First Responders VEBA Trust

2025 Benefits Enrollment Guide

Pre 65 Members

BENEFITS Medical Vision

CONTENTS

3 – 4	**ENROLLMENT & ELIGIBILITY**
5 6 – 15 16	**HEALTHCARE BENEFITS** Health Plan Service Partners Health Plan Options Vision Benefits
17	**COMMON QUESTIONS**
18	**PRICING SUMMARY**

About the First Responders VEBA

The First Responders VEBA (Voluntary Employees' Beneficiary Association) is a specialized health benefits trust designed to provide comprehensive medical and vision coverage for retired, pre-Medicare eligible first responders, including police officers, firefighters, emergency medical personnel, and public sector employees.

The mission of the First Responders VEBA, in consultation with the Health Benefit Alliance (HBA), is to provide and maintain quality, cost effective benefits, including medical, prescription drugs, and vision programs, for all eligible Police, Fire, Emergency and Public Sector workers.

FIRST RESPONDERS
POLICE FIRE AND EMERGENCY
VEBA

First Responders VEBA Board

The First Responders VEBA Board is drawn from volunteers with experience on boards with health and disability benefits. The responsibilities and objectives of the Board include:

- Oversee the selection of healthcare plans that will be offered each year to members of the VEBA, including medical, prescription drug, and vision plans;
- Manages the selection of the plan administrator for the VEBA plans each year as they support the membership in completing the necessary steps to enroll and participate in the VEBA benefit offerings;
- The VEBA Insurance Representatives will provide timely updates about the First Responders VEBA annual enrollment process as well as any changes to the plans offered, including the cost of the programs during open enrollment.

Please Keep Your Contact Information Up-to-Date!

It is important to have the most up-to-date contact information for active duty and retirees who are eligible to participate in these healthcare plans. Please go to our website **www.FirstRespondersUS.com** and click on “Join Our Mailing List” link and provide your contact information.

WELCOME TO YOUR 2025 ENROLLMENT GUIDE

Benefit elections are among the most important choices that we make for ourselves and our family. That is why the First Responders VEBA offers a comprehensive package of medical, prescription drug, and vision benefits to meet the unique protection needs of our Membership.

Please take the time to carefully consider your benefit choices during this Special Enrollment period.

ENROLL ONLINE

Go to **FirstRespondersUS.benelist.com** to complete your enrollment in minutes.

First Responders Enrollment Center

(774) RESPOND
(774-737-7663)

ENROLL BY PHONE

Call us at **774-RESPOND** (774-737-7663) and let one of our Benefit Counselors help you enroll over the phone.

ENROLL BY FORM

Complete the First Responders VEBA enrollment form and return via email to: **FRenrollment@HBAAdministrators.com** or via regular mail to:

HBA Administrators
Attn: First Responders VEBA Enrollment
4100 Monument Corner Drive, Suite 500
Fairfax, VA 22030

ELIGIBILITY

ELIGIBILITY

Eligible Members are pre-Medicare Retirees of the Public Sector, First Responders, Police, Fire, Paramedics, Emergency Medical Technicians, and affiliated services groups. Eligible Members must be under age 65 and include:

- **Retiree Member** – First Responder, Police, Fire, Emergency, and Public Sector industry retirees
- **Spouse* Member** – The spouse, surviving spouse, and/or ex-spouse of a current, disabled, or deceased Retiree Member
- **Dependent Child(ren)** – A natural born child, stepchild, adopted child, or grandchild of any age claimed as a dependent on the Retiree Member's or Spouse Member's federal tax return

Your eligible dependents include:

- Spouse
- A dependent child (natural, adopted and step children) under the age 26 regardless of student status, marital status or residence. Coverage will terminate at the end of the month in which the dependent turns 26.
- Disabled children of any age who live with you and depend on you for support due to a mental or physical disability (additional validation documentation may be required).

Your eligible dependents *do not* include:

- Individuals on active duty in any branch of military service (except to the extent and for the period required by law)
- Permanent residents of a country other than the United States
- Parents, grandparents, or other ancestors
- Grandchildren who do not meet the definition of dependent grandchildren and who are not claimed on your or your spouse's federal income tax return.

Qualified Spouse Members may enroll in the Plan as otherwise allowed, regardless of whether the eligible Retiree Member is enrolled, and may make enrollment elections independent from those of the Retiree Member.

*Note: Plan eligibility for qualified same-sex Domestic Partners is extended on the same basis as for Spouse Members.

HEALTH PLAN SERVICE PARTNERS

The First Responders VEBA, in consultation with the Health Benefit Alliance, has assembled a menu of health plan design options supported by best-in-class service partners to deliver valuable benefits to our Members and their covered dependents.

Reflect Health (*formerly S&S Health*) – As the health plan service center, Reflect Health provides efficient claims processing in accordance with plan provisions and professional Member service support.

HBAeHealth℠ – 24/7/365 virtual access to qualified Primary Care and Behavioral Health medical professionals as close as a phone, tablet, or computer…all for a $0 copay.

PHCS for Value Driven Health Plans – A national Preferred Provider (PPO) network consisting of over 990,000 practitioners and 78,000 ancillary providers, PHCS for Value Driven Health Plans is the largest independent, NCQA (National Committee for Quality Assurance) accredited network in the U.S.

You can search In-Network providers online at https://portal.hstechnology.com/PHCS.

