PROFESSIONAL FIREFIGHTERS
OF ARIZONA

July 1, 2025 – June 30, 2026

Benefits Guide

Highlands Fire District

HIGHLANDS FIRE DISTRICT

Revised 09/24/2025

Welcome to the PFFA Healthcare Trust!

Welcome to Open Enrollment with the PFFA Healthcare Trust!

At the PFFA Healthcare Trust, we proudly serve those who dedicate their lives to protecting our communities. Our comprehensive healthcare plan is built specifically for firefighters, first responders, and essential personnel—providing you and your loved ones with firefighter-founded benefits that prioritize your physical, mental, and financial well-being.

More than just coverage, our plan delivers proactive, personalized care tailored to the unique demands of your profession. Created by first responders, for first responders, we are committed to supporting you—whenever and wherever you need it most.

We're honored to serve you with excellence and compassion, every step of the way.

Dan Freiberg
President, PFFA

Getting Started

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Using This Guide

Our health plan cycle is from **July 1 to June 30** annually. This guide offers a summary of benefit options to assist you in making informed decisions for yourself and your family. Keep a copy of this guide accessible throughout the year, as it can be beneficial when dealing with specific care situations.

Enrollment Checklist

- ☐ **SELECT YOUR PLAN**
  Choose a medical program option and decide who you will cover.
- ☐ **CONTRIBUTE TO YOURSELF**
  If you can enroll in a high-deductible health plan (HDHP), consider making health savings account (HSA) contributions.
- ☐ **REVIEW BENEFICIARIES**
  Review and update beneficiary designations for life insurance benefits, as necessary.
- ☐ **CONFIRM DEPENDENT ELIGIBILITY**
  Ensure that any dependents up to age 26 are still eligible for enrollment.
- ☐ **CHOOSE ADDITIONAL COVERAGES**
  Review and decide whether to elect any additional employee-paid benefits, if applicable.

Questions?

PFFA HEALTH
General plan questions, claims questions, and ID cards
Ashley Pearse | 949.524.1456 | apearse@icmsbenefits.com

BLUE CROSS BLUE SHIELD OF ARIZONA
Medical benefits, eligibility, and ID cards
www.azblue.com | 602.864.4400

What's New?

The IRS has increased Health Savings Account (HSA) contribution limits for 2025. Individuals can now contribute up to $4,300 (up from $4,150 in 2024), while families can contribute up to $8,550 (up from $8,300). The catch-up contribution for those 55 and older remains $1,000.

Blue Cross Blue Shield of Arizona will replace the UHC plans as the district's new Medical Provider effective 7/1/2025.

MetLife will replace Delta Dental as the district's new Dental Provider. Additionally, MetLife will be the new Vision, Life, AD&D, and Voluntary Life carrier under the PFFA Trust.

Enrolling in the medical plan gives you access to first responder enhanced benefits like cancer screenings, mental health support, on-demand physical therapy, orthopedic care, PGx testing, and a dedicated nurse advocate. See this Benefits Guide for details on eligibility and limitations.

Eligibility

Who is Eligible?

- ✓ Full-time employees
- ✓ Dependents of enrolled employees, including:
  - — Lawfully married spouses
  - — Domestic partners (signed affidavit and proof required)
  - — Dependent children up to age 26

When Can I Make a Change?

You can make changes or elect benefits once a year during open enrollment. Outside of open enrollment, the IRS says a "qualified life event" must occur in order to make changes. If you experience a qualified life event and need to make a change to your benefits, you must notify your employer within 30 days of the event. Otherwise, you will have to wait until the next open enrollment period.

Below are examples of qualified life events that may make a mid-year change possible:

- ✓ Marriage, divorce, legal separation, or annulment
- ✓ Birth, adoption, placement for adoption, or legal guardianship of a child
- ✓ Death of a dependent
- ✓ Change in your spouse's employment or involuntary loss of health coverage under another employer's plan
- ✓ Change in your dependent's eligibility status

REMINDER

Newborns are not automatically added to your medical coverage. You must notify **Jayme Jones (jjones@highlandsfire.org)** within 30 days of the date of birth and pay the full premium amount for the month the child is added. All other qualifying life events must be communicated to **Jayme** within 30 days of the event occurring.

Enrollment

How Do I Enroll?

You can complete your benefit enrollment online through an easy-to-use system provided by our GIS Benefits and Boon Chapman partners. Online enrollment with GIS Connect is simple, secure and can be done in a few minutes from any computer or mobile device with internet access. After enrolling online, you will have access to your benefit information year-round, 24 hours a day.

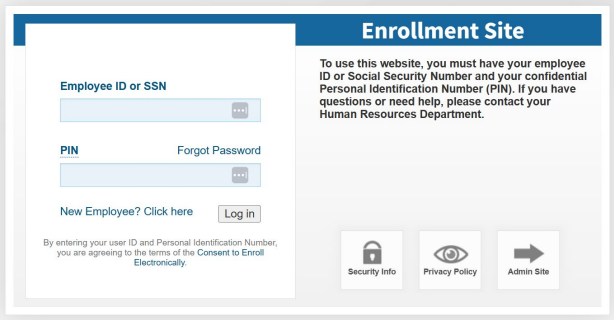
Access your enrollment at https://boonchapman.benselect.com/uafhct.

During the enrollment process you will be asked to provide some basic information that you should have available.

- Your social security number
- Your dependent's social security numbers and birth dates
- Your primary care physician information and number (if applicable)

Your login is your Social Security Number. The initial PIN (password) for the system is the last four numbers of your social security number plus the last two numbers of your birth year.

You will be prompted to change your password when you log in for the first time.



The system will step you through verifying your personal contact information, reviewing and adding dependent information, and learning about and choosing your benefits.

Once you have completed the enrollment for each plan available, the system will take you to the Sign and Submit page.

- Review/Sign Forms that may open using your login password as the signature PIN
- If you need to log off before completing enrollment, any data you entered will be saved.
- Enrollment is complete when you see the CONGRATULATIONS! Message
- Always make sure to log out upon completion

Use the same login to access the system year-round to review your benefit elections, process life event enrollment changes, or update beneficiaries. You can also change your PIN (password) at any time using the Change My Pin option on the You & Your Family menu.

Insurance Terminology

Deductible
This is the annual amount you're responsible for paying out of pocket for covered services before your health insurance coverage starts to pay.

Coinsurance
This is the percentage of covered medical expenses you are responsible for after you have met your deductible. The plan covers the remaining costs.

Out-Of-Pocket Maximum (OOP)
This is the highest amount you'll be responsible for paying for covered services in a single plan year. The out-of-pocket maximum limits your healthcare costs, providing financial protection in case of a major illness or injury.

Embedded Deductible
Each family member has their own deductible, and there is also a deductible for the entire family. Once an individual meets their deductible, the plan begins to pay benefits for that person. When the family deductible is met, the plan pays benefits for all family members.

Non-Embedded Deductible
The entire family shares one deductible. This means that the family deductible must be met before the plan starts to pay benefits.

HDHP Plan
An HDHP is a medical plan with a lower monthly premium and a higher annual deductible. It is often paired with a health savings account (HSA) to cover medical expenses.

In-Network vs. Out-Of-Network
Network providers have agreements to offer services at discounted rates, while out-of-network providers do not. Staying in-network is typically the most cost-effective way to manage your healthcare expenses.

Inpatient vs. Outpatient
Inpatient services are those you receive during a hospital or facility admission, typically involving an overnight stay. Outpatient services, meanwhile, are received in a facility without requiring an overnight stay.

