First Responders VEBA Trust - 2025 Benefit Offerings

Coverage Tier	HBA ULTRA PLAN	HBA PLUS PLAN	HBA BASIC PLAN	Bronze Plan	Silver Plan
Single	$1,162.93	$932.88	$786.40	$1,120.30	$1,413.77
Retiree + Spouse	$1,995.03	$1,669.78	$1,353.94	$2,146.46	$2,749.80
Retiree + Child(ren)	$1,950.18	$1,561.76	$1,304.51	$2,164.46	$2,749.80
Family	$2,827.13	$2,265.71	$1,892.20	$3,086.74	$3,963.94

Plan Benefits	HBA ULTRA PLAN		HBA PLUS PLAN		HBA BASIC PLAN		Bronze Plan		Silver Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$500 Individual $1,000 Family	$1,000 Individual $2,000 Family	$1,200 Individual $2,400 Family	$2,400 Individual $4,800 Family	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	$500 Individual $1,000 Family	$1,000 Individual $2,000 Family
(per calendar year)										
Coinsurance							20%	40%	20%	40%
Out-Of-Pocket Maximum	$4,500 Individual	$9,000 Individual	$6,000 Individual	$12,000 Individual	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family
(includes deductible excludes all copays and penalty amounts)	$9,000 Family	$18,000 Family	$12,000 Family	$24,000 Family						
Preventive Care Services										
Adult Routine Physical Exam (every 24 months), Annual Routine Mammogram, GYN Exam and PSA.	No Charge	Deductible & 80% coinsurance	No Charge	Deductible & 80% coinsurance	No Charge	Deductible & 80% coinsurance	Covered 100%; no deductible, no copay	Not covered	Covered 100%; no deductible, no copay	Not covered
Routine Eye and Hearing Screening (one exam every 24 months)	Not Covered	Not Covered	Not Covered	Not Covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Physician Services										
Primary Doctor Office Visit	$25 copay	Deductible & 80% coinsurance	$35 copay	Deductible & 80% coinsurance	$15 copay	Deductible & 80% coinsurance	20% co-insurance after deductible	40% co-insurance, after deductible	$20 office visit copay; deductible waived	40% co-insurance, after deductible
Specialist Office Visits	$50 copay	Deductible & 80% coinsurance	$65 copay	Deductible & 80% coinsurance	$15 copay	Deductible & 80% coinsurance	20% co-insurance after deductible	40% co-insurance, after deductible	$20 office visit copay; deductible waived	40% co-insurance, after deductible
X-ray and Lab Services (during office visit)	Deductible & 20% coinsruance	Deductible & 80% coinsurance	Deductible & 20% coinsurance	Deductible & 80% coinsurance	Deductible applies, then covered 100%	Deductible & 80% coinsurance	20% co-insurance after deductible	40% co-insurance, after deductible	20% co-insurance after deductible	40% co-insurance, after deductible
Emergency Services										
Emergency Room (copay waived if admitted)	$500 copay / waived if admitted, subject to deductible & coinsurance	Deductible & 80% coinsurance	$500 copay / waived if admitted, subject to deductible & coinsurance	Deductible & 80% coinsurance	$1,000 copay / waived if admitted, subject to deductible & coinsurance	Deductible & 80% coinsurance	20% co-insurance after deductible	20% co-insurance after deductible	$150 copay;	$150 copay;
Urgent Care										
Immediate Medical Attention	$40 copay	Deductible & 80% coinsurance	$40 copay	Deductible & 80% coinsurance	$50 copay	Deductible & 80% coinsurance	20% co-insurance after deductible	40% co-insurance, after deductible	$20 copay	40% co-insurance, after deductible
Hospital Services										
Hospital Admission	Deductible & 20 coinsruance	Deductible & 80% coinsurance	Deductible & 20 coinsruance	Deductible & 80% coinsurance	deductible applies, then covered 100%	Deductible & 80% coinsurance	20% co-insurance after deductible	40% co-insurance, after deductible	20% copay, after deductible	40% co-insurance, after deductible
Outpatient Hospital	Deductible & 20% co-insurance	Deductible & 80% co-insurance	Deductible & 20% co-insurance	Deductible & 80% co-insurance	Deductible applies, then covered 100%	Deductible & 80% coinsurance	20% co-insurance after deductible	40% co-insurance, after deductible	20% co-insurance after deductible	40% co-insurance, after deductible

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Alternatives to Hospital Care										
Skilled Nursing (max. 120 days), this is facility benefit and covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible
Home Health (max. 120 days) and Urgent Care	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible
Other Services										
Outpatient Short-Term Rehabilitation (includes speech, physical, occupational and spinal manipulation therapy), in office setting	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	20% after deductible	40% co-insurance, after deductible	20% co-insurance after deductible	40% co-insurance, after deductible
Prescription Drug Plan—Retail Pharmacy										
Generic	$0-$15 copay	Not covered	$0-$15 copay	Not covered	$0-$15 copay	Not covered	After deductible, $15 co-pay for retail	After deductible, $30 co-pay for retail	$10 copay	25% after Rx plan $10 copay
Preferred Brand-Name Drugs	20% coinsurance	Not covered	20% coinsurance	Not covered	Not covered	Not covered	After deductible/$50 copay for retail or mail order	After deductible, $100 co-pay for retail or mail order	$40 copay	25% after Rx plan $40 copay
Non-Preferred Brand-Name Drugs	30% coinsurance, deductible applies	Not covered	30% coinsurance, deductible applies	Not covered	Not covered	Not covered	After deductible/$70 copay or 50% co-insurance of approved amount (whichever is greater) no more than $100 copay	After deductible/$70 copay additional 20% approved amount	$80 copay	25% after Rx plan $80 copay
Managed Specialty	Included	Not Covered	Included	Not Covered	Not Covered	Not Covered	Included		Included	
Prescription Drug Plan—Mail Order (90 Day Supply)										
Generic	$0-$45 copay	N/A	$0-$45 copay	N/A	$0-$45 copay	N/A	After deductible/$30 co-pay for 30 day supply	After deductible, co-pay plus 20% of approved amount	$20 copay	N/A
Preferred Brand	20% coinsurance	N/A	20% coinsurance	N/A	Not covered	N/A	$100 co-pay for mail order 90-day supply	After deductible, co-pay plus 20% of approved amount	$80 copay	N/A
Non-Preferred Brand	30% coinsurance, deductible applies	N/A	30% coinsurance, deductible applies	N/A	Not covered	N/A	$140 or 50 %whichever is greater, max of $200 after deductible	After deductible, co-pay plus 20% of approved amount	$160 copay	N/A