HBACareNav℠ – A specially trained team of Care Guides to help Members navigate a complex healthcare system to optimize plan benefits, avoid claim complications, and minimize out-of-pocket expenses.

AvantaRx – The plans' Pharmacy Benefit Manager supporting easy, affordable access to a wide range of the most commonly used prescription medications. Members may fill up to a 30-day supply of covered prescription medications at over 65,000 participating retail pharmacies, or use mail order service for up to a 90-day supply of covered maintenance drugs for home delivery.

HBAVision℠ – Each health plan option includes access to exclusive savings on high-quality eye care and designer eyewear, powered by *Alliance* member XP Health.

Hospital Care

The plans use an open network for hospital and facility care. Claims for services performed at a hospital and other outpatient facilities are reimbursed using ***Reference Based Pricing (RBP)*** at a fair and reasonable level above what Medicare would pay for the same service.

Under the Plan's ***Patient Liability Protection (PLP)*** feature, when a Member adheres to the Care Navigation support provided, that Member will not be responsible for a balance bill for charges related to those covered services.

BASIC PLAN

PLAN PROVISION		BASIC PLAN	
		In-Network	*Out-of-Network[1]*
Deductible[2] *(Individual | Family)*		$5,000 | $10,000	$10,000 | $20,000
Coinsurance *(Plan Payment)*		100%	100%
Maximum Out of Pocket[2] *(Individual | Family)*		$5,000 | $10,000	$10,000 | $20,000
PREVENTIVE CARE SERVICES			
ACA Preventive Services Schedule		$0 Copay	100% after deductible
Adult Routine Physical Exam, Mammogram, GYN Exam and PSA		$0 Copay	100% after deductible
PHYSICIAN SERVICES			
Primary Care Office Visit		$15 Copay *(3 visits max per year)[2]*	100% after deductible
Specialist Visit		$15 Copay *(3 visits max per year)[2]*	100% after deductible
X-ray and Lab Services Performed in the Office		100% after deductible	100% after deductible
Other Physician Services Performed in the Office		100% after deductible	100% after deductible
Urgent Care Visit		$50 Copay *(3 visits max per year)[2]*	100% after deductible
Telemedicine Vendor Services		$0 Copay	Not Applicable
HOSPITAL/FACILITY SERVICES (Subject to Reference Based Pricing)			
Inpatient Hospital Services *(RBP)[3]*		100% covered after deductible	
Outpatient Hospital Services/ Freestanding Surgery *(RBP)[3]*		100% covered after deductible	
Anesthesia *(RBP)[3]*		100% covered after deductible	
Emergency Room Facilities and Covered Services *(RBP)[3]*		$1,000 Copay *(copay waived if admitted)* *(Hospital charges subject to deductible and coinsurance)*	
OUTPATIENT: DIAGNOSTIC SERVICES (Non-Hospital Based)			
Lab/X-Ray		100% after deductible	100% after deductible
Advanced Medical Imaging *(RBP)[3]*		100% covered after deductible	
PREGNANCY BENEFITS			
Professional Services		100% after deductible	100% after deductible
Maternity/Childbirth/Delivery *(RBP)[3]*		100% covered after deductible	
OTHER SERVICES			
Chemotherapy/Radiation Therapy *(RBP)[3]*		100% covered after deductible	
Chiropractic Care *(Limited to 10 visits per plan year)[2]*		100% after deductible	100% after deductible
Colonoscopy *(RBP)[3] (Diagnostic purposes)*		100% covered after deductible	
Dialysis *(RBP)[3]*		100% covered after deductible	
Durable Medical Equipment *(Subject to limitations)*		100% after deductible	100% after deductible
Emergency Medical Transportation *(Subject to limitations)*		100% covered after deductible	
Home Health Care *(Limited to 120 days per plan year)[2]*		100% after deductible	100% after deductible
Rehabilitation/Habilitation Services *(Physical, Speech, and Occupational; Combined limit of 25 visits per plan year. Pre-authorization is required after 6 visits)[2]*		100% after deductible	100% after deductible
Skilled Nursing Care *(Limited to 120 days per plan year)[2]*		100% covered after deductible	
Sleep Apnea *(Limited to at-home testing and $500 annual maximum benefit for machine and supplies)[2]*		100% after deductible	100% after deductible
Transplant – Facility *(RBP)[3]*		100% covered after deductible	
Transplant – Physician and Anesthesiologist Charges during Inpatient Hospitalization *(RBP)[3]*			
Mental Health, Behavioral Health, or Substance Abuse Services	**Inpatient or Partial Day** *(RBP)[3]*	100% covered after deductible	
	Outpatient	100% after deductible	100% after deductible

BASIC PLAN (CONTINUED)

PLAN PROVISION	BASIC PLAN	
	In-Network	*Out-of-Network*[1]
VISION BENEFITS[4]		
In-Office Comprehensive Vision Exams	$0 Copay	Up to $35 benefit
Eyewear Allowance for frames or contacts	$150 every two (2) years	
PRESCRIPTION DRUG PLAN	**Retail** *(30-day supply)*	**Mail Order** *(90-day supply)*
Prescriptions		
ACA Preventive Drugs	$0 Copay	$0 Copay
Non-Preventive Generic Drugs	$5 Copay	$10 Copay
Preferred Brand Drugs	Not Covered	
Non-Preferred Brand Drugs	Not Covered	
Specialty Drugs	Not Covered	
Automated Diabetic Supplies *(Continuous glucose monitors (CGMs) and insulin pumps)*	Plan pays 80% *(60% if dispensed by non-participating pharmacy)*	
MONTHLY RATES		
Member Only	**$802.40**	
Member + Spouse	**$1,369.94**	
Member + Child(ren)	**$1,320.51**	
Member + Family	**$1,908.20**	

