First Responders VEBA Trust

2026 Benefits Enrollment Guide

Pre 65 Members

FIRST RESPONDERS
POLICE FIRE AND EMERGENCY
VEBA

BENEFITS | Medical | Pharmacy | Vision

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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 2026 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 carefully review your benefit choices during this annual Open Enrollment period and take action before this window of opportunity closes on ***December 15th***.

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.


ENROLLMENT/CHANGE FORM

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) regardless of student status, marital status or residence
- 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.

THE MENU OF HEALTH PLAN OPTIONS

The menu of First Responders VEBA health plan options consists of two (2) distinct approaches to managing hospital and facility costs and access to care.

The **Basic**, **Plus**, **Ultra**, **Bronze**, and **Silver** plans, supported by the **PHCS for Value Driven Health Plans** network, use ***Reference Based Pricing (RBP)*** when determining benefits for covered hospital and facility services. Benefits for covered services provided by physicians and ancillary providers are determined based on contracted fees when using In-Network providers, and at a percentage above Medicare reimbursement rates for Non-Network Providers.

The **Basic PPO**, **Plus PPO**, **Ultra PPO**, **Bronze PPO**, and **Silver PPO** plans, supported by the **Anthem Blue Cross and Blue Shield *BlueCard* National PPO** network, use a contracted provider network for all covered services. Benefits for covered services from Non-Network providers are based on a percentage above Medicare reimbursement rates.

Here are some general differences between **RBP** plans and **PPO** plans:

RBP Health Plans

- **Open network** for hospital and facility services - Since RBP plan do not rely on a contracted provider network, you can seek care from any qualified provider you choose.
- **Costs are based on a "reference price"** - Instead of negotiating rates with hospitals and other covered facilities, RBP plans determine benefit payments based on a fair and reasonable percentage above what Medicare would pay for the same services.
- **Lower premium rates** - Because benefit payments are controlled through this model, RBP plans typically offer lower monthly premium costs.
- **Some providers may not accept the plan benefit as payment in full** - If a hospital charges significantly more than the reference price, they may insist that the patient cover the difference, commonly referred to as a "balance bill."
- **Member *Care Navigation* support is important** - While the choice of providers always rests with the Member, Care Guides are available to assist in locating providers that accept reimbursement in accordance with the plan's benefit determination. Members will always be presented with at least one available option for which the plan's **Patient Liability Protection (PLP)** provision will apply. So long as the Member adheres to the plan rules and Care Navigation guidance, the Member will not be responsible for a balance bill for charges related to those covered services.

PPO Health Plans

- **Contracted provider network for all covered services** - You pay the lowest out-of-pocket costs when you stay within the PPO network.
- **Predictable, negotiated pricing** - Providers agree to discounted rates, which reduces the risk of balance billing.
- **Higher premium rates** - Monthly premiums are generally higher than RBP plans because the network contracts and discounts come at a cost.
- **Non-Network care options exist but cost more** - You can seek care outside of the network, but you'll usually pay higher copays, deductibles, and/or coinsurance and could be subject to a balance bill.

RBP PLAN SERVICE PARTNERS

The First Responders VEBA, in consultation with the Health Benefit Alliance, has assembled a menu of RBP health plan 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

PHCS for Value-Driven Health Plans

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 *(3 visits max per year)*[2]		$15 Copay	100% after deductible
Specialist Visit *(3 visits max per year)*[2]		$15 Copay	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 *(3 visits max per year)*[2]		$50 Copay	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 *(Ground service only)*		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**	100% covered after deductible	
	Outpatient	100% after deductible	100% after deductible
	Office Visits *(3 visits max per year)*[2]	$15 Copay	100% after deductible

BASIC PLAN (CONTINUED)

