BENEFITS GUIDE 2023

Pre-65 Retirees Health Benefit Guide

FIRST RESPONDERS
POLICE FIRE AND EMERGENCY
VEBA

SECTION 1 – Introduction of the First Responders Retiree VEBA

Overview

The Board of Directors of the First Responders Retiree VEBA would like to welcome you to review this Benefits Enrollment Guide that has been created for Retirees of all First Responders Industry Companies. Please refer to the Summary Plan Description (SPD) for complete details about your plan. If there is a conflict between this Benefits Guide and a Certificate or Summary Plan Description (SPD), the Certificate or SPD will govern. To receive a copy of the benefit plan materials, please go to www.MyMedPlans.com and download copies of benefit materials. If you would like to have them mailed to you, please contact, Benistar, the plan administrator @ **1-800-236-4782** and they will mail/email you an enrollment packet.

Mission Statement

The goal of the First Responders Retiree VEBA is to provide and maintain quality, cost effective benefits, including medical, prescription drugs, dental and vision programs and other healthcare benefits for all eligible First Responders Retirees that have worked for in the First Responders industry, Police, Fire, Public Service and subsidiaries for at least 5 years.

Protecting Your PHI

The Board, Cone Retiree Healthcare the Healthcare Providers understand the importance of protecting your personal health information. We have the ability to communicate with plan participants and protect their PHI.

Coverage Contact Information

Benistar

Phone: 1-800-236-4782

Your Call Center and Plan Administrator

Mailing Address:
Benistar Retiree Service Center
10 Tower Lane, Suite100
Avon, CT 06001

Fax Enrollment Forms:
1(860)408-7025
Make Checks Payable to:
Benistar Retiree Services

Medical Plan Information:

Blue Cross Blue Shield Medical Plans

Blue Cross Blue Shield of Michigan	
Post-Enrollment Benefits and Claims	
Benistar Call Center	(800)236-4782
BCBSM Claims Department	(877)354-2583

Prescription Drug Plan Information:

Blue Cross Blue Shield Prescription Drug Plans

BCBSM Pre-Enrollment Benefit Inquiries:	(800)236-4782
Post-Enrollment Benefits & Claims	
Prescription Drug Formulary	(877)354-2583

Dental Plan Information:

Blue Cross Blue Shield Nationwide Plans (Dental)

Blue Cross Blue Shield	
www.Mibluedentist.com	
Dental Customer Service Find a Doctor	(888)826-8152

Vision Plan Information:

Blue Cross Blue Shield (Blue Vision VSP)

BCBSM Customer Service	(800)877-7195
www.VSP.com or www.BCBSM.com	

enroll NOW

CALL 1-800-236-4782

Overview

This benefits enrollment guide provides an overview of the benefits offered by the First Responders VEBA for Retirees. In the event of a conflict between this benefits enrollment guide and a Certificate or Summary Plan Description (SPD), the Certificate or SPD will govern. Please refer to them for additional information. An official detailed description of benefits, exclusions, limitations, eligibility and other terms and conditions is contained in the individual benefit Summary Plan Descriptions. Copies of benefit plan materials are available to you via mail or email and may be requested by calling the First Responders VEBA Call Center at **1-800-236-4782.**

Mission Statement

The mission of the First Responders VEBA for Retirees, is to establish and maintain quality benefits including medical, prescription drug, dental and vision benefits, at a reasonable cost to its members. The objective of the VEBA is to deliver benefits efficiently and effectively with a focus on providing quality benefits in a cost-conscious manner.

Goals

- The First Responders will provide quality benefit programs to all retirees in the First Responders, Police, Fire and Public Service industries. Participants include people eligible between the ages of 55 – 64, as well as their qualifying dependents under age 65. The dependent eligibility ends 24 months after the Retiree's 65th birth month.
- Pre-65 Retirees and their dependents to enroll or to remain in these BCBSM plans.. For detailed information, you can visit the First Responders, Police, Fire and Public Service Industry website at **www.mymedplans.com**
- The VEBA Board will oversee the selection of healthcare plans that will be offered each year to members of the VEBA, including medical, prescription drug, dental and vision plans.
- The Board manages the selection of the plan administrator for the VEBA plans each year as they support the membership in enrolling, and completing the necessary documents.
- 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.