[1] *Charges in excess of reasonable and customary rates for services performed by non-Network providers are not eligible for benefits.*
[2] *Visit, service, deductible, and Out-of-Pocket limits accumulate during a calendar year and reset on January 1st each year.*
[3] *Claims for services performed at hospitals and other outpatient facilities are reimbursed using reference based pricing (RBP).*
[4] *Vision benefits are provided outside of the Group Health Plan through a service contract with XP Health.*

Click or scan the QR code for a detailed Basic Plan benefit summary, including limitations and exclusions.

First Responders Benefit Line

(774) RESPOND
(774-737-7663)

PLUS PLAN

PLAN PROVISION		PLUS PLAN	
		In-Network	*Out-of-Network*[1]
Deductible[2] *(Individual | Family)*		$1,200 | $2,400	$2,400 | $4,800
Coinsurance *(Plan Payment)*		80%	20%
Maximum Out of Pocket[2] *(Individual | Family)*		$6,000 | $12,000	$12,000 | $24,000
PREVENTIVE CARE SERVICES			
ACA Preventive Services Schedule		$0 Copay	20% after deductible
Adult Routine Physical Exam, Mammogram, GYN Exam and PSA		$0 Copay	20% after deductible
PHYSICIAN SERVICES			
Primary Care Office Visit		$35 Copay	20% after deductible
Specialist Visit		$65 Copay	20% after deductible
X-ray and Lab Services Performed in the Office		80% after deductible	20% after deductible
Other Physician Services Performed in the Office		80% after deductible	20% after deductible
Urgent Care Visit		$40 Copay	20% after deductible
Telemedicine Vendor Services		$0 Copay	Not Applicable
HOSPITAL/FACILITY SERVICES ***(Subject to Reference Based Pricing)***			
Inpatient Hospital Services *(RBP)*[3]		80% covered after deductible	
Outpatient Hospital Services/ Freestanding Surgery *(RBP)*[3]		80% covered after deductible	
Anesthesia *(RBP)*[3]		80% covered after deductible	
Emergency Room Facilities and Covered Services *(RBP)*[3]		$500 Copay *(copay waived if admitted)* *(Hospital charges subject to deductible and coinsurance)*	
OUTPATIENT: DIAGNOSTIC SERVICES ***(Non-Hospital Based)***			
Lab/X-Ray		80% after deductible	20% after deductible
Advanced Medical Imaging *(RBP)*[3]		80% covered after deductible	
PREGNANCY BENEFITS			
Professional Services		80% after deductible	20% after deductible
Maternity/Childbirth/Delivery *(RBP)*[3]		80% covered after deductible	
OTHER SERVICES			
Chemotherapy/Radiation Therapy *(RBP)*[3]		80% covered after deductible	
Chiropractic Care *(Limited to 10 visits per plan year)*[2]		80% after deductible	20% after deductible
Colonoscopy *(RBP)*[3] *(Diagnostic purposes)*		80% covered after deductible	
Dialysis *(RBP)*[3]		80% covered after deductible	
Durable Medical Equipment *(Subject to limitations)*		80% after deductible	20% after deductible
Emergency Medical Transportation *(Subject to limitations)*		80% covered after deductible	
Home Health Care *(Limited to 120 days per plan year)*[2]		80% after deductible	20% after deductible
Rehabilitation/Habilitation Services *(Physical, Speech, and Occupational; Combined limit of 25 visits per plan year. Pre-authorization is required after 6 visits)*[2]		80% after deductible	20% after deductible
Skilled Nursing Care *(Limited to 120 days per plan year)*[2]		80% covered after deductible	
Sleep Apnea *(Limited to at-home testing and $500 annual maximum benefit for machine and supplies)*[2]		80% after deductible	20% after deductible
Transplant – Facility *(RBP)*[3]		80% covered after deductible	
Transplant – Physician and Anesthesiologist Charges during Inpatient Hospitalization *(RBP)*[3]			
Mental Health, Behavioral Health, or Substance Abuse Services	**Inpatient or Partial Day** *(RBP)*[3]	80% covered after deductible	
	Outpatient	80% after deductible	20% after deductible

PLUS PLAN (CONTINUED)

PLAN PROVISION	PLUS PLAN	
	In-Network	*Out-of-Network[1]*
VISION BENEFITS[4]		
In-Office Comprehensive Vision Exams	$0 Copay	Up to $35 benefit
Eyewear Allowance for frames or contacts	$150 every two (2) years	
PRESCRIPTION DRUG PLAN	**Retail** *(30-day supply)*	**Mail Order** *(90-day supply)*
Prescriptions		
ACA Preventive Drugs	$0 Copay	$0 Copay
Non-Preventive Generic Drugs	$5 Copay	$10 Copay
Preferred Brand Drugs	Plan pays 80%	
Non-Preferred Brand Drugs	Plan pays 70% after deductible	
Specialty Drugs	Managed	N/A
Automated Diabetic Supplies *(Continuous glucose monitors (CGMs) and insulin pumps)*	Plan pays 80% *(60% if dispensed by non-participating pharmacy)*	
MONTHLY RATES		
Member Only	**$948.88**	
Member + Spouse	**$1,685.78**	
Member + Child(ren)	**$1,577.76**	
Member + Family	**$2,281.71**	

[1] *Charges in excess of reasonable and customary rates for services performed by non-Network providers are not eligible for benefits.*
[2] *Visit, service, deductible, and Out-of-Pocket limits accumulate during a calendar year and reset on January 1st each year.*
[3] *Claims for services performed at hospitals and other outpatient facilities are reimbursed using reference based pricing (RBP).*
[4] *Vision benefits are provided outside of the Group Health Plan through a service contract with XP Health.*

Click or scan the QR code for a detailed Plus Plan benefit summary, including limitations and exclusions.