PHCS for Value-Driven Health Plans

PLAN PROVISION	BASIC PLAN	
	In-Network	*Out-of-Network*[1]
VISION BENEFITS[4]		
In-Office Comprehensive Vision Exams	$0 Copay	Up to $35 benefit
Frame Discount (1 per 24 months) *Discount on prescription and non-prescription frames*	**800+ frames at $20 member cost** additional 2,700+ frames at 75% off retail	
Contact Lens Discount (1 per 12 months) *Discount in addition to frames and lenses discounts*	**Member cost at wholesale pricing** for up to a 12-month supply	
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	**$858.54**	
Member + Spouse	**$1,466.47**	
Member + Child(ren)	**$1,416.53**	
Member + Family	**$2,045.31**	

[1] *Charges in excess of 140% of the Medicare reimbursement rate for institutional providers (e.g., hospitals), and 120% for non-institutional providers (e.g., doctors & clinics) 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 Enrollment Center

(774) RESPOND
(774-737-7663)

PLUS PLAN

PHCS for Value-Driven Health Plans

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 *(Ground service only)*		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
	Office Visits	$65 Copay	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
Frame Discount (1 per 24 months) *Discount on prescription and non-prescription frames*	**800+ frames at $20 member cost** additional 2,700+ frames at 75% off retail	
Contact Lens Discount (1 per 12 months) *Discount in addition to frames and lenses discounts*	**Member cost at wholesale pricing** for up to a 12-month supply	
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[5]	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	**$992.52**	
Member + Spouse	**$1,803.23**	
Member + Child(ren)	**$1,690.82**	
Member + Family	**$2,443.56**	

[1] *Charges in excess of 140% of the Medicare reimbursement rate for institutional providers (e.g., hospitals), and 120% for non-institutional providers (e.g., doctors & clinics) 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.*
[5] *Specialty Rx support service assists members to access consumer resources, including Patient and Manufacturer Assistance Programs, to obtain medically necessary specialty drugs not otherwise covered under the plan.*

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

First Responders Enrollment Center

(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 *(Ground service only)*		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
	Office Visits	$50 Copay	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
Frame Discount (1 per 24 months) *Discount on prescription and non-prescription frames*	**800+ frames at $20 member cost** additional 2,700+ frames at 75% off retail	
Contact Lens Discount (1 per 12 months) *Discount in addition to frames and lenses discounts*	**Member cost at wholesale pricing** for up to a 12-month supply	
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[5]	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	**$1,273.83**	
Member + Spouse	**$2,150.02**	
Member + Child(ren)	**$2,104.97**	
Member + Family	**$3,042.16**	

[1] *Charges in excess of 140% of the Medicare reimbursement rate for institutional providers (e.g., hospitals), and 120% for non-institutional providers (e.g., doctors & clinics) 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.*
[5] *Specialty Rx support service assists members to access consumer resources, including Patient and Manufacturer Assistance Programs, to obtain medically necessary specialty drugs not otherwise covered under the plan.*

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

First Responders Enrollment Center

(774) RESPOND
(774-737-7663)

BRONZE PLAN

PHCS for Value-Driven Health Plans

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 *(Ground service only)*		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
	Office Visits	80% after deductible	60% after deductible

BRONZE PLAN (CONTINUED)

PHCS for Value-Driven Health Plans

PLAN PROVISION	BRONZE PLAN		
	In-Network	*Out-of-Network[1]*	
VISION BENEFITS[4]			
In-Office Comprehensive Vision Exams	$0 Copay	Up to $35 benefit	
Frame Discount (1 per 24 months) *Discount on prescription and non-prescription frames*	**800+ frames at $20 member cost** additional 2,700+ frames at 75% off retail		
Contact Lens Discount (1 per 12 months) *Discount in addition to frames and lenses discounts*	**Member cost at wholesale pricing** for up to a 12-month supply		
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[5]	N/A	N/A
Automated Diabetic Supplies *Continuous glucose monitors (CGMs) and insulin pumps*	80%	80%	60%
MONTHLY RATES			
Member Only	**$1,214.57**		
Member + Spouse	**$2,311.27**		
Member + Child(ren)	**$2,333.44**		
Member + Family	**$3,318.96**		

[1] Charges in excess of 140% of the Medicare reimbursement rate for institutional providers (e.g., hospitals), and 120% for non-institutional providers (e.g., doctors & clinics) 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.
[5] Specialty Rx support service assists members to access consumer resources, including Patient and Manufacturer Assistance Programs, to obtain medically necessary specialty drugs not otherwise covered under the plan.

