2025 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 one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since July 31, 2024 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/E-mail	Phone
Alabama (Medicaid)	http://www.myalhipp.com/	1-855-692-5447
Alaska (Medicaid)	Premium Payment Program: http://myakhipp.com/ Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/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 Email: hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado (Medicaid and CHIP)	Medicaid: https://www.healthfirstcolorado.com/ CHIP: https://hcpf.colorado.gov/child-health-plan-plus HIBI: https://www.mycohibi.com/	1-800-221-3943 1-800-359-1991 1-855-692-6442 State relay 711
Florida (Medicaid)	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268

State	Website/E-mail	Phone
Georgia (Medicaid)	HIPP: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance- program-reauthorization-act-2009-chipra	678-564-1162, press 1 678-564-1162, press 2
Indiana (Medicaid)	Healthy Indiana Plan for low-income adults 19-64: http://www.in.gov/fssa/dfr/	1-800-403-0864
	All other Medicaid: https://www.in.gov/medicaid	1-800-457-4584
Iowa (Medicaid and CHIP)	Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid	1-800-338-8366
	CHIP: http://dhs.iowa.gov/Hawki	1-800-257-8563
	HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	1-888-346-9562
Kansas (Medicaid)	https://www.kancare.ks.gov/	1-800-792-4884 HIPP: 1-800-967-4660
Kentucky (Medicaid and CHIP)	Medicaid: https://chfs.ky.gov/agencies/dms	
	KI-HIPP: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.apsx	1-855-459-6328
	KI-HIPP E-mail: KIHIPP.PROGRAM@ky.gov	
	KCHIP: https://kynect.ky.gov	1-877-524-4718
Louisiana (Medicaid)	www.medicaid.la.gov	1-888-342-6207
	www.ldh.la.gov/lahipp	1-855-618-5488
Maine (Medicaid)	https://www.mymaineconnection.gov/benefits/s/?language=e n US 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/masshealth/pa	1-800-862-4840
	Email: masspremassistance@accenture.com	TTY: 711
Minnesota (Medicaid)	https://mn.gov/dhs/health-care-coverage/	1-800-657-3672
Missouri (Medicaid)	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana (Medicaid)	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HHSHIPPProgram@mt.gov	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/programs-services/medicaid/health-insurance-premium-program	603-271-5218 or
	Email:DHHS.ThirdPartyLiabi@dhhs.nh.gov	1-800-852-3345, ext. 15218
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 (TTY: 711)
New York (Medicaid)	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina (Medicaid)	https://medicaid.ncdhhs.gov/	919-855-4100
North Dakota (Medicaid)	https://www.hhs.nd.gov/healthcare	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	1-800-699-9075
Pennsylvania (Medicaid and CHIP)	Medicaid: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance- premium-payment-program-hipp.html CHIP: https://www.pa.gov/en/agencies/dhs/resources/chip.html	Medicaid: 1-800-692-7462 CHIP: 1-800-986-KIDS (5437)
Rhode Island (Medicaid and CHIP)	http://www.eohhs.ri.gov/	1-855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina (Medicaid)	https://www.scdhhs.gov	1-888-549-0820
South Dakota (Medicaid)	http://dss.sd.gov	1-888-828-0059
Texas (Medicaid)	https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	1-800-440-0493
Utah (Medicaid and CHIP)	Medicaid: https://medicaid.utah.gov/ CHIP: https://chip.utah.gov/ Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/	1-888-222-2542
Vermont (Medicaid)	https://dvha.vermont.gov/members/medicaid/hipp-program	1-800-250-8427
Virginia (Medicaid and CHIP)	https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment- hipp-programs	1-800-432-5924
Washington (Medicaid)	https://www.hca.wa.gov/	1-800-562-3022
West Virginia (Medicaid)	https://dhhr.wv.gov/bms/ http://mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 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

2025 EMPLOYEE BENEFITS GUIDE

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IMPORTANT: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug program gives you more choices about your prescription drug coverage. Please see pages 23 and 24 for more details.