First Responders Benefit Line

(774) RESPOND
(774-737-7663)

ULTRA PLAN

PLAN PROVISION		ULTRA PLAN	
		In-Network	*Out-of-Network*[1]
Deductible[2] *(Individual | Family)*		$500 | $1,000	$1,000 | $2,000
Coinsurance *(Plan Payment)*		80%	20%
Maximum Out of Pocket[2] *(Individual | Family)*		$4,500 | $9,000	$9,000 | $18,000
PREVENTIVE CARE SERVICES			
ACA Preventive Services Schedule		$0 Copay	20% after deductible
Adult Routine Physical Exam, Mammogram, GYN Exam and PSA		$0 Copay	20% after deductible
PHYSICIAN SERVICES			
Primary Care Office Visit		$25 Copay	20% after deductible
Specialist Visit		$50 Copay	20% after deductible
X-ray and Lab Services Performed in the Office		80% after deductible	20% after deductible
Other Physician Services Performed in the Office		80% after deductible	20% after deductible
Urgent Care Visit		$40 Copay	20% after deductible
Telemedicine Vendor Services		$0 Copay	Not Applicable
HOSPITAL/FACILITY SERVICES ***(Subject to Reference Based Pricing)***			
Inpatient Hospital Services *(RBP)*[3]		80% covered after deductible	
Outpatient Hospital Services/ Freestanding Surgery *(RBP)*[3]		80% covered after deductible	
Anesthesia *(RBP)*[3]		80% covered after deductible	
Emergency Room Facilities and Covered Services *(RBP)*[3]		$500 Copay *(copay waived if admitted)* *(Hospital charges subject to deductible and coinsurance)*	
OUTPATIENT: DIAGNOSTIC SERVICES ***(Non-Hospital Based)***			
Lab/X-Ray		80% after deductible	20% after deductible
Advanced Medical Imaging *(RBP)*[3]		80% covered after deductible	
PREGNANCY BENEFITS			
Professional Services		80% after deductible	20% after deductible
Maternity/Childbirth/Delivery *(RBP)*[3]		80% covered after deductible	
OTHER SERVICES			
Chemotherapy/Radiation Therapy *(RBP)*[3]		80% covered after deductible	
Chiropractic Care *(Limited to 10 visits per plan year)*[2]		80% after deductible	20% after deductible
Colonoscopy *(RBP)*[3] *(Diagnostic purposes)*		80% covered after deductible	
Dialysis *(RBP)*[3]		80% covered after deductible	
Durable Medical Equipment *(Subject to limitations)*		80% after deductible	20% after deductible
Emergency Medical Transportation *(Subject to limitations)*		80% covered after deductible	
Home Health Care *(Limited to 120 days per plan year)*[2]		80% after deductible	20% after deductible
Rehabilitation/Habilitation Services *(Physical, Speech, and Occupational; Combined limit of 25 visits per plan year. Pre-authorization is required after 6 visits)*[2]		80% after deductible	20% after deductible
Skilled Nursing Care *(Limited to 120 days per plan year)*[2]		80% covered after deductible	
Sleep Apnea *(Limited to at-home testing and $500 annual maximum benefit for machine and supplies)*[2]		80% after deductible	20% after deductible
Transplant – Facility *(RBP)*[3]		80% covered after deductible	
Transplant – Physician and Anesthesiologist Charges during Inpatient Hospitalization *(RBP)*[3]			
Mental Health, Behavioral Health, or Substance Abuse Services	**Inpatient or Partial Day** *(RBP)*[3]	80% covered after deductible	
	Outpatient	80% after deductible	20% after deductible

ULTRA PLAN (CONTINUED)

PLAN PROVISION	ULTRA PLAN	
	In-Network	*Out-of-Network*[1]
VISION BENEFITS[4]		
In-Office Comprehensive Vision Exams	$0 Copay	Up to $35 benefit
Eyewear Allowance for frames or contacts	$150 every two (2) years	
PRESCRIPTION DRUG PLAN	**Retail** *(30-day supply)*	**Mail Order** *(90-day supply)*
Prescriptions		
ACA Preventive Drugs	$0 Copay	$0 Copay
Non-Preventive Generic Drugs	$5 Copay	$10 Copay
Preferred Brand Drugs	Plan pays 80%	
Non-Preferred Brand Drugs	Plan pays 70% after deductible	
Specialty Drugs	Managed	N/A
Automated Diabetic Supplies *(Continuous glucose monitors (CGMs) and insulin pumps)*	Plan pays 80% *(60% if dispensed by non-participating pharmacy)*	
MONTHLY RATES		
Member Only	**$1,178.93**	
Member + Spouse	**$2,011.03**	
Member + Child(ren)	**$1,966.18**	
Member + Family	**$2,843.13**	

[1] *Charges in excess of reasonable and customary rates for services performed by non-Network providers are not eligible for benefits.*
[2] *Visit, service, deductible, and Out-of-Pocket limits accumulate during a calendar year and reset on January 1st each year.*
[3] *Claims for services performed at hospitals and other outpatient facilities are reimbursed using reference based pricing (RBP).*
[4] *Vision benefits are provided outside of the Group Health Plan through a service contract with XP Health.*

Click or scan the QR code for a detailed Ultra Plan benefit summary, including limitations and exclusions.