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

First Responders Enrollment Center

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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]		$150 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 *(Ground service only)*		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
	Office Visits	$20 Copay	60% after deductible

SILVER PLAN (CONTINUED)

PHCS for Value-Driven Health Plans

PLAN PROVISION	SILVER PLAN		
	In-Network	*Out-of-Network[1]*	
VISION BENEFITS[4]			
In-Office Comprehensive Vision Exams	$0 Copay	Up to $35 benefit	
Frame Discount (1 per 24 months) *Discount on prescription and non-prescription frames*	**800+ frames at $20 member cost** additional 2,700+ frames at 75% off retail		
Contact Lens Discount (1 per 12 months) *Discount in addition to frames and lenses discounts*	**Member cost at wholesale pricing** for up to a 12-month supply		
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[5]	N/A	N/A
Automated Diabetic Supplies *Continuous glucose monitors (CGMs) and insulin pumps*	80%	80%	60%
MONTHLY RATES			
Member Only	**$1,527.49**		
Member + Spouse	**$2,954.78**		
Member + Child(ren)	**$2,957.55**		
Member + Family	**$4,254.25**		

[1] Charges in excess of 140% of the Medicare reimbursement rate for institutional providers (e.g., hospitals), and 120% for non-institutional providers (e.g., doctors & clinics) 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.
[5] Specialty Rx support service assists members to access consumer resources, including Patient and Manufacturer Assistance Programs, to obtain medically necessary specialty drugs not otherwise covered under the plan.

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

First Responders Enrollment Center

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PPO PLAN SERVICE PARTNERS

New PPO Plans for 2026

New to the First Responders VEBA plan menu are the **Basic PPO**, **Plus PPO**, **Ultra PPO**, **Bronze PPO**, and **Silver PPO** plans featuring access to the **Anthem Blue Cross and Blue Shield *BlueCard*** national PPO network.

International Benefits Administrators (IBA) – As the health plan service center, IBA 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.

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.

CarelonRx – 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 62,000 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.

Anthem Blue Cross and Blue Shield *BlueCard* Network – With 1 in 3 Americans enrolled in a Blue plan[1], and supported by over 2 million doctors and hospitals across the United States, the **Anthem Blue Cross and Blue Shield *BlueCard*** national PPO network is one of the most expansive and widely recognized networks among providers and employers alike.

You can search In-Network providers online at https://anthem.com/find-care/ and use prefix **LDV**.

[1] *Blue Cross Blue Shield Association: Advancing Affordable and Equitable Health Care for Everyone (October 2025): https://www.bcbs.com/media/documents/Blue-Fact-Sheet.pdf.*

BASIC PPO PLAN

Anthem

PLAN PROVISION		BASIC PPO 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 *(3 visits max per year)*[2]		$15 Copay	100% after deductible
Specialist Visit *(3 visits max per year)*[2]		$15 Copay	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 *(3 visits max per year)*[2]		$50 Copay	100% after deductible
Telemedicine Vendor Services		$0 Copay	Not Applicable
HOSPITAL/FACILITY SERVICES			
Inpatient Hospital Services		100% after deductible	100% after deductible
Outpatient Hospital Services/ Freestanding Surgery		100% after deductible	100% after deductible
Anesthesia		100% after deductible	100% after deductible
Emergency Room Facilities and Covered Services		$1,000 Copay *(copay waived if admitted)* *(Hospital charges subject to deductible and coinsurance)*	
OUTPATIENT DIAGNOSTIC SERVICES			
Lab/X-Ray		100% after deductible	100% after deductible
Advanced Medical Imaging		100% after deductible	100% after deductible
PREGNANCY BENEFITS			
Professional Services		100% after deductible	100% after deductible
Maternity/Childbirth/Delivery		100% after deductible	100% after deductible
OTHER SERVICES			
Chemotherapy/Radiation Therapy		100% after deductible	100% after deductible
Chiropractic Care *(Limited to 10 visits per plan year)*[2]		100% after deductible	100% after deductible
Colonoscopy *(Diagnostic purposes)*		100% after deductible	100% after deductible
Dialysis		100% after deductible	100% after deductible
Durable Medical Equipment *(Subject to limitations)*		100% after deductible	100% after deductible
Emergency Medical Transportation *(Ground service only)*		100% 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% after deductible	100% 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		100% after deductible	100% after deductible
Transplant – Physician and Anesthesiologist Charges during Inpatient Hospitalization		100% after deductible	100% after deductible
Mental Health, Behavioral Health, or Substance Abuse Services	**Inpatient or Partial Day**	100% after deductible	100% after deductible
	Outpatient	100% after deductible	100% after deductible
	Office Visits *(3 visits max per year)*[2]	$15 Copay	100% after deductible