VEBA Board

The First Responders VEBA Board is drawn from volunteers with experience on boards with health and disability benefits. They have volunteered their time and energy to serve as Board members for the First Responders VEBA. If you are interested in serving on the board when vacancies occur, please contact the Board to express your interest. The email address for the Board Mail is **info@mymedplans.com**

Keep Your Contact Information Up-to-Date!

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

Questions	Company	Phone	Web Site
Eligibility and Administration	Benistar	800-236-4782	N/A
Health Plan Benefits/Providers	Blue Cross Blue Shield	877-354-2583	www.bcbsm.com
Dental Plan Benefits/Providers	Blue Cross Blue Shield	877-354-2583	www.bcbsm.com
Vision Plan Benefits/Providers	Blue Cross Blue Vision (VSP)	877-354-2583	www.bcbsm.com
Contact the Board of the VEBA	First Responders VEBA Board		www.info@mymedplans.com
Important Information for retirees eligible for the First Responders VEBA	Cone Retiree Healthcare Group, LLC. Insurance Representatives		Cathy@mymedplans.com John@mymedplans.com Lisa@mymedplans.com

Enrollment Period

The annual enrollment period for the First Responders VEBA for Retirees will be from November 01 - December 31 each year.

Retiree Eligibility

Retirees, survivors and their families, as outlined in the eligibility section of this booklet, have the ability to enroll in the plans offered through the VEBA.

Pre-Medicare retirees, survivors and their families, who are:

· Retirees of the First Responders Industry including those, but not limited to, the companies of police, fire, first responders and public service workers..
· Retirees under the age of 65 and dependents listed on the federal tax return of the eligible Retiree
· Retiree has worked at least 5 years for a company eligible to participate in the First Responders VEBA.

Retiree - As an First Responders Retiree VEBA member, you and your dependents are eligible for the medical, prescription drug, dental and vision benefits outlined in this benefit guide.
Spouse/Domestic Partner/Dependents - Your spouse or same-gender domestic partner may also be eligible for medical, prescription drug, dental and vision benefits if they meet the guidelines established by the VEBA.
Under Age 65 - Your spouse/domestic partner are not required to enroll in the same coverage as the retiree. It is not necessary for the retiree and the spouse to be enrolled in the same benefits plans.
Dependents - If you have dependents under age 65 and the retiree is under 65 or on Medicare for less than 24 months, your dependents may be eligible to participate.

Spouse	A legally married spouse, including a declared common-law spouse.* Only one spouse or same-gender domestic partner may be covered at any one time. *Where recognized by state.
Domestic Partner	The individual who lives in the same household and shares the common resources of life in a close, personal, intimate relationship with a retiree if, under state law, the individual would not be prevented from marrying the retiree on account of age, consanguinity, or prior undissolved marriage to another. An eligible domestic partner must be of the same gender as the retiree. Only one spouse or same-gender domestic partner may be covered at any one time.
Children	Your biological children, stepchildren, legally adopted children, children for whom you have obtained court-ordered guardianship or conservatorship; qualified children placed pending adoption; grandchildren; and children of your domestic partner if you also cover your domestic partner for the same benefit. Your children must be on the federal income tax of the Retiree to be eligible to enroll in the Dental and Vision plans through the VEBA.
Dependent Grandchildren	Your unmarried grandchild must meet the requirements listed above and must also qualify as a dependent as defined by the Internal Revenue Service on your or your spouse's federal income tax return.
Disabled Children	To continue coverage past the age limit, your disabled child must otherwise meet the requirements for eligible dependents and must also meet the following definitions: A disabled child is a child who, due to a mental or physical disability, is incapable of earning a living at the time he or she would otherwise cease to be a dependent if the child is covered as a dependent at that time and if at that time he or she depends on you for principal support and maintenance. A disabled child continues to be considered and eligible dependent as long as the child remains incapacitated, unmarried, dependent on you for principal support and maintenance, and you continuously maintain the child's coverage as a dependent under the plan from the date he or she otherwise would lose dependent status. A dependent child who loses eligibility and later becomes disabled is not eligible to be covered. A disabled child who was not covered as a dependent immediately prior to the time he or she would otherwise cease to be a dependent is not eligible to be covered.