Prior Authorization
This refers to the pre-approval required for specific services, prescriptions, and medical equipment to be covered by the plan. It may also be known as "preauthorization" or "precertification."

Understanding Your Medical Plan

Medical Benefits

Medical Benefits

BLUECROSS BLUESHIELD AZ

Manage Your Benefits

Login to your member portal: **https://identity.azblue.com/member-login** to take full advantage of your medical benefits. You'll need to have your ID card handy to register. Once you're in, you can:

- ✓ View/print/order ID cards
- ✓ View medical claims
- ✓ Monitor your deductible and out-of-pocket limits
- ✓ Shop for the best and most cost-effective care

Find a Doctor

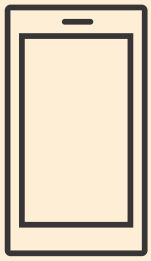
- ✓ Go to azblue.com
- ✓ Select For Members
- ✓ Select Find a Doctor, Provider, or Facility
- ✓ Search an BCBSAZ Member, or Browse as a Guest

Search doctors and places by name and specialty.

Medical Benefits

BLUECROSS BLUESHIELD AZ

As a **BCBS member**, take advantage of these valuable benefits:



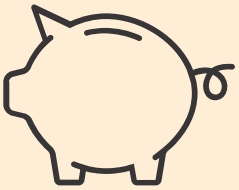
On-Demand Virtual Care
Visit a physician, counselor, or psychiatrist from your computer, smartphone, or tablet 24/7

Nurse On Call
Talk to a BCBS nurse anytime, day or night at 1-866-422-2729 – TTY: 711

Healthy Lifestyle
Access personalized programs, customized challenges, and more through ShareCare

Clinical Rapid Response Team
Talk to a BCBS nurse anytime, day or night at 1-866-422-2729 – TTY: 711

Preventative Care
Annual checkups, preventative services and screenings offered at no cost to you



Blue365 Discount Program
Access 12,200+ gyms and save money on national health brands through Active&Fit Direct

To learn more visit https://www.azblue.com/

Medical Benefits

BLUECROSS BLUESHIELD AZ

NEW IN 2025-2026!

HDHP 3300 BENEFIT OVERVIEW	IN-NETWORK	OUT-OF-NETWORK
Plan Year Deductible *Embedded Deductible*	$3,300 individual $6,000 family	$5,000 individual $10,000 family
Coinsurance *after Deductible*	BCBSAZ pays 100% You pay 0% Copays will still apply for RX until OOP is met	BCBSAZ pays 60% You pay 40%
Out of Pocket Maximum *Deductible AND copays included in maximum*	$4,000 individual $8,000 family	$6,000 individual $12,000 family
Preventive Services (Certain Screenings, Immunizations, Routine Physicals, Mammography, Vincere Cancer Screening)	100% coverage	40% coinsurance & balance bill
Primary Care Office Visit	Deductible	40% coinsurance & balance bill
Specialist Office Visit	Deductible	40% coinsurance & balance bill
Virtual Office Visit / Telehealth *BlueCare Anywhere*	Deductible	40% coinsurance & balance bill
Manipulative Treatment	Deductible	40% coinsurance & balance bill
Convenience Care Clinic Visit	Deductible	40% coinsurance & balance bill
Urgent Care Visit	Deductible	40% coinsurance & balance bill
Emergency Room Visit	Deductible	No charge after deductible
Laboratory Services	Deductible	40% coinsurance & balance bill
Radiology Services	Deductible	40% coinsurance & balance bill may apply
Major Diagnostic Services (MRI, CT, PET, etc.)	Deductible	40% coinsurance & balance bill may apply
Outpatient Services	Deductible	40% coinsurance & balance bill may apply
Inpatient Services	Deductible	40% coinsurance & balance bill may apply
Prescriptions *	Deductible then $5/$15/$30	Deductible then $5/$15/$30
Mail Order Prescriptions *90-day supply*	2x retail cost	Not Covered

**If you purchase a brand-name medication when a generic equivalent is available, you will pay your applicable cost share for the generic medication PLUS the difference between the generic and the brand-name medication, even if the prescribing provider indicates on the prescription that the brand-name medication should be dispensed.*

Medical Benefits

BLUECROSS BLUESHIELD AZ

NEW IN 2025-2026!

HDHP 5000 BENEFIT OVERVIEW	IN-NETWORK	OUT-OF-NETWORK
Plan Year Deductible *Embedded Deductible*	$5,000 individual $10,000 family	$10,000 individual $20,000 family
Coinsurance *after Deductible*	BCBSAZ pays 80% You pay 20% Copays will still apply for RX until OOP is met	BCBSAZ pays 50% You pay 50%
Out of Pocket Maximum *Deductible AND copays included in maximum*	$6,450 individual $12,900 family	$1,000,000 individual $2,000,000 family
Preventive Services (Certain Screenings, Immunizations, Routine Physicals, Mammography, Vincere Cancer Screening)	No Charge, Deductible Waived	50% coinsurance & balance bill
Primary Care Office Visit	Deductible & 20% Coinsurance	50% coinsurance & balance bill
Specialist Office Visit	Deductible & 20% Coinsurance	50% coinsurance & balance bill
Virtual Office Visit / Telehealth *BlueCare Anywhere*	Deductible	50% coinsurance & balance bill
Manipulative Treatment	Deductible & 20% Coinsurance	50% coinsurance & balance bill
Convenience Care Clinic Visit	Deductible & 20% Coinsurance	50% coinsurance & balance bill
Urgent Care Visit	Deductible & 20% Coinsurance	50% coinsurance & balance bill
Emergency Room Visit	Deductible & 20% Coinsurance	20% coinsurance & balance bill
Laboratory Services	Deductible & 20% Coinsurance	50% coinsurance & balance bill
Radiology Services	Deductible & 20% Coinsurance	50% coinsurance & balance bill may apply
Major Diagnostic Services (MRI, CT, PET, etc.)	Deductible & 20% Coinsurance	50% coinsurance & balance bill may apply
Outpatient Services	Deductible & 20% Coinsurance	50% coinsurance & balance bill may apply
Inpatient Services	Deductible & 20% Coinsurance	50% coinsurance & balance bill may apply
Prescriptions *	Deductible then $10/$60/$110/$150	Not Covered
Mail Order Prescriptions *90-day supply*	$20/$120/$220	Not Covered

*If you purchase a brand-name medication when a generic equivalent is available, you will pay your applicable cost share for the generic medication PLUS the difference between the generic and the brand-name medication, even if the prescribing provider indicates on the prescription that the brand-name medication should be dispensed.

Health Savings Account (HSA)

Health Equity

An HSA is a personal bank account that you can use to pay out-of-pocket health care expenses with pre-tax dollars. Funds in your HSA can be used for your expenses and those of your spouse/domestic partner and eligible dependents, even if they are not covered by the High-Deductible Health Plan (HDHP).

- Eligible expenses include deductibles, copays, prescription drugs, dental and vision expenses, and more.
- Visit IRS.gov (Publication 502) or www.HealthEquity.com for a current list of eligible expenses.

Money deposited in the account stays with you and unused balances roll over from year to year.

You determine how much you will contribute to your account. Your HSA is funded by your own pretax contributions and your employer's contributions.