BASIC PPO PLAN (CONTINUED)

Anthem

PLAN PROVISION	BASIC PPO PLAN	
	In-Network	*Out-of-Network[1]*
VISION BENEFITS[3]		
In-Office Comprehensive Vision Exams	$0 Copay	Up to $35 benefit
Frame Discount (1 per 24 months) *Discount on prescription and non-prescription frames*	**800+ frames at $20 member cost** additional 2,700+ frames at 75% off retail	
Contact Lens Discount (1 per 12 months) *Discount in addition to frames and lenses discounts*	**Member cost at wholesale pricing** for up to a 12-month supply	
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	**$884.76**	
Member + Spouse	**$1,552.51**	
Member + Child(ren)	**$1,496.47**	
Member + Family	**$2,205.57**	

[1] *Charges in excess of 140% of the Medicare reimbursement rate for institutional providers (e.g., hospitals), and 120% for non-institutional providers (e.g., doctors & clinics) 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] *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 PPO benefit summary, including limitations and exclusions.

First Responders Enrollment Center

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PLUS PPO PLAN

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PLAN PROVISION		PLUS PPO 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			
Inpatient Hospital Services		80% after deductible	20% after deductible
Outpatient Hospital Services/ Freestanding Surgery		80% after deductible	20% after deductible
Anesthesia		80% after deductible	20% after deductible
Emergency Room Facilities and Covered Services		$500 Copay *(copay waived if admitted)* *(Hospital charges subject to deductible and coinsurance)*	
OUTPATIENT DIAGNOSTIC SERVICES			
Lab/X-Ray		80% after deductible	20% after deductible
Advanced Medical Imaging		80% after deductible	20% after deductible
PREGNANCY BENEFITS			
Professional Services		80% after deductible	20% after deductible
Maternity/Childbirth/Delivery		80% after deductible	20% after deductible
OTHER SERVICES			
Chemotherapy/Radiation Therapy		80% after deductible	20% after deductible
Chiropractic Care *(Limited to 10 visits per plan year)*[2]		80% after deductible	20% after deductible
Colonoscopy *(Diagnostic purposes)*		80% after deductible	20% after deductible
Dialysis		80% after deductible	20% after deductible
Durable Medical Equipment *(Subject to limitations)*		80% after deductible	20% after deductible
Emergency Medical Transportation *(Ground service only)*		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% after deductible	20% 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		80% after deductible	20% after deductible
Transplant – Physician and Anesthesiologist Charges during Inpatient Hospitalization		80% after deductible	20% after deductible
Mental Health, Behavioral Health, or Substance Abuse Services	**Inpatient or Partial Day**	80% after deductible	20% after deductible
	Outpatient	80% after deductible	20% after deductible
	Office Visits	$65 Copay	20% after deductible

PLUS PPO PLAN (CONTINUED)