Documentation

To provide coverage for a dependent under any of the VEBA benefits programs, you must submit documentation that supports your relationship to the dependent when dependents are added after initial enrollment into the VEBA plans.

Persons Not Eligible to Participate

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.

Changes in Family Status

If you have a change in your family status, such as adding or dropping a dependent, you must notify Benistar within 31 days of any changes in family status at 1-800-236-4782 . If you add or drop a dependent during open enrollment, the change becomes effective on the first day of January, the following year.

Special Qualifying Life Events

A special qualifying life event will allow you to change or enroll in coverage outside the normal open enrollment window provided you have notified Benistar within 31 days of the qualifying life event.

Special qualifying events include:

· Certain changes in employment status for your spouse or an eligible dependent;
· Marriage or divorce
· Addition of a dependent
· Loss of a spouse or dependent
· Eligibility for Medicare due to turning 65 or classified as Social Security disabled
· Gaining or losing a dependent resulting from marriage, divorce, birth or adoption
· Involuntary loss of other insurance coverage (proof is required)

Pre65-Eligible Survivor /Dependents upon Death of Retiree	A Pre-65 survivor or dependent is eligible for medical, prescription drug, dental and vision coverage for up to 24 months following the death of the retiree, when eligible. The Spouse/Domestic Partner/Survivor will remain eligible for the Pre-65 program until they reach the age of 65 or become Medicare.
Former Eligible Spouse	The plan administrator, Benistar, will send enrollment materials to the former spouse following a request from the individual..
Qualified Family Member(s)	A qualified family member (QFM) also is eligible to elect medical, prescription drug, dental and vision benefits. QFMs include the spouse or dependent of an eligible retiree who has reached the age of 65. The spouse or dependent must be claimed on the retiree's Federal Income Tax return.

Pre Medicare Health Insurance Options for Participants

The Medical plans offered for Pre-Medicare retirees and their dependents provide:

- Nationwide coverage in the United States
- PPO plans provide you with access to covered benefits through a network of healthcare providers and facilities. You are not required to have a referral from your primary care doctor before going to a specialist.
- Members and their dependents under the age of 65 will qualify for Medical programs offered through the VEBA have the ability to select from the following health insurance options offered through BlueCross BlueShield:

  Gold, Silver, Bronze and Copper Bundled plans (all include medical, prescription drugs, dental and vision)

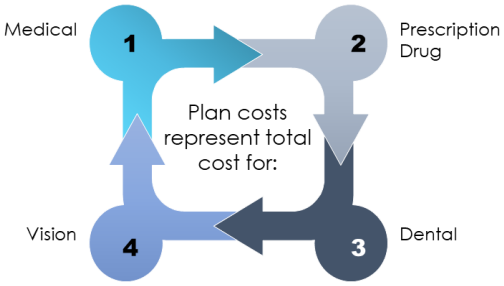
Plan Options

Nationwide insurance plans are provided by Blue Cross Blue Shield. Gold, Silver, Bronze and Copper plans are bundled to include medical, prescription drugs, dental and vision.