First Responders Benefit Line

(774) RESPOND
(774-737-7663)

BRONZE PLAN

PLAN PROVISION		BRONZE PLAN	
		In-Network	*Out-of-Network[1]*
Deductible[2] *(Individual | Family)*		$2,000 | $4,000	$4,000 | $8,000
Coinsurance *(Plan Payment)*		80%	60%
Maximum Out of Pocket[2] *(Individual | Family)*		$3,000 | $6,000	$6,000 | $12,000
PREVENTIVE CARE SERVICES			
ACA Preventive Services Schedule		$0 Copay	60% after deductible
Adult Routine Physical Exam, Mammogram, GYN Exam and PSA		$0 Copay	Not Covered
PHYSICIAN SERVICES			
Primary Care Office Visit		80% after deductible	60% after deductible
Specialist Visit		80% after deductible	60% after deductible
X-ray and Lab Services Performed in the Office		80% after deductible	60% after deductible
Other Physician Services Performed in the Office		80% after deductible	60% after deductible
Urgent Care Visit		80% after deductible	60% after deductible
Telemedicine Vendor Services		$0 Copay	Not Applicable
HOSPITAL/FACILITY SERVICES ***(Subject to Reference Based Pricing)***			
Inpatient Hospital Services *(RBP)*[3]		80% covered after deductible	
Outpatient Hospital Services/ Freestanding Surgery *(RBP)*[3]		80% covered after deductible	
Anesthesia *(RBP)*[3]		80% covered after deductible	
Emergency Room Facilities and Covered Services *(RBP)*[3]		80% covered after deductible	
OUTPATIENT: DIAGNOSTIC SERVICES ***(Non-Hospital Based)***			
Lab/X-Ray		80% after deductible	60% after deductible
Advanced Medical Imaging *(RBP)*[3]		80% covered after deductible	
PREGNANCY BENEFITS			
Professional Services		80% after deductible	60% after deductible
Maternity/Childbirth/Delivery *(RBP)*[3]		80% covered after deductible	
OTHER SERVICES			
Chemotherapy/Radiation Therapy *(RBP)*[3]		80% covered after deductible	
Chiropractic Care *(Limited to 10 visits per plan year)*[2]		80% after deductible	60% after deductible
Colonoscopy *(RBP)*[3] *(Diagnostic purposes)*		80% covered after deductible	
Dialysis *(RBP)*[3]		80% covered after deductible	
Durable Medical Equipment *(Subject to limitations)*		80% after deductible	60% after deductible
Emergency Medical Transportation *(Subject to limitations)*		80% covered after deductible	
Home Health Care *(Limited to 120 days per plan year)*[2]		80% after deductible	60% after deductible
Rehabilitation/Habilitation Services *(Physical, Speech, and Occupational; Combined limit of 25 visits per plan year. Pre-authorization is required after 6 visits)*[2]		80% after deductible	60% after deductible
Skilled Nursing Care *(Limited to 120 days per plan year)*[2]		80% covered after deductible	
Sleep Apnea *(Limited to at-home testing and $500 annual maximum benefit for machine and supplies)*[2]		80% after deductible	60% after deductible
Transplant – Facility *(RBP)*[3]		80% covered after deductible	
Transplant – Physician and Anesthesiologist Charges during Inpatient Hospitalization *(RBP)*[3]			
Mental Health, Behavioral Health, or Substance Abuse Services	**Inpatient or Partial Day** *(RBP)*[3]	80% covered after deductible	
	Outpatient	80% after deductible	60% after deductible

BRONZE PLAN (CONTINUED)

PLAN PROVISION	BRONZE PLAN		
	In-Network	*Out-of-Network[1]*	
VISION BENEFITS[4]			
In-Office Comprehensive Vision Exams	$0 Copay	Up to $35 benefit	
Eyewear Allowance for frames or contacts	$150 every two (2) years		
PRESCRIPTION DRUG PLAN	**In-Network Retail** *(30-day supply)*	**In-Network Mail Order** *(90-day supply)*	**Out-of-Network Retail** *(30-day supply)*
Prescriptions ACA Preventive Drugs	$0 Copay	$0 Copay	$0 Copay
Non-Preventive Generic Drugs	$15 Copay, after ded.	$30 Copay, after ded.	$15 Copay, after ded. plus 20% of approved amount
Preferred Brand Drugs	$50 Copay, after ded.	$100 Copay, after ded.	$50 Copay, after ded. plus 20% of approved amount
Non-Preferred Brand Drugs	$70 Copay, after ded.	$140 Copay, after ded.	$70 Copay, after ded. plus 20% of approved amount
Specialty Drugs	Managed	Managed	N/A
Automated Diabetic Supplies *(Continuous glucose monitors (CGMs) and insulin pumps)*	80%	80%	60%
MONTHLY RATES			
Member Only	**$1,136.30**		
Member + Spouse	**$2,162.46**		
Member + Child(ren)	**$2,180.46**		
Member + Family	**$3,102.74**		

[1] Charges in excess of reasonable and customary rates for services performed by non-Network providers are not eligible for benefits.
[2] Visit, service, deductible, and Out-of-Pocket limits accumulate during a calendar year and reset on January 1st each year.
[3] Claims for services performed at hospitals and other outpatient facilities are reimbursed using reference based pricing (RBP).
[4] Vision benefits are provided outside of the Group Health Plan through a service contract with XP Health.