PLAN PROVISION	PLUS PPO PLAN	
	In-Network	*Out-of-Network[1]*
VISION BENEFITS[3]		
In-Office Comprehensive Vision Exams	$0 Copay	Up to $35 benefit
Frame Discount (1 per 24 months) *Discount on prescription and non-prescription frames*	**800+ frames at $20 member cost** additional 2,700+ frames at 75% off retail	
Contact Lens Discount (1 per 12 months) *Discount in addition to frames and lenses discounts*	**Member cost at wholesale pricing** for up to a 12-month supply	
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[4]	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	**$1,025.88**	
Member + Spouse	**$1,928.32**	
Member + Child(ren)	**$1,802.57**	
Member + Family	**$2,649.99**	

[1] *Charges in excess of 140% of the Medicare reimbursement rate for institutional providers (e.g., hospitals), and 120% for non-institutional providers (e.g., doctors & clinics) 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] *Vision benefits are provided outside of the Group Health Plan through a service contract with XP Health.*
[4] *Specialty Rx support service assists members to access consumer resources, including Patient and Manufacturer Assistance Programs, to obtain medically necessary specialty drugs not otherwise covered under the plan.*

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

First Responders Enrollment Center

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ULTRA PPO PLAN

Anthem

PLAN PROVISION		ULTRA PPO 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			
Inpatient Hospital Services		80% after deductible	20% after deductible
Outpatient Hospital Services/ Freestanding Surgery		80% after deductible	20% after deductible
Anesthesia		80% after deductible	20% after deductible
Emergency Room Facilities and Covered Services		$500 Copay *(copay waived if admitted)* *(Hospital charges subject to deductible and coinsurance)*	
OUTPATIENT DIAGNOSTIC SERVICES			
Lab/X-Ray		80% after deductible	20% after deductible
Advanced Medical Imaging		80% after deductible	20% after deductible
PREGNANCY BENEFITS			
Professional Services		80% after deductible	20% after deductible
Maternity/Childbirth/Delivery		80% after deductible	20% after deductible
OTHER SERVICES			
Chemotherapy/Radiation Therapy		80% after deductible	20% after deductible
Chiropractic Care *(Limited to 10 visits per plan year)*[2]		80% after deductible	20% after deductible
Colonoscopy *(Diagnostic purposes)*		80% after deductible	20% after deductible
Dialysis		80% after deductible	20% after deductible
Durable Medical Equipment *(Subject to limitations)*		80% after deductible	20% after deductible
Emergency Medical Transportation *(Ground service only)*		80% 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% after deductible	20% 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		80% after deductible	20% after deductible
Transplant – Physician and Anesthesiologist Charges during Inpatient Hospitalization		80% after deductible	20% after deductible
Mental Health, Behavioral Health, or Substance Abuse Services	**Inpatient or Partial Day**	80% after deductible	20% after deductible
	Outpatient	80% after deductible	20% after deductible
	Office Visits	$50 Copay	20% after deductible

ULTRA PPO PLAN (CONTINUED)

Anthem

PLAN PROVISION	ULTRA PPO PLAN	
	In-Network	*Out-of-Network*[1]
VISION BENEFITS[3]		
In-Office Comprehensive Vision Exams	$0 Copay	Up to $35 benefit
Frame Discount (1 per 24 months) *Discount on prescription and non-prescription frames*	**800+ frames at $20 member cost** additional 2,700+ frames at 75% off retail	
Contact Lens Discount (1 per 12 months) *Discount in addition to frames and lenses discounts*	**Member cost at wholesale pricing** for up to a 12-month supply	
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[4]	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	**$1,330.47**	
Member + Spouse	**$2,315.33**	
Member + Child(ren)	**$2,264.73**	
Member + Family	**$3,317.98**	

[1] *Charges in excess of 140% of the Medicare reimbursement rate for institutional providers (e.g., hospitals), and 120% for non-institutional providers (e.g., doctors & clinics) 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] *Vision benefits are provided outside of the Group Health Plan through a service contract with XP Health.*
[4] *Specialty Rx support service assists members to access consumer resources, including Patient and Manufacturer Assistance Programs, to obtain medically necessary specialty drugs not otherwise covered under the plan.*