	Gold Plan		Silver Plan		Bronze Plan		Copper Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (per calendar year)	$250 Individual $500 Family	$500 Individual $1,000 Family	$500 Individual $1,000 Family	$1,000 Individual $2,000 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 Family
Coinsurance	20%	40%	20%	40%	20%	40%	50%	50%
Out-Of-Pocket Maximum (includes deductible excludes all copays and penalty amounts)	$1,250 Individual $2,500 Family	$2,250 Individual $4,500 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family	$6,350 Individual $12,700 Family	$12,700 Individual $25.400 Family
Preventive Care Services								
Adult Routine Physical Exam (every 24 months), Annual Routine Mammogram, GYN Exam and PSA.	Covered 100%; no deductible, no copay	Not covered	Covered 100%; no deductible, no copay	Not covered	Covered 100%; no deductible, no copay	Not covered	No Charge	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
Physician Services								
Primary Doctor Office Visit	$10 office visit copay; deductible waived	40% copay, after deductible	$20 office visit copay; deductible waived	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance after deductible	50% co-insurance after deductible
Specialist Office Visits	$10 office visit copay; deductible waived	40% copay, after deductible	$20 office visit copay; deductible waived	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance after deductible	50% co-insurance after deductible
X-ray and Lab Services (during office visit)	20% co-insurance after deductible	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance after deductible	50% co-insurance after deductible
Emergency Services								
Emergency Room (copay waived if admitted)	$50 copay;	$50 copay;	$150 copay;	$150 copay;	20% co-insurance after deductible	20% co-insurance after deductible	50% co-insurance	50% co-insurance
Urgent Care								
Immediate Medical Attention	$10 copay	40% copay, after deductible	$20 copay	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance	50% co-insurance
Hospital Services								
Hospital Admission	20% co-insurance after deductible	40% copay, after deductible	20% copay, after deductible	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance after deductible	50% co-insurance after deductible
Outpatient Hospital	20% co-insurance after deductible	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance after deductible	50% co-insurance after deductible

	Gold Plan		Silver Plan		Bronze Plan		Copper Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Alternatives to Hospital Care								
Skilled Nursing (max. 120 days), this is facility benefit and covered	20% after copay, after deductible	20% after copay, after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	50% co-insurance after deductible	50% co-insurance after deductible
Home Health (max. 120 days) and Urgent Care	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	50% co-insurance after deductible	50% co-insurance after deductible
Other Services								
Outpatient Short-Term Rehabilitation (includes speech, physical, occupational and spinal manipulation therapy), in office setting.	20% co-insurance after deductible.	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	20% after deductible	40% copay, after deductible	50% co-insurance after deductible	Applied behavioral analysis treatment for Autism— by behavioral analyst, up to 18 pre-authorization
Prescription Drug Plan—Retail Pharmacy								
Generic	$10 copay	25% after Rx plan $10 copay	$10 copay	25% after Rx plan $10 copay	After deductible, $15 co-pay for retail	After deductible, $30 co-pay for retail	After deductible, 50% co-pay of approved amount	After deductible, co-pay plus 20% of approved amount
Preferred Brand-Name Drugs	$20 copay	25% after Rx plan $20 copay	$40 copay	25% after Rx plan $40 copay	After deductible/$50 copay for retail or mail order	After deductible, $100 co-pay for retail or mail order	After deductible, 50% co-pay of approved amount	After deductible, co-pay plus 20% of approved amount
Non-Preferred Brand-Name Drugs	$40 copay	25% after Rx plan $40 copay	$80 copay	25% after Rx plan $80 copay	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	After deductible, 50% co-pay of approved amount	After deductible, co-pay plus 20% of approved amount
Prescription Drug Plan—Mail Order (90 Day Supply)								
Generic	$20 copay	N/A	$20 copay	N/A	After deductible/$30 co-pay for 30 day supply	After deductible, co-pay plus 20% of approved amount	50% co-pay of amount	Not covered
Preferred Brand	$40 copay	N/A	$80 copay	N/A	$100 co-pay for mail order 90-day supply	After deductible, co-pay plus 20% of approved amount	50% co-pay of amount	Not covered
Non-Preferred Brand	$80 copay	N/A	$160 copay	N/A	$140 or 50 %whichever is greater, max of $200 after deductible	After deductible, co-pay plus 20% of approved amount	50% co-pay of amount	Not covered

2023 PLANS AND RATES



Blue Cross Blue Shield is the Insurance provider of choice for these Nationwide group plans available to First Responders VEBA members.