Click or scan the QR code for a detailed Bronze Plan benefit summary, including limitations and exclusions.

First Responders Benefit Line

(774) RESPOND
(774-737-7663)

SILVER PLAN

PLAN PROVISION		SILVER PLAN	
		In-Network	*Out-of-Network[1]*
Deductible[2] *(Individual | Family)*		$500 | $1,000	$1,000 | $2,000
Coinsurance *(Plan Payment)*		80%	60%
Maximum Out of Pocket[2] *(Individual | Family)*		$2,000 | $4,000	$4,000 | $8,000
PREVENTIVE CARE SERVICES			
ACA Preventive Services Schedule		$0 Copay	60% after deductible
Adult Routine Physical Exam, Mammogram, GYN Exam and PSA		$0 Copay	Not Covered
PHYSICIAN SERVICES			
Primary Care Office Visit		$20 Copay	60% after deductible
Specialist Visit		$20 Copay	60% after deductible
X-ray and Lab Services Performed in the Office		80% after deductible	60% after deductible
Other Physician Services Performed in the Office		80% after deductible	60% after deductible
Urgent Care Visit		$20 Copay	60% after deductible
Telemedicine Vendor Services		$0 Copay	Not Applicable
HOSPITAL/FACILITY SERVICES ***(Subject to Reference Based Pricing)***			
Inpatient Hospital Services *(RBP)*[3]		80% covered after deductible	
Outpatient Hospital Services/ Freestanding Surgery *(RBP)*[3]		80% covered after deductible	
Anesthesia *(RBP)*[3]		80% covered after deductible	
Emergency Room Facilities and Covered Services *(RBP)*[3]		$500 Copay *(copay waived if admitted)* *(Hospital charges subject to deductible and coinsurance)*	
OUTPATIENT: DIAGNOSTIC SERVICES ***(Non-Hospital Based)***			
Lab/X-Ray		80% after deductible	60% after deductible
Advanced Medical Imaging *(RBP)*[3]		80% covered after deductible	
PREGNANCY BENEFITS			
Professional Services		80% after deductible	60% after deductible
Maternity/Childbirth/Delivery *(RBP)*[3]		80% covered after deductible	
OTHER SERVICES			
Chemotherapy/Radiation Therapy *(RBP)*[3]		80% covered after deductible	
Chiropractic Care *(Limited to 10 visits per plan year)*[2]		80% after deductible	60% after deductible
Colonoscopy *(RBP)*[3] *(Diagnostic purposes)*		80% covered after deductible	
Dialysis *(RBP)*[3]		80% covered after deductible	
Durable Medical Equipment *(Subject to limitations)*		80% after deductible	60% after deductible
Emergency Medical Transportation *(Subject to limitations)*		80% covered after deductible	
Home Health Care *(Limited to 120 days per plan year)*[2]		80% after deductible	60% after deductible
Rehabilitation/Habilitation Services *(Physical, Speech, and Occupational; Combined limit of 25 visits per plan year. Pre-authorization is required after 6 visits)*[2]		80% after deductible	60% after deductible
Skilled Nursing Care *(Limited to 120 days per plan year)*[2]		80% covered after deductible	
Sleep Apnea *(Limited to at-home testing and $500 annual maximum benefit for machine and supplies)*[2]		80% after deductible	60% after deductible
Transplant – Facility *(RBP)*[3]		80% covered after deductible	
Transplant – Physician and Anesthesiologist Charges during Inpatient Hospitalization *(RBP)*[3]			
Mental Health, Behavioral Health, or Substance Abuse Services	**Inpatient or Partial Day** *(RBP)*[3]	80% covered after deductible	
	Outpatient	80% after deductible	60% after deductible

SILVER PLAN (CONTINUED)

PLAN PROVISION	SILVER PLAN		
	In-Network	*Out-of-Network[1]*	
VISION BENEFITS[4]			
In-Office Comprehensive Vision Exams	$0 Copay	Up to $35 benefit	
Eyewear Allowance for frames or contacts	$150 every two (2) years		
PRESCRIPTION DRUG PLAN	**In-Network Retail** *(30-day supply)*	**In-Network Mail Order** *(90-day supply)*	**Out-of-Network Retail** *(30-day supply)*
Prescriptions ACA Preventive Drugs	$0 Copay	$0 Copay	$0 Copay
Non-Preventive Generic Drugs	$10 Copay	$20 Copay	$10 Copay, after ded. plus 25% of approved amount
Preferred Brand Drugs	$40 Copay	$80 Copay	$40 Copay, after ded. plus 25% of approved amount
Non-Preferred Brand Drugs	$80 Copay	$160 Copay	$80 Copay, after ded. plus 25% of approved amount
Specialty Drugs	Managed	Managed	N/A
Automated Diabetic Supplies *(Continuous glucose monitors (CGMs) and insulin pumps)*	80%	80%	60%
MONTHLY RATES			
Member Only	**$1,429.77**		
Member + Spouse	**$2,765.80**		
Member + Child(ren)	**$2,765.80**		
Member + Family	**$3,979.94**		

[1] Charges in excess of reasonable and customary rates for services performed by non-Network providers are not eligible for benefits.
[2] Visit, service, deductible, and Out-of-Pocket limits accumulate during a calendar year and reset on January 1st each year.
[3] Claims for services performed at hospitals and other outpatient facilities are reimbursed using reference based pricing (RBP).
[4] Vision benefits are provided outside of the Group Health Plan through a service contract with XP Health.