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

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BRONZE PPO PLAN

Anthem

PLAN PROVISION		BRONZE PPO 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			
Inpatient Hospital Services		80% after deductible	60% after deductible
Outpatient Hospital Services/ Freestanding Surgery		80% after deductible	60% after deductible
Anesthesia		80% after deductible	60% after deductible
Emergency Room Facilities and Covered Services		80% after deductible	
OUTPATIENT DIAGNOSTIC SERVICES			
Lab/X-Ray		80% after deductible	60% after deductible
Advanced Medical Imaging		80% after deductible	60% after deductible
PREGNANCY BENEFITS			
Professional Services		80% after deductible	60% after deductible
Maternity/Childbirth/Delivery		80% after deductible	60% after deductible
OTHER SERVICES			
Chemotherapy/Radiation Therapy		80% after deductible	60% after deductible
Chiropractic Care *(Limited to 10 visits per plan year)*[2]		80% after deductible	60% after deductible
Colonoscopy *(Diagnostic purposes)*		80% after deductible	60% after deductible
Dialysis		80% after deductible	60% after deductible
Durable Medical Equipment *(Subject to limitations)*		80% after deductible	60% after deductible
Emergency Medical Transportation *(Ground service only)*		80% 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% after deductible	60% 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		80% after deductible	60% after deductible
Transplant – Physician and Anesthesiologist Charges during Inpatient Hospitalization		80% after deductible	60% after deductible
Mental Health, Behavioral Health, or Substance Abuse Services	**Inpatient or Partial Day**	80% after deductible	60% after deductible
	Outpatient	80% after deductible	60% after deductible
	Office Visits	80% after deductible	60% after deductible

BRONZE PPO PLAN (CONTINUED)

PLAN PROVISION	BRONZE PPO PLAN		
	In-Network	*Out-of-Network*[1]	
VISION BENEFITS[3]			
In-Office Comprehensive Vision Exams	$0 Copay	Up to $35 benefit	
Frame Discount (1 per 24 months) *Discount on prescription and non-prescription frames*	**800+ frames at $20 member cost** additional 2,700+ frames at 75% off retail		
Contact Lens Discount (1 per 12 months) *Discount in addition to frames and lenses discounts*	**Member cost at wholesale pricing** for up to a 12-month supply		
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[4]	N/A	N/A
Automated Diabetic Supplies *Continuous glucose monitors (CGMs) and insulin pumps*	80%	80%	60%
MONTHLY RATES			
Member Only	**$1,264.08**		
Member + Spouse	**$2,494.90**		
Member + Child(ren)	**$2,519.67**		
Member + Family	**$3,626.85**		

[1] *Charges in excess of 140% of the Medicare reimbursement rate for institutional providers (e.g., hospitals), and 120% for non-institutional providers (e.g., doctors & clinics) 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] *Vision benefits are provided outside of the Group Health Plan through a service contract with XP Health.*
[4] *Specialty Rx support service assists members to access consumer resources, including Patient and Manufacturer Assistance Programs, to obtain medically necessary specialty drugs not otherwise covered under the plan.*

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

First Responders Enrollment Center

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SILVER PPO PLAN

Anthem

PLAN PROVISION		SILVER PPO 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			
Inpatient Hospital Services		80% after deductible	60% after deductible
Outpatient Hospital Services/ Freestanding Surgery		80% after deductible	60% after deductible
Anesthesia		80% after deductible	60% after deductible
Emergency Room Facilities and Covered Services		$150 Copay *(copay waived if admitted)* *(Hospital charges subject to deductible and coinsurance)*	
OUTPATIENT DIAGNOSTIC SERVICES			
Lab/X-Ray		80% after deductible	60% after deductible
Advanced Medical Imaging		80% after deductible	60% after deductible
PREGNANCY BENEFITS			
Professional Services		80% after deductible	60% after deductible
Maternity/Childbirth/Delivery		80% after deductible	60% after deductible
OTHER SERVICES			
Chemotherapy/Radiation Therapy		80% after deductible	60% after deductible
Chiropractic Care *(Limited to 10 visits per plan year)*[2]		80% after deductible	60% after deductible
Colonoscopy *(Diagnostic purposes)*		80% after deductible	60% after deductible
Dialysis		80% after deductible	60% after deductible
Durable Medical Equipment *(Subject to limitations)*		80% after deductible	60% after deductible
Emergency Medical Transportation *(Ground service only)*		80% 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% after deductible	60% 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		80% after deductible	60% after deductible
Transplant – Physician and Anesthesiologist Charges during Inpatient Hospitalization		80% after deductible	60% after deductible
Mental Health, Behavioral Health, or Substance Abuse Services	**Inpatient or Partial Day**	80% after deductible	60% after deductible
	Outpatient	80% after deductible	60% after deductible
	Office Visits	$20 Copay	60% after deductible