☆ Total cost includes medical, prescription drug, dental (high and low options), and vision which maximizes benefits for retirees and qualified dependents.

BUNDLED PLANS (MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION) **Pre 65 Rates with LOW Dental**		TOTAL MONTHLY PREMIUM
GOLD PLAN	Gold Single	$1,594.16
	Gold Family	$4,735.36
SILVER PLAN	Silver Single	$1,420.39
	Silver Family	$4,214.04
BRONZE PLAN	Bronze Single	$1,130.54
	Bronze Family	$3,344.46
COPPER PLAN	Copper Single	$930.10
	Copper Family	$2,743.16

BUNDLED PLANS (MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION) **Pre 65 HCTC Rates with HIGH Dental**		TOTAL MONTHLY PREMIUM
GOLD PLAN	Gold Single	$1,601.71
	Gold Family	$4,761.79
SILVER PLAN	Silver Single	$1,427.94
	Silver Family	$4,240.47
BRONZE PLAN	Bronze Single	$1,138.09
	Bronze Family	$3,370.89
COPPER PLAN	Copper Single	$937.65
	Copper Family	$2,769.59

Dental Plan Benefit

BCBSM Dental Plan - $50 Deductible for Class 2 and 3 Services

Network access information
With Blue Dental PPO Plus, members can choose any licensed dentist anywhere . However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.
Blue Dental PPO network- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit mibluedentist.com or call 1-888-826-8152.
1) Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.
2) A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.
Blue Par Select Arrangement- Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services - members pay only applicable coinsurance and deductibles . To find a dentist who may participate with BCBSM, please visit mibluedentist.com.
Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Standalone Dental Rates	Monthly Low Dental Rate	Monthly High Dental Rate
The rates below are priced for eligible plan participants enrolling in the Low or High Dental Plan Only.		
Single	$64.41	$71.96
Two-Person	$124.57	$139.67
Family	$214.81	$241.24
An Administration Fee of $4.25 is INCLUDED in the rate above.		

enroll NOW

CALL TODAY! 1-800-236-4782

BCBSM Dental Plan (Low Plan and High Plan with Bundled Plans)

The VEBA offers dental coverage through Blue Cross Blue Shield. The dental plan provides a wide variety of covered services – either covered in full or partially by the plan.

The table below provides an overview of the high and low dental plan benefit options. For specific details about the plan, please refer to the Benefits-at-a-Glance summary of benefits on the website at www.MyMedPlans.com

LOW PLAN

Annual Dental Maximum per Person	$3,000
Class I Service	
Includes but not limited to: Oral Exams Bitewing X-rays Full Mouth X-Rays Dental prophylaxis (Teeth Cleaning) Fluoride Treatment - Under 19y/o	$0 = Your Deductible 0% = Your Coinsurance * 100% coverage for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class II Service	
Includes but not limited to: Fillings (for permanent & primary teeth) Root Canal Oral Surgery General anesthesia or IV sedation	$50 = Your Deductible per member to a maximum of $150 per family per calendar year 20% = Your Coinsurance * 80% Coverage is for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class III Service	
Includes but not limited to: Dentures (complete & partial) Occlusal biteguards Endosteal Implants Onlays, crowns and veneer fillings- permanent teeth age 12 and older Bridge Installations	$50 = Your Deductible 50% = Your Coinsurance * 50% Coverage is for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class IV Service	
Orthodontic services for dependents under age 19	Not Covered