For the 2025 calendar year, the maximum HSA contributions are:

- Single coverage contribution limit $4,300
- Family coverage contribution limit $8,550
- Individuals aged 55 and over can contribute an
- additional $1,000

When you enroll in a HDHP, you will be automatically enrolled into an HSA account with Health Equity. You will receive an email from Health Equity for instructions on how to access your HSA account. If you would like to transfer your HSA balance from another bank to Health Equity, you will need to complete the transfer form and submit directly to the address listed on the form.

Your employer will contribute the following amounts into your HSA Account if you elect the High-Deductible Health Plan for the calendar year:

Employer HSA Contribution Schedule by Plan Type	July 2025	January 2026
3300 Employee only	$650.00	$650.00
3300 Employee + Dependents	$650.00	$650.00
5000 Employee Only	$1,250.00	$1,250.00
5000 Employee + Dependents	$1,250.00	$1,250.00

HEALTH SAVINGS ACCOUNT (HSA)

IRS Annual Deposit Limits	$4,300 for individual coverage, and $8,550 for family coverage. ($1,000 additional catch-up contribution available for those age 55+)
Employer Contribution to Accounts Eligible for Bank Account	Any employee insured in the $3,300 or $5,000 HDHP medical plan with BlueCross BlueShield. Persons NOT eligible to open an HSA bank account: if you are covered by Medicare, AHCCCS, TriCare Military, dually covered in another medical plan elsewhere, or if someone claims you as a dependent on their tax return.
Paying for Expenses	Upon account activation, you will receive a debit card to pay for your qualified expenses, as funds are deposited and available.
Non-Qualified Expenses	If you use HSA funds for non-qualified expenses before age 65, you will owe a 20% penalty tax PLUS income tax on the withdrawal. After age 65, if you use HSA funds for non-qualified expenses, you will owe income tax only. Visit irs.gov/ publications/p502 for details.

Benefits With Your Medical Benefits

Did You Know?

When you enroll in the PFFA Healthcare Trust medical plan, you gain access to a **comprehensive suite of additional benefits** designed to support your health and well-being. These programs are **included as part of your medical coverage** and provide valuable resources to help you and your family stay healthy, recover from injuries, and access specialized care when needed.

The following benefits are available to enrolled members:

- **Vincere Cancer Screening**: Access to advanced cancer screening services to support early detection and proactive care.
- **Solveglobal Physical Therapy**: Convenient, expert-guided physical therapy programs designed to help you recover from injuries and maintain mobility.
- **PFFA Nurse Advocate**: Personalized support from a dedicated nurse advocate to help you navigate your healthcare journey, understand benefits, and coordinate care.
- **Public Safety Crisis Solutions Behavioral Health Assistance**: Access to mental wellness resources, including counseling and support services, to promote emotional and psychological well-being.
- **Ketamine Treatment**: Therapeutic ketamine treatment options to support mental health and well-being under professional supervision.
- **Regenexx Orthopedic Treatment**: Innovative, non-surgical treatment options for orthopedic conditions, including joint pain, through advanced regenerative medicine.
- **BlueGenes PGx Testing**: Pharmacogenomic testing to help ensure medications are safe and effective based on your genetic profile.

Important Notice

These benefits are offered exclusively to members enrolled in the PFFA Healthcare Trust medical plan. Each benefit is subject to specific eligibility requirements, exclusions, and limitations as outlined in this Benefits Guide. Please review the full guide for more information or contact your PFFA Healthcare Trust Client Manager for assistance with any questions regarding eligibility or access to these services.

PFFA Nurse Advocate

NEW IN 2025-2026!

The **PFFA Nurse Advocate Program**, led by Wendi Denham, MBA BSN RN NI-BC, is here to provide personalized support for members navigating complex or chronic health conditions.

Whether you need help understanding a diagnosis, managing treatment plans, or coordinating care, Wendi is your dedicated resource. If you've had a nurse advocate before, re-engage right away. Otherwise, feel free to reach out whenever you need guidance.

All queries will be returned within 24 hours, Monday–Friday.

Personalized Support
Your dedicated nurse can offer personalized support and guidance, helping you navigate complex healthcare systems and understand their treatment options.

Care Coordination
Your nurse can help coordinate care among different healthcare providers, ensuring you receive appropriate and timely care.

Education and Empowerment
Get educated about your health conditions and feel empowered to make informed decisions about your care.

Improved Health Outcomes
By providing personalized support and care coordination, your nurse can help improve health outcomes, leading to better overall health and reduced healthcare costs.

Cost Savings
Your nurse may reduce healthcare costs by ensuring you receive appropriate care and avoid unnecessary treatments or hospitalizations.

To get started, email Wendi Denham at nurseadvocate@pffahealth.org

Cancer Screening

VINCERE CANCER CENTER

NEW IN 2025-2026!

Vincere Cancer Center offers comprehensive first responder screenings for plan-enrolled employees and their spouses/domestic partners at **no additional cost**. Cancer screening services will be individualized and determined by factors including age, gender, and health history. Services include:

Oncology Consult
- Reviews your personal medical and family history
- Reviews any environmental and occupation exposure
- Reviews all imaging, bloodwork, and genetic testing
- Formulates a diagnostic workout or surveillance plan to minimize your risk for cancer

Comprehensive Male Urologic Exam
- Screens Prostate and Testicular and Genitourinary tumors through bloodwork, imaging, and clinical exams

Dermatological Skin Exam
- Full body exam to screen for Melanoma Squamous Cell Carcinoma, and Basal Cell Carcinoma and precancerous lesions
- Perform biopsies and any necessary surgical procedures

Total Body MRI
- Using a powerful magnet with no radiation, we scan the body looking for early cancer in multiple organs as well as over 500 medical conditions
- To date, we have diagnosed over 250 cancers using this technology and are considered experts in the field

Clinical Trials
- Harvard Public Health – looks at toxins and their links to cancer
- Elypta with the Karolinska Institute – looks at metabolic markers to predict your likelihood of cancer
- Department of Defense with Cornell and Columbia University – looks at different autoantibodies that increase your risk of Breast Cancer

Low Dose Lung CT
- CT Scan with lower dose of radiation
- Screens for Lung Cancer and Mediastinal Cancers (Thymoma, Lymphoma, and Mesothelioma)
- Can pick up cardiovascular disease

QT Breast Ultrasound
- One of five centers in the world to house this technology
- Uses two types of ultrasound to detect the presence of Breast Cancer without ionizing radiation, compression, or contrast

Liquid Biopsy
- Pioneers for the use of liquid biopsies
- Performed more Galleri tests than any other center in the country
- Vincere is honored to be one of the three sites in the country to bring you CancerGuard from Exact Sciences
- Looks at methylation status of cell-free DNA patterns and protein markers to detect cancer early

Genetic Testing
- Helps identify those who are born with a genetic predisposition to increase their risk of cancer by looking for changes in genes, chromosomes, or proteins

Eligibility

Eligible Recipients Include:
- Plan-Enrolled Employees
- Plan-Enrolled Spouses/Domestic Partners

There is **no age limitation** associated with this benefit. Screenings may be scheduled **every 3 years**.

To learn more visit https://vincerecancer.com or call 480.306.5390

Behavioral Health Assistance

PUBLIC SAFETY CRISIS SOLUTIONS

At PSCS, their staff of Mental Wellness Coaches provide a concierge service to assess and connect first responders or their family members with a therapist that understands the public safety culture.

First Responders deserve better and faster connection to caring professionals. PSCS has developed a referral process to connect our members in need of mental wellness services in a timely manner.