SILVER PPO PLAN (CONTINUED)

Anthem

PLAN PROVISION	SILVER PPO PLAN		
	In-Network	*Out-of-Network[1]*	
VISION BENEFITS[3]			
In-Office Comprehensive Vision Exams	$0 Copay	Up to $35 benefit	
Frame Discount (1 per 24 months) *Discount on prescription and non-prescription frames*	**800+ frames at $20 member cost** additional 2,700+ frames at 75% off retail		
Contact Lens Discount (1 per 12 months) *Discount in addition to frames and lenses discounts*	**Member cost at wholesale pricing** for up to a 12-month supply		
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[4]	N/A	N/A
Automated Diabetic Supplies *Continuous glucose monitors (CGMs) and insulin pumps*	80%	80%	60%
MONTHLY RATES			
Member Only	**$1,613.30**		
Member + Spouse	**$3,213.36**		
Member + Child(ren)	**$3,216.13**		
Member + Family	**$4,670.55**		

[1] Charges in excess of 140% of the Medicare reimbursement rate for institutional providers (e.g., hospitals), and 120% for non-institutional providers (e.g., doctors & clinics) 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] Vision benefits are provided outside of the Group Health Plan through a service contract with XP Health.
[4] Specialty Rx support service assists members to access consumer resources, including Patient and Manufacturer Assistance Programs, to obtain medically necessary specialty drugs not otherwise covered under the plan.

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

First Responders Enrollment Center

(774) RESPOND
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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 **Eyewear:** Every 24 months
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	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 and non-prescription frames	**800+ frames at $20 member cost** additional 2,700+ frames at 75% off retail
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.	
Polycarbonate Lens	Included
UV Protection	Included
Advanced Anti-Glare Protection	Included
Advanced Blue-Violet Light Filtering	Included
Dust, Smudge, Water, and Scratch Resistance	Included
Contact Lens Discount Discount in addition to frames and lenses discounts	**Member cost at wholesale pricing** for up to a 12-month supply
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%
Contact Lenses Evaluation/Fitting	
Daily Wear	Up to $40
Extended Wear	Up to $50
Specialty Wear	Up to $70
OTHER DISCOUNTS	
Refractive Surgery	Members receive $1,000 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 IBA and what do they do?

Reflect Health (*formerly S&S Health*) and International Benefit Administrators (IBA) are the Service Centers 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. Reflect Health supports the RBP health plans and IBA supports the PPO health plans.

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

The First Responders VEBA **RBP 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.

The **PPO health plans** include access to contracted providers for all covered services through the **Anthem Blue Cross and Blue Shield *BlueCard*** national PPO network.

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?

Hospitals are included in the Anthem BlueCard provider network supporting the First Responders VEBA **PPO health plans**.

The **RBP 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 all covered Members navigate today's complex healthcare delivery system, clarifying available options and simplifying choices along the way. 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.

RBP health plan Members are especially encouraged to contact the ***Care Navigation*** Team prior to scheduling:

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

to ensure that the **RBP health plan's Patient Liability Protection (PLP)** feature applies to covered services, provided that the Member adheres to plan rules and care delivery guidance.