HIGH PLAN

Annual Dental Maximum per Person	$3,000
Class I Service	
Includes but not limited to: Oral Exams Bitewing X-rays Full Mouth X-Rays Dental prophylaxis (Teeth Cleaning) Fluoride Treatment -Any age**	$0 = Your Deductible 0% = Your Coinsurance * 100% coverage for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class II Service	
Includes but not limited to: Fillings (for permanent & primary teeth) Onlays, Crowns, Veneers, Inlays - permanent teeth** Occlusal biteguards** Oral Surgery Root Canal	$50 = Your Deductible per member to a maximum of $150 per family per calendar year 20% = Your Coinsurance * 80% Coverage is for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class III Service	
Includes but not limited to: Dentures (complete & partial) Endosteal Implants Bridge Installations	$50 = Your Deductible 50% = Your Coinsurance * 50% Coverage is for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class IV Service	
Orthodontic services for dependents under age 19**	50% = Your Coinsurance
Class IV Lifetime Maximum per Individual	$2,500

*Before getting any major procedure, make sure to check with your provider for complete rates and coverage information.
**Consider these upgraded benefits when selecting the High Plan vs. Low Plan.

High Dental Plan

Class I services

Benefits	Coverage
Oral exams	100% of approved amount Note: Twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount Note: Twice per calendar year
Panoramic or full-mouth x-rays	100% of approved amount Note: Once every 60 months
Prophylaxis (cleaning)	100% of approved amount Note: Twice per calendar year
Sealants - for members age 19 and younger	100% of approved amount Note: Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Emergency palliative treatment	100% of approved amount
Fluoride treatments	100% of approved amount Note: Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	100% of approved amount Note: Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	80% of approved amount after deductible Note: Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	80% of approved amount after deductible Note: Replacement fillings covered after 12 months or more after initial filling
***Crowns, onlays, inlays, and veneer restorations - permanent teeth - for members age 12 and older**	80% of approved amount after deductible **Note:** Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	80% of approved amount after deductible Note: Three times per tooth per calendar year after six months from original restoration
Oral surgery	80% of approved amount after deductible
***Root canal treatment**	80% of approved amount after deductible Note: Once every 12 months
***Scaling and root planning**	80% of approved amount after deductible Note: Once every 24 months per quadrant
Limited occlusal adjustments	80% of approved amount after deductible Note: Limited occlusal adjustments covered up to five times in any 60 consecutive months
***Occlusal biteguards**	80% of approved amount after deductible Note: Once every 12 months
General anesthesia or IV sedation	80% of approved amount after deductible Note: When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	80% of approved amount after deductible Note: Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	80% of approved amount after deductible Note: Once per arch in any 36 consecutive months
Tissue conditioning	80% of approved amount after deductible Note: Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount after deductible Note: Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount after deductible Note: Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount after deductible Note: Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	50% of approved amount
Minor treatment to control harmful habits	50% of approved amount
Interceptive and comprehensive orthodontic treatment	50% of approved amount
Post-treatment stabilization	50% of approved amount
Cephalometric film (skull) and diagnostic photos	50% of approved amount

Low Dental Plan

Class I services

Benefits	Coverage
Oral exams	100% of approved amount Note: Twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount Note: Twice per calendar year
Panoramic or full-mouth x-rays	100% of approved amount Note: Once every 60 months
Prophylaxis (cleaning)	100% of approved amount Note: Once every 6 months per member
Sealants - for members age 19 and younger	100% of approved amount Note: Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Emergency palliative treatment	100% of approved amount
Fluoride treatment - for members age 19 and younger	100% of approved amount Note: Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	100% of approved amount Note: Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	80% of approved amount after deductible Note: Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	80% of approved amount after deductible Note: Replacement fillings covered after 12 months or more after initial filling
Recementation of crowns, veneers, inlays, onlays and bridges	80% of approved amount after deductible Note: Three times per tooth per calendar year after six months from original restoration
Oral surgery	80% of approved amount after deductible
Limited occlusal adjustments	80% of approved amount after deductible Note: Limited occlusal adjustments covered up to five times in any 60 consecutive months
General anesthesia or IV sedation	80% of approved amount after deductible Note: When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	80% of approved amount after deductible Note: Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	80% of approved amount after deductible Note: Once per arch in any 36 consecutive months
Tissue conditioning	80% of approved amount after deductible Note: Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
***Scaling and root planning**	50% of approved amount after deductible Note: Once every 24 months per quadrant
***Occlusal biteguards**	50% of approved amount after deductible Note: Once every 12 months
***Root canal treatment**	50% of approved amount after deductible Note: Once every 12 months
Removable dentures (complete and partial)	50% of approved amount after deductible Note: Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount after deductible Note: Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount after deductible Note: Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31
***Crowns, onlays, inlays, and veneer restorations - permanent teeth - for members age 12 and older**	50% of approved amount after deductible Note: Once every 60 months per tooth