- Behavioral Health Assistance Program
- Peer Support Team Oversight
- Trainings

- ✓ Stress and Anxiety
- ✓ Relationship/Marital Conflicts
- ✓ Grief, Loss, and Life Adjustments
- ✓ Work-Life Balance
- ✓ Burnout
- ✓ Sleep Deprivation
- ✓ Minor Depression Management
- ✓ Anger Management

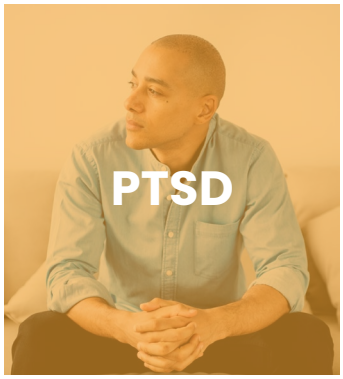
12 Free Counseling Sessions Per Year

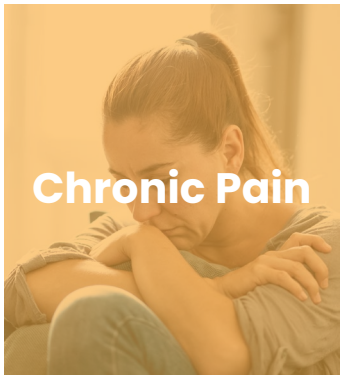
This benefit includes 12 free counseling sessions per year for each member and their dependents, along with access to other valuable mental health support services. To start using this benefit, simply call, text, or fill out an online form using the contact information provided below.

To learn more visit https://pscrisissolutions.com or call 602.466.9456

Ketamine Treatment

NEW IN 2025-2026!





PFFA Ketamine Partners

Advanced Wellness and Pain | inLIGHTen Wellness | Alevea Mental Health

Rapid Relief: Ketamine can provide fast relief from symptoms, often within hours or days, which is significantly quicker than traditional antidepressants that might take weeks to become effective.

Alternative for Treatment-Resistant Cases: Ketamine has shown promise for individuals who have not responded well to conventional treatments like SSRIs or psychotherapy. It offers an alternative approach when other methods fail.

Neuroplasticity: Research suggests that ketamine may promote neuroplasticity, helping the brain form new neural connections that can aid in recovery from trauma and depression.

Reduced Suicide Risk: Some studies indicate that ketamine can reduce suicidal ideation more effectively than traditional antidepressants, which is critical for first responders who may be at higher risk for such thoughts.

Therapeutic Potential: Through the Trust, Ketamine is used in conjunction with therapy, enhancing the overall effectiveness of treatment by helping patients engage more fully in therapeutic work.

Eligibility

Plan-Enrolled Employees, Spouses/Domestic Partners, and Children

Program Details

Includes 1 round of ketamine treatment, integrated coaching, and a $500 cost share

Ready to get started?

Contact Public Safety Crisis Solutions to discuss if ketamine treatment is right for you.

Physical Therapy

NEW IN 2025-2026!

Welcome to Solveglobal, your comprehensive musculoskeletal care partner. As a Healthcare Trust Subscriber, you gain **no-cost access** to services aimed at optimizing your musculoskeletal health and well-being to ensure you are moving and feeling your best at work, at home and while doing the things you love.

Experiencing pain, discomfort, or not moving as well as you would like to? The Solveglobal team is your first stop for urgent and ongoing aches, pains, and strains. Our team will meet you either virtually, on-site, or in a partner clinic nearby to ensure you get the right care, at the right time, with the right provider.

Personalized Care
At Solveglobal, we understand that each individual's musculoskeletal needs are unique. Our team of experienced physical therapists works closely with Healthcare Trust Subscribers to develop personalized care plans tailored to your specific requirements, ensuring effective treatment and faster recovery.

Comprehensive Support
Beyond treatment, Solveglobal provides comprehensive support to Healthcare Trust Subscribers throughout your musculoskeletal care journey. Our dedicated team will guide you through every step of the process, from scheduling appointments to coordinating follow-ups, ensuring a seamless and hassle-free experience.

Accessible and Convenient
We understand the demanding nature of your profession, which is why Solveglobal offers convenient access to care. With convenient locations across the Phoenix valley, as well as virtual care options, Healthcare Trust Subscribers receive the care you need when and where it's most convenient for you–minimizing disruptions to your work and personal lives.

Solveglobal provides complimentary physical therapy services exclusively focused on addressing your musculoskeletal conditions. There are no restrictions on the frequency of visits.

SOLVEGLOBAL

Help Starts Here

Completing the Monthly Check-In is **ESSENTIAL** to providing you with access to care.

Delivered directly to your email inbox and through text message, the Check-In allows the Solveglobal team to prioritize care for Healthcare Trust Subscribers.

Not experiencing any aches or pains? Just select “No” and your done!

If you ARE experiencing some discomfort at work, at home or at leisure, the survey only takes a minute to complete and provides the Solveglobal team with (CONFIDENTIAL) critical information and the ability to provide you with the care you need.

Eligibility

- Plan-Enrolled Employees

To learn more visit https://www.solveglobal.com/pffa, email help@solveglobal.com, or call 480.937.1021

Orthopedic Treatment

NEW IN 2025-2026!

What is Regenexx?

Regenexx is an innovative treatment for orthopedic injuries that enhances your body's natural healing processes. To treat damaged tendons, ligaments, muscle, bone, and cartilage, our physicians draw your blood platelets and bone marrow aspirate and process them in our advanced orthobiologics laboratories. We then inject them precisely at the site of your injury using image guidance. Regenexx procedures provide a lower-risk, lower-cost, minimally invasive alternative for up to 70 percent of elective orthopedic surgeries.

The Regenexx Difference

Regenexx is a nonsurgical outpatient procedure performed either in a single day or in a series of three treatments over two weeks. Most patients are encouraged to return to activity within a week of their procedure. Patients with health factors such as heart issues or risk of stroke can find a safer alternative to surgery with Regenexx.

Your Benefit

Regenexx is covered as an **in-network** benefit within the PFFA health plans. In-network benefits for specialist services within your plan and in-network deductibles and out-of-pocket maximums apply for all Regenexx services. Non-Regenexx services may fall under a different benefit level and may or may not be treated as in-network.

Eligibility

- Plan-Enrolled Employees
- Plan-Enrolled Spouses/Domestic Partners
- Plan-Enrolled Children

REGENEXX

Conditions Treated

Ankle/Foot
- Achilles tendinopathy
- Arthritis
- Bunions
- Instability
- Ligament sprain or tear
- Plantar fasciitis

Hand/Wrist/Elbow
- Arthritis
- Carpal tunnel
- CMC joint arthritis (thumb)
- Tennis elbow
- Trigger finger
- Ulnar nerve entrapment

Hip
- Arthritis
- Bursitis Labral/labrum tear
- Joint-replacement alternative
- Osteonecrosis
- Tendinopathy

Knee
- Arthritis
- Joint-replacement alternative
- Meniscus tear
- Sprain or tear of ACL/PCL
- Sprain or tear of the MCL/LCL
- Tendinopathy

Shoulder
- Arthritis
- Joint-replacement alternative
- Labral tear
- Rotator cuff tear
- Rotator cuff tendinosis

Spine
- Back or neck nerve pain
- Bulging, collapsed, or herniated disc
- Ruptured or torn disc
- Degenerative disc disease
- Disc extrusion
- Disc protrusion

To learn more visit https://regenexx.com or call 855.906.5492

PGx Testing

BLUEGENES

NEW IN 2025-2026!