COMMON QUESTIONS

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

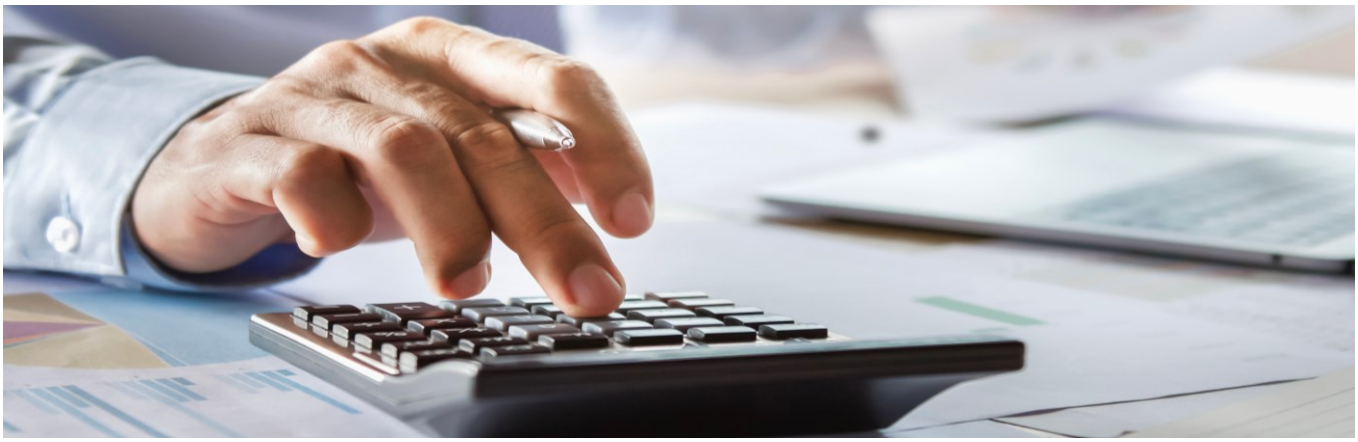
When engaging the ***Care Navigation*** team to review available options prior to scheduling non-emergency hospital or surgical services, diagnostic testing and imaging, or specialist care, **RBP health plan** Members will be presented with at least one option that involves facilities that accept reimbursement 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.

Since the **PPO health plans** include access to In-Network providers for all covered services, **PPO health plan** Members are protected against balance billing only when receiving services from In-Network providers.

Q: When I Google Anthem providers in my area, the results show that Anthem is not available in my state.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. and an independent licensee of the Blue Cross and Blue Shield Association. While Anthem Health Plans operates in 14 states, the Anthem Blue Cross and Blue Shield *BlueCard* PPO network leverages the strength of national Blue Cross and Blue Shield Association and extends access across all 50 U.S. states.

PRICING SUMMARY



MEDICAL, PHARMACY, AND VISION BENEFITS

RBP PLAN MONTHLY RATES†	BASIC PLAN	PLUS PLAN	ULTRA PLAN	BRONZE PLAN	SILVER PLAN
Member Only	$858.54	$992.52	$1,273.83	$1,214.57	$1,527.49
Member + Spouse	$1,466.47	$1,803.23	$2,150.02	$2,311.27	$2,954.78
Member + Child(ren)	$1,416.53	$1,690.82	$2,104.97	$2,333.44	$2,957.55
Member + Family	$2,045.31	$2,443.56	$3,042.16	$3,318.96	$4,254.25

PPO PLAN MONTHLY RATES†	BASIC *PPO*	PLUS *PPO*	ULTRA *PPO*	BRONZE *PPO*	SILVER *PPO*
Member Only	$884.76	$1,025.88	$1,330.47	$1,264.08	$1,613.30
Member + Spouse	$1,552.51	$1,928.32	$2,315.33	$2,494.90	$3,213.36
Member + Child(ren)	$1,496.47	$1,802.57	$2,264.73	$2,519.67	$3,216.13
Member + Family	$2,205.57	$2,649.99	$3,317.98	$3,626.85	$4,670.55

†*Monthly rates include projected health plan administration and claim costs, and vision benefit fees and are valid from January 1, 2026 thru December 31, 2026.*

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

Health Benefit
ALLIANCE

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