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	Not covered
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered
Post-treatment stabilization	Not covered
Cephalometric film (skull) and diagnostic photos	Not covered

2023 Vision Benefits

Member's responsibility (copays)		
Benefits	VSP network doctor	Non-VSP provider
Eye exam	$10 copay	$10 copay applies to charge
Prescription glasses (lenses and/or frames)	Combined $15 copay	Member responsible for difference between approved amount and provider's charge, after $15 copay
Medically necessary contact lenses	$15 copay	Member responsible for difference between approved amount and provider's charge, after $15 copay
Note: No copay is required for prescribed contact lenses that are not medically necessary.		
Eye exam		
Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$10 copay	Reimbursement up to $45 less $10 copay (member responsible for any difference)
One eye exam in any period of 12 consecutive months		
Lenses and frames		
Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or grounded, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	$15 copay (one copay applies to both lenses and frames)	Reimbursement up to approved amount based on lens type less $15 copay (member responsible for any difference)
Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor •Progressive Lenses – Covered when rendered by a VSP network doctor	One pair of lenses, with or without frames in any period of 12 consecutive months	
Standard frames	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance)	Reimbursement up to $70 less %15 copay (member responsible for any difference)
One frame in any period of 24 consecutive months Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.		
Contact Lenses		
Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$15 copay	Reimbursement up to $210 less $15 copay (member responsible for any difference)
One pair of contact lenses in any period of 12 consecutive months		
Elective contact lenses that improve vision (prescribed, but not meet criteria of medically necessary)	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)

Blue Vision Plan Information (VSP)

Insurance offered through VSP

Blue Vision insurance can be elected with any of the medical or prescription drug options, but if elected without a medical plan, you must purchase dental and vision together.
To enroll in a vision plan, please complete, sign and date the enrollment form and return it to **Benistar** at the address on the form.

Eyewear: Choose the eyewear that's right for you and your budget. From classic styles to the latest designer fashions, you'll find hundreds of options for you or your family.
Choice of Providers: With open access to see any provider, you can see the one who's right for you.

2023 Blue Cross Blue Shield Vision Rates (VSP)

Single	$ 8.62	These Rates do NOT include the admin fee
Two-Person	$ 17.25	
Family	$ 28.63	
Must be purchased with a Dental Plan.		

FIRST RESPONDERS
POLICE FIRE AND EMERGENCY
VEBA

VEBA WEBSITE
www.MyMedPlans.com

First Responders RETIREE VEBA

VEBA BOARD

Doug Guerdat, Chairman

Gary Conley, Board Member

Richard Davis, Secretary / Treasurer

BENISTAR RETIREE SERVICE CENTER

CALL CENTER & PLAN ADMINISTRATOR

1-800-236-4782

Fax: 1-860-408-7025

10 Tower Lane, Suite 100
Avon, CT 06001

CONE RETIREE HEALTHCARE GROUP

VEBA REPRESENTATIVES

Cathy Cone

John Cone

Lisa Andrews

INSURANCE PROVIDERS

Blue Cross Blue Shield Nationwide Providers

BCBSM - Medical Plans
BCBSM - Prescription Drugs

BCBSM - Dental

VSP Blue Vision - Vision

First Responders Enrollment Form

1. Name:

Address

2. Date of Birth:

☐ Male ☐ Female

This is an electronic fillable form. Please complete by typing in your information and signing electronically or print, complete and sign.