Pharmacogenomic (PGx) testing by BlueGenes is offered at no additional cost and allows you and your physician to better understand how you respond to certain medications.

PGx Testing in 5 Easy Steps

- **Step 1:** Click here to claim your benefit. Use code 'PFFA'
- **Step 2:** BlueGenes will ship your test kit.
- **Step 3:** Return your kit with prepaid shipping.
- **Step 4:** Wait 7-10 days for results.
- **Step 5:** Access your results through your portal.

Benefits of PGx Testing

Mitigate Adverse Drug Events
PGx testing not only helps in choosing the most effective drug for each patient but also substantially decreases the risk of adverse drug events, leading to safer treatments and more efficient healthcare management.

Personalized Dosage Optimization
By predicting the optimal medication dosage for each patient, PGx testing brings a new level of refinement to treatment plans, enabling improved patient responses and financial sustainability in healthcare.

Preemptive Drug Efficacy
With PGx testing, we can evaluate a patient's susceptibility to adverse drug reactions before the medication regimen begins. This proactive approach bolsters patient safety and curtails potential costs incurred by healthcare facilities.

Enhanced Patient Care and Quality of Life
Incorporating PGx test results into a patient's medical record provides a powerful tool for prescribing future medications, fostering a higher standard of care and improved patient quality of life.

Eligibility

Plan-Enrolled Employees, Spouses/Domestic Partners, and Children

To learn more visit https://bluegeneslab.com/, email support@bluegeneslab.com, or call 888.215.2784

Additional Benefits

Dental Benefits

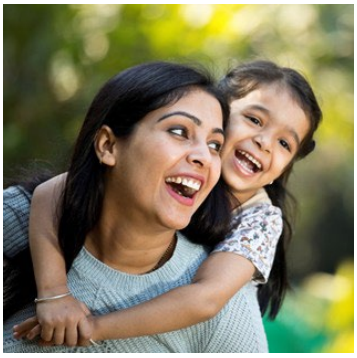
METLIFE

NEW IN 2025-2026!

Discover the Benefits of MetLife Dental

Finding the Right Dentist

With MetLife, you can seek care from over 133,000 licensed dentists in more than 475,000 dental provider locations nationwide.[1] To find a participating dentist or specialist, visit metlife.com/dental to access our *Find a Dentist* directory.[2]



Premium Dental Care at Discounted Prices

Top-quality care doesn't have to come with a top-shelf price tag. MetLife Dental Insurance can save you up to 35–50% on dentist list prices for everything from fillings to crowns.[3]

Overall, Health Starts with Oral Health

If you're searching for a dentist who aligns with your goals for maintaining a healthy lifestyle, look for one on metlife.com/dental who has earned the MetLife SpotLite on Oral Health℠ recognition.[2] They're focused on preventive and improved oral health outcomes.

1. Based on MetLife internal contracting system analysis as of January 2024.
2. All information provided on this website ("Website") is intended for your general knowledge only and is not a substitute for obtaining medical or dental advice for specific medical or dental conditions or other advice from your dentists or doctors. By making this Website available to you, Metropolitan Life Insurance Company and its affiliates (collectively, "MetLife") is not engaged in rendering any such advice. Use of this Website is subject to all the terms stated herein. The Website is developed, provided and maintained by an independent vendor, not by MetLife. Insofar as the information provided on this Website is from third parties or links to third party websites, it has no association whatsoever with MetLife, unless expressly stated.
3. Based on internal analysis by MetLife. Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often participants visit a dentist and the cost of services rendered.

Dental Benefits

METLIFE

NEW IN 2025-2026!

DENTAL BENEFIT OVERVIEW	**PPO PLAN** IN-NETWORK	**PPO PLAN** OUT-OF-NETWORK
Calendar Year Deductible January 1st – December 31st	$50 individual $150 family *waived for preventive*	$50 individual $150 family *waived for preventive*
Annual Maximum Benefit Per Insured Person	$2,000	$2,000
Preventive Exams, Routine Cleanings, X-rays, Space Maintainers, Fluoride (children to age 18), Sealants (children to age 19)	100%	100%
Basic Fillings, Emergency Treatment, Oral Surgery/Endodontics/Periodontics	80%	80%
Major Bridges, Partial Dentures, Complete Dentures, Bridge and Denture Repair, Implants, Crowns, Onlays	60%	60%
Orthodontia – Adult and Child	50% Lifetime Maximum Benefit $2,000	50% Lifetime Maximum Benefit $2,000

Vision Benefits

METLIFE

NEW IN 2025-2026!

Enroll in MetLife Vision Insurance with the VSP Choice Network

Help Maintain Your Vision

From exams to frames to contact lenses, MetLife Vision Insurance helps keep your vision—and its associated costs—in check.[1]

Find a Provider

MetLife Vision features a network of predominantly private practice and retail providers[2] and the freedom to choose an out-of-network provider,[3] which helps you find a provider you like and trust.

Find a VSP Choice provider >

Access to a Wide Selection of Frames

Take advantage of a selection of eyewear from classic styles to the latest designer frames so you can choose what's right for you and your budget.

1. Your actual savings from enrolling in a vision plan will depend on various factors, including the plan chosen, plan premiums, number of visits to an eye care professional by your family per year, and the cost of services and materials received. Be sure to review the Schedule of Benefits for your plan's specific benefits and other important details.
2. For a list of participating providers, use the Find a Vision Provider tool at metlife.com. Select Find a Vision Provider, choose VSP Choice as your network, complete the information requested and hit the Search Now button.
3. If you choose an out-of-network provider, you may have increased out-of-pocket expenses, pay in full at the time of services and file a claim with MetLife for reimbursement.

Vision Benefits

METLIFE

NEW IN 2025-2026!

VISION (NETWORK: VSP) BENEFIT OVERVIEW	**IN-NETWORK BENEFITS**
Eye Exam *Every 12 Months*	Eye health exam, dilation, prescription and refraction for glasses: At no additional cost after a $10 copay. Retinal imaging: At no additional cost Up to a $39 copay on routine retinal screening when performed by a private practice provider.
Frame *Every 12 Months*	Allowance: $175 after $10 eyewear copay. Costco, Walmart and Sam's Club: $70 allowance after $10 eyewear copay. You will receive an additional 20% savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco, Walmart and Sam's Club.
Standard Corrective Lenses *Every 12 Months*	Single vision, lined bifocal, lined trifocal, lenticular: At no additional cost after $10 eyewear copay. Progressive Standard, Progressive Premium/Custom, Polycarbonate (adult), Photochromic, Anti-reflective, Scratch-resistant coatings and Tints: Your cost will be limited to a copay that MetLife has negotiated for you. These copays can be viewed after enrollment at www.metlife.com/mybenefits.
Contact Lenses Instead of Eyeglasses *Every 12 Months*	Contact fitting and evaluation: At no additional cost with a maximum copay of $60. Elective lenses: $130 allowance. Necessary lenses: At no additional cost after eyewear copay.

Find a Vision Provider at
www.metlife.com/vision

Download a claim form at
www.metlife.com/mybenefits

For general questions go to
www.metlife.com/mybenefits
or call 1-855-638-3931

Life & AD&D Benefit

METLIFE

NEW IN 2025-2026!

Benefits To Help Protect Your Financial Wellness

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security and pay for large expenses such as housing and education, as well as day-to-day living expenses.