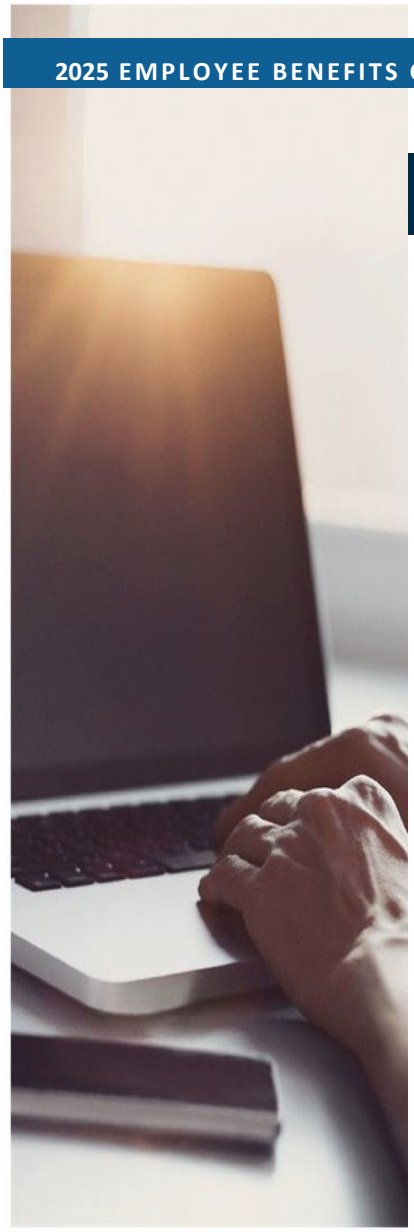
As an employee of Professional Employment Group of Colorado, enjoying your work and making valuable contributions to business are equally vital. The health, satisfaction and security of you and your family are important, not only to your well-being, but ultimately, in terms of achieving the goals of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

For the 2025 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, and vision coverage effective the first of the month following 30 days of employment. Deductions will begin the week prior to your benefits effective date.

The choices you make will remain the same through December 31, 2025. 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

1. Log into UKG with your username and password
2. To begin, once you are on the Employee Dashboard click the three bars on the top left. Then click the “My Info Single Person” Icon
3. Select “My Benefits”. Then select "Enrollment" Then click "Start" the benefit enrollment.

Please reach out to HR at hrpeg@pegrecuriting.com if you have any questions.

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 Local 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 four medical plan options - Cigna Local Plus HDHP, Open Access Plus HDHP, Open Access Plus Base and Open Access Plus Buy-Up Plans.

The Local Plus medical plan delivers a cost-effective option designed to be flexible and help you control health care costs. Cigna collaborates with health care communities to create local, limited, networks of health care providers, specialists, and hospitals that deliver value and results right where you live. The 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. 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	Local Plus HDHP	
	In-Network	Out-Of-Network
Calendar Year Deductible Amount you must pay before the plan begins to pay benefits unless otherwise noted	$7,500 Individual $15,000 Family	$15,000 Individual $30,000 Family
Out-Of-Pocket-Maximum Maximum amount you pay toward deductible, coinsurance, copays, and covered expenses per calendar year	$7,500 Individual $15,000 Family	$30,000 Individual $60,000 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

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 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	$7,500 Individual $15,000 Family	$15,000 Individual $30,000 Family
Out-Of-Pocket-Maximum Maximum amount you pay toward deductible, coinsurance, copays, and covered expenses per calendar year	$7,500 Individual $15,000 Family	$30,000 Individual $60,000 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

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

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

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	Local HDHP	OAP HDHP	OAP Base	OAP Buy-Up
	In-Network	In-Network	In-Network	In-Network
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	Integrated with the Medical Out-of-Pocket-Max
Retail 30-Day Supply				
Tier 1	0% after deductible	0% after deductible	$15 copay	$15 copay
Tier 2	0% after deductible	0% after deductible	$35 copay	$35 copay
Tier 3	0% after deductible	0% after deductible	$75 copay	$75 copay
Tier 4 / Tier 5	0% after deductible	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	2.5 times the 30-day copay

Dental Plan

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.

Please Note:

Out-of-Network Providers: When you use out-of-network providers, your benefits will be paid based on 90% of the Reasonable & Customary (R&C) amount for each type of service that is determined by Cigna. If your dentist's fee is lower than the R&C amount, the plan will pay benefits based on the actual fee. If the fee is higher, the plan will pay benefits based only on the R&C amount, and you are responsible for the difference.

Dental coverage helps you maintain good oral health. PEG's dental coverage is provided through Cigna. The dental plan covers preventive care including regular checkups and routine cleanings, as well as fillings and other dental procedures.

In the DPPO Advantage plan, you may visit any dentist you choose, but you'll receive a higher level of benefits when you go to an in-network dentist.

Visit **www.cigna.com** to find an in-network dentist. If searching for dentists in the DPPO Advantage plan, select the Cigna Dental PPO network.

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
Orthodontia For dependent children up to age 26	50% up to Lifetime Maximum of $1,500	50% up to Lifetime Maximum of $1,500

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.

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.

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

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 2025 IRS contribution maximums of $4,300 for employee-only coverage and $8,550 for all other tiers. Employees age 55 and older may contribute additional funds to their HSA (up to $1,000 for 2025).

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.

2025 Weekly Rates

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

Dental and vision plans are 100% voluntary.