Click or scan the QR code for a detailed Silver Plan benefit summary, including limitations and exclusions.

First Responders Benefit Line

(774) RESPOND
(774-737-7663)

VISION

HBA Vision benefits are automatically included when enrolling in any of the Medical Plan options and are provided in partnership with XP Health.

BENEFIT COVERAGE	MEMBER BENEFIT
Benefit Period Benefit and coverage provisions renew/reset	**Exams:** Annual **Materials:** Every Two (2) Calendar Years
XP VISION CARE PLATFORM	
In-Office Comprehensive Vision Exams Eye health assessment, refractive tests, and dilation when necessary	**In-Network:** $0 copay exam at 99,000 provider-location combinations **Out-of-Network:** Up to $35 reimbursement
Online Rx Renewal (Virtual Visual Acuity Test) When appropriate in ~6 minutes, can be done from anywhere	$35 per use
XP Health Care Navigation Helps members find the right provider for them	Included
XP MARKETPLACE	
Technology-Driven Convenience and Personalization Artificial intelligence powered face scan and recommendations, augmented reality try-on, virtual identification cards, live order tracking, etc.	Included
Eyewear Discounts For prescription, non-prescription eyewear and contact lens purchases	Frames: $150 credit, $35 lab fee applied to eyewear orders
Best-in-Class Lens Features The XP Health program includes coverage of most lens options and quality tiers. Other add-ons (e.g., light-responsive lenses) do have additional associated costs that are listed in-platform.	
Advanced Anti-Reflective Coating	Included
Advanced Blue/Violet Light Protection	Included
UV Protection	Included
Dust, Smudge, and Water Resistance	Included
Scratch Resistance Coating	Included
High-Index Lenses	Included
OTHER BENEFITS	
IN-OFFICE EYEWEAR DISCOUNTS Applicable with participating In-Network providers when purchasing eyewear in-person, outside of the XP Marketplace	
Frames Eye health assessment, refractive tests, and dilation when necessary	Retail less 35%
Lenses Discounted fixed-option pricing for lenses and other enhancements	
Single Vision	$35
Bifocal	$55
Trifocal	$70
Lenticular	$70
Contact Lenses	
Evaluation/Fitting	Included
Conventional	Included
Disposable	Included
OTHER DISCOUNTS	
Refractive Surgery	Members receive $1,200 off at preferred providers – LasikPlus, TLC, and The LASIK Vision Institute All other In-Network providers extend 15% off standard pricing or 5% off promotional pricing

COMMON QUESTIONS

Q: What is the Health Benefit Alliance?

The Health Benefit Alliance (HBA) is a health benefit solutions firm specializing in health plan design and service provider curation to deliver efficient, cost-effective health benefit plan options for Plan Sponsors of all sizes.

Q: Who is Reflect Health and what do they do?

Reflect Health (*formerly S&S Health*) is the Service Center behind the First Responders VEBA health plans and provides efficient claims administration and Member call center support, coordinates Care Navigation and preauthorization requests, and performs other important tasks critical to the smooth operation of the First Responders VEBA program.

Q: Do the plans use a network of Preferred Providers (PPO)?

The First Responders VEBA health plans include access to Primary Care and Specialist physicians in the ***PHCS for Value Driven Health Plans (VDHP)*** network. A national Preferred Provider (PPO) network consisting of nearly 990,000 practitioners and 78,000 ancillary providers, PHCS for VDHP is the largest independent, NCQA (National Committee for Quality Assurance) accredited network in the U.S.

You can search In-Network providers online at https://portal.hstechnology.com/PHCS.

Q: What if my doctor's office says they don't accept my coverage?

Provide the Care Navigation team contact information from the Member's ID card and ask that the doctor's office call directly to verify coverage.

Q: Are Hospitals included in the network of Preferred Providers (PPO)?

The First Responders VEBA health plans use an ***open network*** for hospital services, including emergency room care, whereby every hospital facility is eligible to deliver services to Members and their covered dependents. Claims for covered services for facility care are processed using ***Reference Based Pricing (RBP)*** and reimbursed by the Plan at a fair and reasonable level above what Medicare would pay for the same service.

Q: What is the Care Navigation feature and how does it work?