Employer Paid Life and AD&D Insurance

Basic Life Insurance pays your beneficiary a lump sum if you pass away. AD&D Insurance provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by your employer. Coverage is provided by MetLife. To name a beneficiary, you must have the following information:

Basic Life Amount	$50,000
Basic AD&D Amount	An amount equal to Your Basic Life Insurance.

- ✓ Full first and last name
- ✓ Complete address
- ✓ Phone number
- ✓ Relationship to you
- ✓ Date of birth

Beneficiary Reminder

Make sure that you have named a beneficiary for your life insurance benefit. Log in to your benefits portal to update your beneficiaries.

Taxes

A life insurance benefit over $50,000 is a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2.

Term Life Features

- ✓ Grief Counseling
- ✓ Travel Assistance
- ✓ Total Control Account
- ✓ Funeral Discounts
- ✓ Digital Estate Planning
- ✓ Portability

Voluntary Life & AD&D

METLIFE

NEW IN 2025-2026!

Benefits To Help Protect Your Financial Wellness

In addition to the company-paid life insurance, your employer offers you the opportunity to purchase additional life insurance for yourself, your spouse/domestic partner and/or your children:

Employee Life	**Schedule:** Increments of $10,000 **Benefit Maximum:** The lesser of 5x Your Basic Annual Earnings, or $300,000
Spouse/Domestic Partner Life*	**Schedule:** Increments of $5,000 **Benefit Maximum:** $150,000
Child(ren) Life*	**Schedule:** Flat Amount: $1,000, $2,000, $4,000, $5,000, or $10,000 **Benefit Maximum:** $10,000

*To enroll in spouse/domestic partner and/or child(ren) coverage, the employee must be enrolled. Spouse/domestic partner coverage cannot exceed 50% of the employee amount.

Guarantee Issue

The Guarantee Issue amount for new employees is $150,000 for employee, $30,000 for spouse/domestic partner coverage, and $10,000 for child.

Age Reductions

The amount of your employee or spouse life insurance will be reduced by 35% at age 65, and by 50% at age 70.

Monthly Rate per $1,000 of Employee or Spouse Coverage (Based on Insured Age)

Age	Monthly Rate/$1,000 of Coverage
Less than 30	$0.072
30-34	$0.075
35-39	$0.099
40-44	$0.138
45-49	$0.212
50-54	$0.325
55-59	$0.533
60-64	$0.679
65-69	$1.154
70+	$2.051
Child	$0.200
All Active Full Time Employees AD&D	
§ Employee	$0.039
§ Spouse	$0.039
§ Child(ren)	$0.051

Voluntary Identity Protection

METLIFE

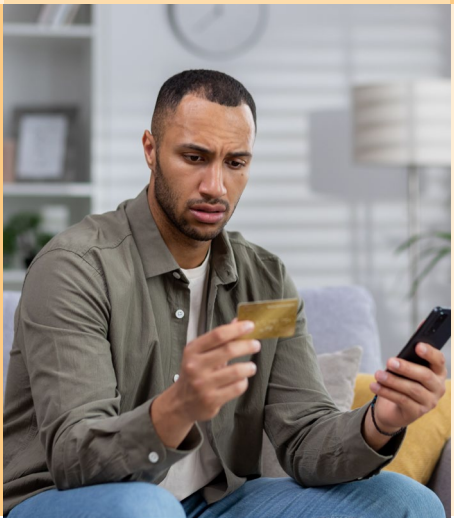
NEW IN 2025-2026!

Identity Theft Protection
Monitors personal info, accounts, and online reputation and sends alerts if we detect threats. Automatically requests removal of information found online to help keep it out of the hands of thieves and spammers.

Financial Fraud Protection
Monitors credit, financial accounts, and property titles and sends alerts if suspicious changes are detected.

Privacy & Device Protection
Shop, bank, and connect online more securely and privately with intelligent safety tools that help protect passwords, devices, and WiFi connections from hackers.

Family Safety
Gives you the tools to protect loved ones — no matter who they are, how old they are, or where they live — from online predators and thieves.



Service & Support
24/7/365 100% US Based Customer Care, White Glove Resolution Services, one MetLife account team, and much more.

Voluntary Program Pricing

Protection Individual	Protection Family	Protection Plus Individual	Protection Plus Family
$6.45	**$10.95**	**$8.45**	**$13.95**

Voluntary Legal

METLIFE

NEW IN 2025-2026!

The legal plan provides full coverage of attorney fees for the most common personal legal matters with no additional out-of-pocket cost to employees.[1]

Money Matters	• Debt Collection Defense • Financial Wellness Programs[2]	• Identity Restoration[3] • Identity Theft Defense • Negotiations with Creditors • Personal Bankruptcy	• Promissory Notes • Tax Audit Representation • Tax Collection Defense
Home & Real Estate	• Boundary & Title Disputes • Deeds • Eviction Defense • Foreclosure	• Mortgages • Property Tax Assessments • Refinancing & Home Equity Loan • Sale or Purchase of Home	• Security Deposit Assistance • Tenant Negotiations • Zoning Applications
Estate Planning	• Codicils • Complex Wills • Healthcare Proxies	• Living Wills • Powers of Attorney (Healthcare, Financial, Childcare, Immigration)	• Revocable & Irrevocable Trusts • Simple Wills
Family & Personal	• Adoption • Affidavits • Conservatorship • Demand Letters • Garnishment Defense	• Guardianship • Immigration Assistance • Juvenile Court Defense, Including Criminal Matters • Name Change • Parental Responsibility Matters • Personal Properties Issues	• Prenuptial Agreement • Protection from Domestic Violence • Review of ANY Personal Legal Document • School Hearings
Civil Lawsuits	• Administrative Hearings • Civil Litigation Defense	Disputes Over Consumer Goods & Services Incompetency Defense	Pet Liabilities Small Claims Assistance
Elder-care Issues	Consultation & Document Review for Issues Related to Your Parents: • Deeds • Leases	• Medicaid • Medicare • Notes • Nursing Home Agreements	• Powers of Attorney • Prescription Plans • Wills
Traffic & Other Matters	• Defense of Traffic Tickets[4] • Driving Privileges Restoration	• Habeas Corpus	• Repossession
Rate[5]	**$17.25** per employee per month (Covers spouse and dependents)		
Additional Features	These features include unlimited legal support via phone, in-office consultations, demand letters, and document reviews for personal legal matters. Additionally, employees receive four extra hours of attorney time annually for non-covered issues. They also get discounted rates for personal injury, probate, and estate administration services, along with access to a digital tool for estate planning, including wills, living wills, power of attorney, and trusts.		

Questions?
Call the **MetLife Legal Plans Client Service Center** at **800-821-6400** Monday-Friday, 8:00am-8:00pm, EST.

Create an account at **members.legalplans.com**

1. Exclusions apply. Please see MetLife Group Legal Plan document for more details.
2. MetLife administers the PlanSmart program and has arranged to have specially trained third-party financial professionals offer financial education. The financial professionals providing financial education are not affiliated with MetLife but are providing the program under a service provider contract offered to groups with 500 or more employees. The MetLife Personal Finance app is available at no cost to all individuals and regardless of any MetLife relationship or project.
3. Aura is a product of Aura Sub, LLC. Aura Sub, LLC. is not affiliated with MetLife, and the services and benefits they provide are separate and apart from any MetLife product.
4. Does not cover DUI.
5. Rate is standard and subject to change. Rate may include broker commissions or associated platform fees. Broker commissions will be paid net of any platform fees. Brokers must be properly licensed in the state of issue for each legal plan contract at the time of purchase.
6. No more than a combined maximum total of four hours of attorney time and service are provided for the member, spouse, and qualified dependents, annually.
7. The self-help library is offered by Standard Legal. Standard Legal is not a corporate affiliate of MetLife Legal Plans.