Medical	Local HDHP w/ HSA	OAP HDHP w/ HSA	OAP Base	OAP Buy-Up
Employee Only	$51.99	$63.04	$102.76	$122.52
Employee + Spouse	$183.45	$197.49	$281.25	$322.94
Employee + Child(ren)	$141.26	$152.63	$221.69	$256.07
Employee + Family	$288.80	$309.51	$429.96	$489.92

Dental	Cigna DPPO Advantage
Employee Only	$11.02
Employee + Spouse	$21.15
Employee + Child(ren)	$22.32
Employee + Family	$36.58

Vision	Cigna PPO
Employee Only	$2.15
Employee + Spouse	$4.03
Employee + Child(ren)	$4.08
Employee + Family	$6.34

Important Contacts

Benefit	Contact	Phone Number	Website/Email
Human Resources	Julia Hoofnagle	303-875-1969	jhoofnagle@pegrecruiting.com
UKG Employee Benefits Online Portal	HR	303-781-2140	https://secure6.saashr.com/ta/6185489.login?NoRedirect=1
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

Compliance Notices

For Your Files

This guide contains legal notices for participants in group health plan(s) sponsored by Professional Employment Group of Colorado. The notices included in this guide are:

- ***Health Insurance Marketplace Coverage Options and Your Health Coverage*** *that describes the Health Insurance Marketplace and eligibility and tax credit information.*
- ***Notice of Privacy Practices*** *that explains how the health care plan(s) protect your personal medical information.*
- ***Medicare Part D Notice*** *that provides information about how your current prescription drug coverage under the health care plan(s) is affected—and your options for coverage—when you become eligible for Medicare.*
- ***COBRA Rights Notice*** *that explains when you and your family may be able to temporarily continue coverage under the health care plan(s) if coverage would otherwise end for you.*
- ***Newborn & Mothers Health Protection Notice*** *that describes federal laws that govern benefits for hospital stays for mothers following the birth of child.*
- ***Women's Health and Cancer Rights Act*** *that summarizes the benefits available under your medical plan if you have had or are going to have a mastectomy.*
- ***Notice of Special Enrollment Rights*** *that explains when you can enroll in the health care plan(s) due to special circumstances.*
- ***60-Day Special Enrollment Period*** *that describes a special 60-day timeframe to elect or discontinue coverage.*

IMPORTANT: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug program gives you more choices about your prescription drug coverage. Please see pages 23 and 24 for more details.

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 9.02% 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 Human Resources at jhoofnagle.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.

Compliance Notices

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.

3. Employer name: Professional Employment Group of Colorado		3. Employer Identification Number (EIN): 83-3379068
4. Employer address: 7000 E Belleview Ave		5. Employer phone number: 720-409-4965
6. City: Greenwood Village	7. State: CO	8. ZIP code: 80111
9. Who can we contact about employee health coverage at this job? Julia Hoofnagle		
10. Phone number (if different from above)	11. E-mail address: jhoofnagle@pegrecruiting.com	

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
- 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, **www.healthcare.gov** will guide you through the process.

IMPORTANT NOTICE FROM PROFESSIONAL EMPLOYMENT GROUP OF COLORADO ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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 has determined that the prescription drug coverage offered by Professional Employment Group plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

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 Professional Employment Group coverage will be affected. If you do decide to join a Medicare drug plan and drop your current Professional Employment Group coverage, be aware that you and your dependents may not be able to get this coverage back.

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 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…

Compliance Notices

Contact the person listed below 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 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 "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).

Remember: Keep this creditable coverage 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).

Date: 1/1/2025
Name of Entity/Sender: Professional Employment Group of Colorado
Contact/Office: Human Resources
Address: 7000 E Belleview, Greenwood Village, CO 80111
Phone Number: 720-409-4965

COBRA RIGHTS NOTICE

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Compliance Notices

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Professional Employment Group.

How Is COBRA Continuation Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of 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.

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

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Date: 1/1/2025

Name of Entity/Sender: Professional Employment Group of Colorado

Contact/Office: Human Resources

Address: 7000 E Belleview, Greenwood Village, CO 80111

Phone Number: 720-409-4965

Compliance Notices

OTHER NOTICES

60-Day Special Enrollment Period

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

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) 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.

Notice of Special Enrollment Rights

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) 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 30 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 medical coverage as long as you request enrollment by contacting the benefits manager no more than 30 days after the marriage, birth, adoption or placement for adoption. For more information, contact Professional Employment Group, Professional Employment Group at jhoofnagle@pegrecruiting.com.

Newborn & Mothers Health Protection Notice

For maternity hospital stays, in accordance with federal law, the Plan does not 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 delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

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). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultations with the attending physician and the patient, for:

- All states of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact Professional Employment Group of Colorado or your medical plan administrator.