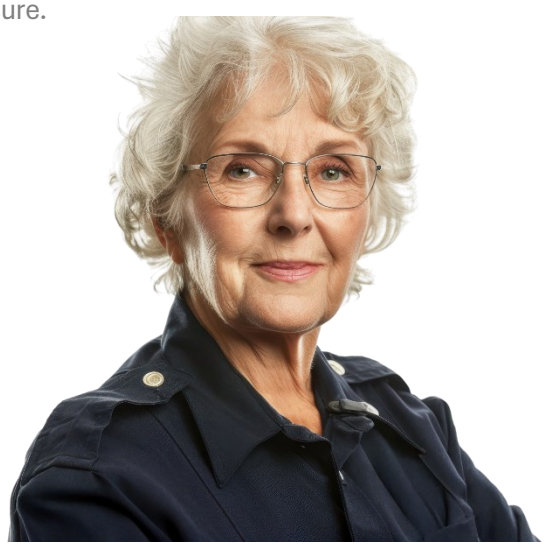
A specially trained team of ***Care Guides*** will help Members navigate today's complex healthcare delivery system, clarifying available options and simplifying choices along the way. Members are encouraged to contact the ***Care Navigation*** Team prior to scheduling:

- Hospital Services
- Outpatient Surgery
- Diagnostic Testing and Imaging
- Specialist Care

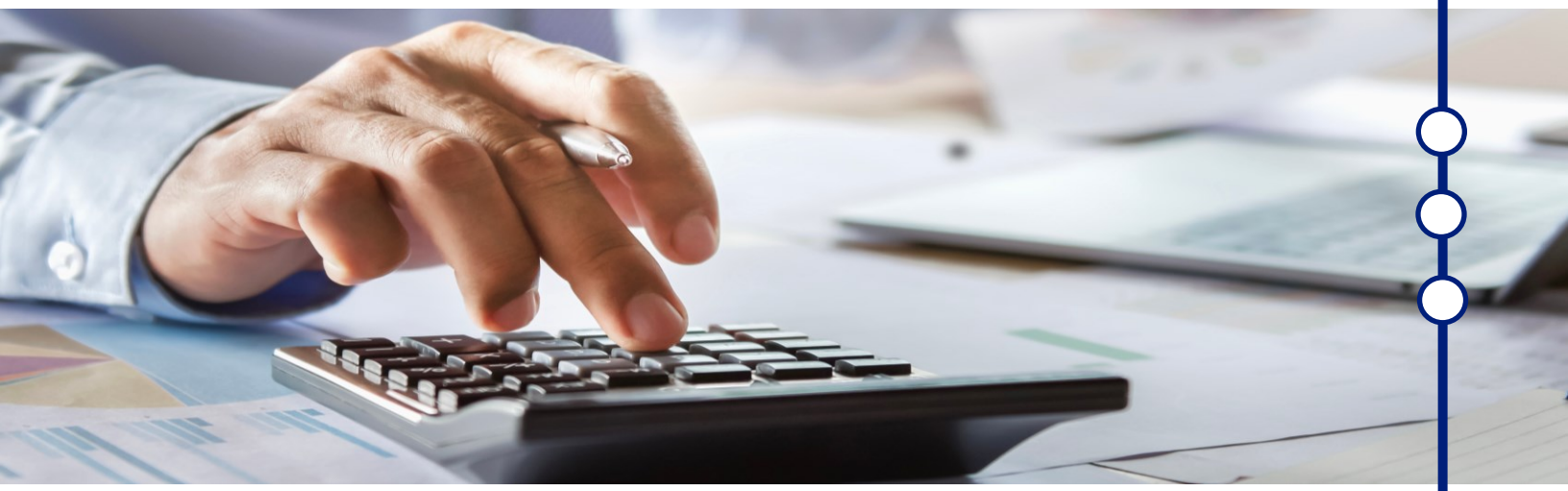
The ***Care Guide*** and Member will review the plan's coverage levels, resources, and limits to help optimize plan benefits, avoid claim complications, and minimize out-of-pocket exposure.

Q: Do the health plans protect me against balance billing?

When engaging the ***Care Navigation*** team to review available options prior to scheduling non-emergency hospital or surgical services, diagnostic testing and imaging, or specialist care, Members will be presented with at least one option that involves facilities that accept reimbursement on behalf of the First Responders VEBA plan for which the plan's ***Patient Liability Protection (PLP)*** feature will apply for covered services. So long as the Member adheres to the plan's preauthorization rules and Care Navigation guidance, they will not be responsible for a balance bill for charges related to those covered services.



PRICING SUMMARY



MEDICAL AND VISION BENEFITS

MONTHLY RATES†	BASIC PLAN	PLUS PLAN	ULTRA PLAN	BRONZE PLAN	SILVER PLAN
Member Only	$802.40	$948.88	$1,178.93	$1,136.30	$1,429.77
Member + Spouse	$1,369.94	$1,685.78	$2,011.03	$2,162.46	$2,765.80
Member + Child(ren)	$1,320.51	$1,577.76	$1,966.18	$2,180.46	$2,765.80
Member + Family	$1,908.20	$2,281.71	$2,843.13	$3,102.74	$3,979.94

†*Monthly rates include projected health plan administration and claim costs, and vision benefit fees.*

BILLING AND REMITTANCE

Member contributions are due on the first business day of the month for which coverage is in effect. Payments are collected via ACH bank draft.

NOTES

FIRST RESPONDERS
POLICE FIRE AND EMERGENCY
VEBA

First Responders Enrollment Center

(774) RESPOND

(774-737-7663)

Monday – Friday

9:00 am – 5:00 pm EST

THE HEALTH BENEFIT ALLIANCE
YOUR ALLY IN HEALTH™

Plans and service providers arranged and managed by the Health Benefit Alliance, LLC