Voluntary Pet Insurance

METLIFE

NEW IN 2025-2026!

The voluntary MetLife Pet Insurance is coverage for dogs and cats that can help you be prepared for unexpected vet costs.

Coverage Includes:

- Accidents
- Illnesses
- Exam Fees
- Surgeries
- Medications
- Ultrasounds
- Hospital Stays
- X-rays
- Diagnostic Tests
- Hip Dysplasia
- Hereditary Conditions
- Congenital Conditions
- Holistic Care
- Chronic Conditions
- Alternative Therapies
- And Much More!

Take Your Pet to the Vet
Visit any licensed vet, emergency clinic or specialist in the U.S. There's no network of providers to worry about.

Send MetLife Your Claim
Pay your pet's vet bill and send your claim along with vet records and invoice from the visit.

Get Money Back Quickly
MetLife will follow up with your vet for any missing info. Most claims processed within 5 days.

To get a quote or enroll visit https://quote.metlifepetinsurance.com or call 1-800-GET-MET8

Your Total Costs

MEDICAL

Medical Plan	BCBSAZ HDHP 3300	BCBSAZ HDHP 5000
Per Pay Period (24 Pay Periods)		
Employee	$0.00	$0.00
Employee + Spouse	$151.82	$151.49
Employee + Child	$100.33	$108.44
Employee + Family	$231.70	$217.62

DENTAL

Dental Plan	MetLife Dental PPO Plan
Per Pay Period (24 Pay Periods)	
Employee	$0.00
Employee + Spouse	$24.02
Employee + Child	$31.04
Employee + Family	$60.80

VISION

Vision Plan	VSP Vision PPO
Per Pay Period (24 Pay Periods)	**Employee Cost**
Employee	$0.00
Employee + Spouse	$3.49
Employee + Child	$2.37
Employee + Family	$6.30

LIFE & AD&D

Life & AD&D	$50,000 Basic Life
Per Pay Period (24 Pay Periods)	**Employee Cost**
Employee	$0.00

Contacts & Resources

Refer to this list when you need to contact one of your benefit vendors.
For general benefits information, contact your PFFA Client Manager.

For Questions About	Contact	Phone	Website/Email	Policy/Group #
Benefits	PFFA Client Manager Ashley Pearse	949.524.1456	apearse@icmsbenefits.com	–
Human Resources	HFD Human Resources Jayme Jones	928.525.1717	Jjones@highlandsfire.org	–
Medical	BlueCross BlueShield AZ	602.864.4400 800.232.2345	azblue.com	Group # 101142
HSA	HealthEquity	866.346.5800	healthequity.com	–
Dental	MetLife	1.800.942.0854	metlife.com	Group # 5374360
Vision	MetLife	1.800.438.6388	metlife.com	Group # 5374360
PFFA Healthcare Trust	Plan Administrator Don Jongewaard	480.518.1796	pffahealth.org donj@pffahealth.org	–
PFFA Nurse Advocate	Wendi Denham	–	nurseadvocate@pffahealth.org	–
Cancer Screening	Vincere Cancer Center	480.306.5390	vincerecancer.com	–
Physical Therapy	Solveglobal	480.937.1021	solveglobal.com/pffa help@solveglobal.com	–
Orthopedic Treatment	Regenexx	855.906.5492	regenexx.com	–
PGx Testing	BlueGenes	888.215.2784	bluegeneslab.com support@bluegeneslab.com	Use Organization Code: PFFA
Behavioral Health Assistance	Public Safety Crisis Solutions	602.466.9456	pscrisissolutions.com	–
Life & AD&D	MetLife	1.800.638.5433	metlife.com	Group # 5374360
Voluntary Disability Coverage	MetLife	1.800.638.5433	metlife.com	Group # 5374360
Voluntary Life & AD&D	MetLife	1.800.638.5433	metlife.com	Group # 5374360
Voluntary Pet Insurance	MetLife	833-216-9220	quote.metlifepetinsurance.com	–
Voluntary Legal	MetLife	833.214.4172	https://www.metlife.com/insurance/legal-plans/	–
Voluntary Identity Protection	MetLife	1.844.931.2872	https://www.metlife.com/identity-and-fraud-protection/	–

The material contained here is for informational purposes only and is not an offer of coverage. Please note that the benefits provides only a brief, general description of coverage's and does not constitute a contract. For a complete listing of your coverage's, including exclusions and limitations relating to your coverage's, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

Legal Notices

Women's Health and Cancer Rights Act:
Your medical plan, as required by the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), provides benefits for mastectomy-related services. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, deductibles and coinsurance apply. Contact your Plan Administrator for more information regarding WHCRA benefits.

Release of Medical Information:
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires health plans to protect the privacy and security of your protected health information.

Your medical, dental, prescription drug, vision, mental health, Employee Assistance Program and health care Flexible Spending Account (FSA) benefits are subject to HIPAA.

Pursuant to HIPAA, the plans (including the plan administration personnel) will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, healthcare operations (which includes plan administration functions) or as permitted or required by law. A plan's use or disclosure of protected health information is governed by the plan's HIPAA policies and procedures and notice of privacy practices. You have been furnished a HIPAA notice of privacy practices describing the practices the plans will follow with regard to your protected health information.
For more information, please consult the applicable HIPAA notice of privacy practices for each plan, which may be obtained by contacting your Plan Administrator.

Social Security Numbers Generally Required for Enrollment:
Under the Medicare, Medicaid and SCHIP Extension Act of 2007, the Centers for Medicare and Medicaid Services (CMS) generally require Social Security numbers for employees and dependents to assist with reporting under the Medicare Secondary Payer requirements. Accordingly, you must provide Social Security numbers at the time of enrollment to assist its health plan enrollment administrators in complying with this requirement. If you need to add a dependent to your coverage who does not have a Social Security number or Taxpayer Identification number, leave the information blank and provide the SSN or TIN to the Benefit Department immediately upon receipt.

Newborns' and Mothers' Health Protection Act Of 1996:
In accordance with this Act, group health plans and health insurance issuers generally may not, under federal law, restrict benefits from 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 if applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Changes to Special Enrollment Period Rules:
Following is a notice regarding your special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as modified by the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP").

Legal Notices

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the plans outlined in this document if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 after your or your dependents' other 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/or your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

If you or your dependent loses eligibility for Medicaid or a state child health plan or are determined to be eligible for group health plan premium assistance under a Medicaid plan or a state child health plan, you may be able to enroll yourself and your dependents in this plan. You must request enrollment within 60 days after the loss of coverage or determination of eligibility.
To request special enrollment or obtain more information, contact the Benefit Department.

Genetic Information Nondiscrimination Act:
Under the Genetic Information Nondiscrimination Act of 2008 (GINA), your health plans may generally not collect genetic information (including family medical history) prior to or in connection with your enrollment in any group health plan. In addition, a group health plan may not request, require, or purchase genetic information for "underwriting purposes," which include the determination of the eligibility for benefits under the group health plan, the computation of premium or contribution amounts, the application of any pre-existing condition exclusion under the plan, and the creation, renewal or replacement of a contract of health insurance or health benefits. GINA also generally prohibits group health plans from requesting or requiring an individual to undergo a genetic test. There is a research exception that permits a plan to request (but not require) that a participant or beneficiary undergo a genetic test. There are other exceptions under GINA. Contact the Benefit Department for more information.

