to the insurer for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the PHI pertains solely to a health care item or service for which you have paid out of pocket in full. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it, the information is needed to provide emergency treatment to you, or the Plan has terminated its agreement to your request.

Compliance Notices

- **Right to Request Confidential Communications.** If you believe that a disclosure of all or part of your PHI may endanger you, you may request that the Plan communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that the Plan only contact you at your work address. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. Once the Plan receives all of the information related to your request (along with the instructions for handling future communications), the request will be reviewed as soon as is practicable under the circumstances. Prior to receiving the information necessary for this request, or during the time it takes to review it, PHI may be disclosed (such as through an Explanation of Benefits, "EOB") without regard to the submitted request. Therefore, it is extremely important that you contact the Plan as soon as you determine that you need to restrict disclosures of your PHI.

If the Plan grants the request, once a request for confidential communications goes into effect, all your PHI will be processed in accordance with your instructions. This means that the Plan cannot process a request to withhold only the PHI relating to a specific condition, diagnosis, or treatment. Therefore, all documents that might contain PHI about all of the services you receive (such as letters or EOBs), will be sent to the alternative location or the alternative matter.

If you terminate your request for confidential communications, the restriction will be removed for all your PHI that the Plan holds, including PHI that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your PHI will endanger you.

- **Right to Inspect and Copy PHI.** The right to inspect and copy your PHI to the extent provided in the HIPAA and HITECH Act implementing regulations. However, you may not inspect or receive a copy of psychotherapy notes or certain other Information.

A response to a request for PHI will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If you request a copy of the information, we may charge a cost-based fee to fulfill your request.

If access is denied, you will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights (if any), and a description of how you may complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services.

- **Right to Amend PHI.** You have the right to request that the Plan amend certain PHI. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied, in whole or part, the Plan must provide you with a written denial that explains the basis for the denial, a description of your right to file a statement of disagreement, a statement that you may alternatively request that a copy of your amendment request and its denial be included in future disclosures of the relevant PHI, and a description of how you may complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services. You may then submit a written statement disagreeing with the denial and have

- **Right to Receive an Accounting.** At your request, you are entitled to receive an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include certain PHI disclosures, such as those made:
  » to carry out treatment, payment, or health care operations;
  » to you about your own PHI;
  » to persons involved in your care or for notification purposes required by law;
  » for national security purposes;
  » to others pursuant to your authorization;
  » to law enforcement officials as permitted by law;
  » as part of a limited data set; or
  » prior to the effective date of this Notice.
  If the accounting cannot be provided within 60 days, an additional 30 days is allowed if you are given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12 month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.
- **Right to be Notified of a Breach.** You have the right to be notified in the event that we (or a Business Employee) discover a breach of unsecured PHI. Except in certain circumstances, we will provide such notice without unreasonable delay and in no case later than 60 days after discovery of the breach.
- **Right to Receive a Paper Copy of This Notice.** We have the obligation to provide and you have the right to obtain a paper copy of this notice from us at least once every three years.
- **Additional Plan Duties.** We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. This Notice is effective as of August 2019 and we are required to abide by the terms of the Notice currently in effect. We reserve the right to change the terms of our Notice and to make the new notice provisions effective for all PHI that we maintain. We will post and you may request a written copy of a revised Notice from this office.
- **Your Right to File a Complaint with the Plan or the HHS Secretary.** You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office for Civil Rights, about violations of the provisions of this Notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Professional Employment Group of Colorado
Attn: Human Resources
7000 E Belleview Ave, Greenwood Village, CO 80111
720-409-4965

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
202-619-0257
Toll Free: 1-877-696-6775

Compliance Notices

60-DAY SPECIAL ENROLLMENT PERIOD

In addition to the qualifying events mentioned above, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

For additional assistance, call Jennifer Walker at 720-409-4965 or jwalker@pegrecruiting.com.

PATIENT PROTECTION DISCLOSURE

Professional Employment Group of Colorado generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Jennifer Walker at 720-409-4965 or jwalker@pegrecruiting.com.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in medical coverage for yourself or your dependents because of other health insurance coverage, you may be able to enroll yourself or your dependents in Professional Employment Group of Colorado medical coverage 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 no more than 31 days after your or your dependent's other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you can enroll yourself and your dependents in Professional Employment Group of Colorado medical coverage as long as you request enrollment by contacting Professional Employment Group of Colorado Human Resources no more than 31 days after the marriage, birth, adoption or placement for adoption. For more information, contact Jennifer Walker at 720-409-4965 or jwalker@pegrecruiting.com.

YOUR RIGHT TO RECEIVE A CERTIFICATE OF HEALTH COVERAGE

If your coverage under the health plans sponsored by Professional Employment Group of Colorado (the "Company") ends, you and your covered dependents will receive a certificate that shows your period of health coverage under the plan. You may need to furnish the certificate if you become eligible under another group health plan if it excludes coverage for certain medical conditions that you have before you enroll. You may also need the certificate to buy, for yourself or your family, an individual insurance policy that does not exclude coverage for medical conditions that are present before you enroll. You and your dependents may also request a certificate from your medical plan provider within 24 months of losing coverage under the Professional Employment Group Health Center plans.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

Since key parts of the health care law took effect in 2014, there is another 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 Marketplace and employment-based health coverage offered by your employer.

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 tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period or if you experience a qualifying life event.

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 9.83% 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.

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.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Jennifer Walker at 720-409-4965 or jwalker@pegrecruiting.com.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<tr><td>3. Employer Name
Professional Employment Group of Colorado</td><td colspan="2">4. Employer Identification Number (EIN)
83-3379068</td></tr>
<tr><td>5. Employer Address
7000 E Belleview Ave</td><td colspan="2">6. Employer phone number
720-409-4965</td></tr>
<tr><td>7. City
Greenwood Village</td><td>8. State
Colorado</td><td>9. ZIP Code
80111</td></tr>
<tr><td colspan="3">10. Who can we contact about employee health coverage at this job?
Jennifer Walker</td></tr>
<tr><td>11. Phone Number (if different from above)</td><td colspan="2">12. Email address
jwalker@pegrecruiting.com</td></tr>
</table>

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☑ All employees. Eligible employees are:

  Full-time employees working 30 hours or more per week or part-time employees working 20 hours or more per week

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:

  Legal Spouse
  Dependent Children (under age 26 and disabled dependent children)

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

Important Contacts

Benefit	Contact	Phone Number	Website/Email
Human Resources	Jennifer Walker	720-409-4965	jwalker@pegrecruiting.com
Ease **Employee Benefits Online Portal**	N/A	N/A	www.ease.com
Medical **Group Number: 635014**	Cigna	800-244-6224	www.mycigna.com
Dental **Group Number: 635014**	Cigna	800-244-6224	www.mycigna.com
Vision **Group Number: 635014**	Cigna	800-244-6224	www.mycigna.com
Accident **Group Number: 46869**	Allstate Benefits	800-348-4489	www.allstateatwork.com/mybenefits