Patient Protection and Affordable Care Act:
This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted on March 23, 2010. Being a grandfathered health plan means that the plan may not include certain consumer protections of the PPACA that apply to other plans (i.e., the requirement for the provision of preventive health services without any cost sharing). However, grandfathered health plans must comply with certain other consumer protections in the PPACA (i.e., the elimination of lifetime limits on benefits). Questions regarding which protections apply, and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status, can be directed to the Benefit Department. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866.444.3272 or www.dol.gov/ebsa/healthreform.
This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Qualified Medical Child Support Orders ("QMCSOS"):
The procedures governing QMCSOs are available from the Plan Administrator upon written request.

Michelle's Law:
Any health care coverage maintained under the plan that requires a certification of student status for any period of dependent coverage shall comply with Michelle's Law.

Eligibility for such coverage for a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence will be extended if the leave normally would cause the dependent child to lose eligibility for coverage under the coverage due to loss of student status. This eligibility extension shall last up to one year beginning on the first day of the leave of absence or the date the coverage would otherwise terminate due to loss of student status, whichever is earlier. If you have any questions regarding your child's right to Michelle's Law's continued coverage, you should contact the Benefit Department.

Legal Notices

Mental Health Parity
For those group health plans that are subject to the Mental Health Parity Act of 1996 and he Mental Health Parity and Addiction Equity Act of 2008 (the "Acts"), the PFFA Healthcare Trust provides and administers mental health and substance abuse disorder benefits in accordance with the Acts, including its disclosure requirements. The criteria for medical necessity determinations made under an applicable group health plan with respect to mental health or substance use disorder benefits will be made available to any current or potential participant, beneficiary or contracting provider upon request. The reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits will be made available to the participant or beneficiary in accordance with the Acts. For more information, please contact your organization's HR Department.

No Surprises Act
The No Surprises Act of the Consolidated Appropriations Act, 2021 (the "CAA") protects you from "surprise billing" or "balance billing" when you receive emergency care from an out-of-network hospital or when you receive care from an out-of-network provider working at an in-network hospital or ambulatory surgical center. In these cases, you should not be charged more than the Plan's copayments, coinsurance and/or deductible.
"Balance billing" occurs when you receive care from an out-of-network provider and the out-of-network provider is permitted to bill you for the difference between what the Plan pays for and the full amount of the service. This amount is likely more than in-network costs for the same service and might not count towards your deductible or annual out-of- pocket limit.
"Surprise billing" is an unexpected balance bill. This may occur when you cannot control who is involved in your care such as in cases of emergency or when you are unexpectedly treated by an out-of-network provider at an in-network facility.
You are protected from balance billing for:

- Emergency Services. If you have an emergency medical condition and get emergency services from an out-of- network provider or facility you cannot be balance billed for these services. The most you can be billed is the Plan's in-network cost-sharing amount. This includes services received after you are in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.
- Certain out-of-network services at an in-network hospital or ambulatory center. This includes emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. The most those providers may bill you is your plan's in-network cost-sharing amount. These services cannot be balance billed and you cannot be asked to give up your protections to not be balance billed. If you receive any other types of services at in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

You can always choose to get care at an in-network facility or from an in-network provider instead of getting care at an out-of-network provider or facility. The Plan covers emergency services without requiring you to get approval for such services in advance, which is known as prior authorization. Further, the Plan covers emergency services even if those services are provided by providers who are outside the Plan's network. Your required cost sharing (co-pays, coinsurance, or deductibles) for emergency care received by an out-of-network provider or facility will be the same as what you pay a provider or facility in the Plan's network. That amount will be included in your explanation of benefits. Finally, the amount of any cost-sharing you pay for emergency services or out-of-network services will count towards your applicable maximum annual deductible and out-of-pocket limits under the Plan. For more information, please contact your organization's HR department.

Legal Notices

Notice of Creditable Coverage Regarding Medicare Part D:
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer and 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. Please see the end of this notice for information regarding getting help making decisions about your prescription drug coverage.

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

First, 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.

Second, your employer has determined that the prescription drug coverage offered by the organization's Comprehensive Welfare Plan is, on average for all plan participants, expected to pay out as much as the 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 decide to later 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 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 employer coverage will not be affected.

See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current employer coverage, be aware that you and your dependents may be able to get this coverage back. If you decide to drop your current medical plan coverage and enroll in a Medicare prescription drug coverage, you may be eligible to re-enroll in an employer medical plan during the next annual enrollment period, provided you are eligible at that time. Contact the Benefit Department for further information.

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 coverage with your employer 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 19 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.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can join a Medicare drug plan, and if this coverage through your employer changes. You may request a copy of this notice from your HR department.

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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 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 the Social Security Administration (SSA) online 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).

Premium Assistance Under The Children's Health Insurance Program (CHIP):
If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.
If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state that has a Medicaid or CHIP office, contact that office to find out if premium assistance is offered. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.
If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

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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.

CALIFORNIA – Medicaid	ALABAMA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	Website: http://myalhipp.com/ Phone: 1-855-692-5447
COLORADO – Health First Colorado & Child Health Plan Plus (CHP+)	**INDIANA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+ Website: https://www.colorado.gov/pacific/hcpf/child health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/heal th-insurancebuy-program HIBI Customer Service: 1-855-692-6442	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
MINNESOTA – Medicaid and CHIP	**PENNSYLVANIA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programsand-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://www.pa.gov/en/services/dhs/apply-for- medicaid-health-insurance-premium-payment- program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
FLORIDA – Medicaid	**TEXAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
NEW YORK – Medicaid	**KANSAS– Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.kancare.ks.gov Phone: 800-792-4884 HIPP Phone: 800-967-4660
OKLAHOMA– Medicaid and CHIP	**SOUTH CAROLINA– Medicaid**
Website: http://www.insureoklahoma.org Phone: 888-365-3742	Website: https://www.scdhhs.gov Phone: 888-549-0820

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:

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

Arizona – CHIP
https://www.azahcccs.gov
602.417.5422

Centers for Medicare & Medical Services
www.insurekidsnow.gov
1.877.543.7669

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USERRA Rights:
Federal law may afford certain participants and their dependents the right to continue their health care coverage during certain periods of military leaves of absence pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). This continuation option is similar in many respects to COBRA continuation coverage. Contact the Plan Administrator for additional information.

General Notice of Cobra Continuation Coverage Rights:
Introduction
This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible
for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.
The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.
You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the plan because of the following qualifying events:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; orThe month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty, and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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 the Benefit Department.

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled, and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. 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.

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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 http://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
Please contact the HR Department for more information.

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This is not a legal document. Please refer to the Summary Plan Descriptions for detailed information. This document is not intended to cover every option in detail. Complete details are in the legal documents, contracts, and administrative policies that govern benefit operation and administration.

If there should ever be any differences between the summaries in this guide and the legal documents, contracts and policies, the legal documents, contracts and policies will be the final authority.

Neither the plan, the Summary Plan Descriptions, nor your coverage under the plan, give you any right to continue your employment with your employer, nor will they interfere in any way with your right or the employer right to terminate your employment at any time for any reason, which right is hereby expressly reserved.

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