Carrier: Blue Cross Blue Shield – Medical, Prescription Drug, Dental and Blue Vision. Spouse/Domestic Partner, Two Person or Dependent have the ability to enroll individually in any plan level of coverage as a Single person if they desire.

*Select the Coverage for the individual(s) enrolling in the plan below under one (1) Enrollment form if you are a qualifying member and/or Spouse and/or Dependent enrolling in the plan as a Family. If two (2) people are enrolling in the plan, selecting enrollment as a single on two (2) forms offers better pricing. The two family members are not required to have the same coverage if they enroll individually. Each family member must complete their own form and send payment individually for their plan options.

Pre-65 participants in stand alone Dental +/- Vision plans must complete this form to enroll or make changes to existing coverage.

3. Type of Enrollment

- ☐ New Enrollment (Bundled Medical, RX, Dental & Vision or Selected Medical Pairings)
- ☐ Dental+/-Vision

4. Change of Status

- ☐ Address Change
- ☐ Terminate Coverage
- ☐ Add Dependent
- ☐ Other _____

5. Enrollee Information

- ☐ Eligible Retiree
- ☐ Eligible Retiree and Souse/Domestic Partner
- ☐ Eligible Retiree and Family (3+)
- ☐ Spouse/Domestic Partner
- ☐ Dependent

6. Plan Option

Gold (Bundled – Medical, RX, Dental and Vision)

☐ New Enrollment (Bundled Medical, RX, LOW Dental & Vision)	☐ New Enrollment (Bundled Medical, RX, HIGH Dental & Vision)
☐ Terminate (Bundled Medical, RX, LOW Dental & Vision)	☐ Terminate (Bundled Medical, RX, HIGH Dental & Vision)

Silver

☐ New Enrollment (Bundled Medical, RX, LOW Dental & Vision)	☐ New Enrollment (Bundled Medical, RX, HIGH Dental & Vision)
☐ New Enrollment (Medical, RX, LOW Dental)	☐ New Enrollment (Bundled Medical, RX, HIGH Dental)
☐ New Enrollment (Medical, RX and Vision)	☐ New Enrollment (Medical Only)
☐ Terminate (Bundled Medical, RX, LOW Dental & Vision)	☐ Terminate (Bundled Medical, RX, HIGH Dental & Vision)
☐ New Enrollment (Medical, RX, LOW Dental)	☐ New Enrollment (Bundled Medical, RX, HIGH Dental)
☐ New Enrollment (Medical, RX and Vision)	☐ New Enrollment (Medical Only)

Bronze

☐ New Enrollment (Bundled Medical, RX, LOW Dental & Vision)	☐ New Enrollment (Bundled Medical, RX, HIGH Dental & Vision)
☐ New Enrollment (Medical, RX, LOW Dental)	☐ New Enrollment (Bundled Medical, RX, HIGH Dental)
☐ New Enrollment (Medical, RX and Vision)	☐ New Enrollment (Medical Only)
☐ Terminate (Bundled Medical, RX, LOW Dental & Vision)	☐ Terminate (Bundled Medical, RX, HIGH Dental & Vision)
☐ Terminate (Medical, RX, LOW Dental)	☐ Terminate (Bundled Medical, RX, HIGH Dental)
☐ Terminate (Medical, RX and Vision)	☐ Terminate (Medical Only)

Copper

☐ New Enrollment (Bundled Medical, RX, LOW Dental & Vision)	☐ New Enrollment (Bundled Medical, RX, HIGH Dental & Vision)
☐ New Enrollment (Medical, RX, LOW Dental)	☐ New Enrollment (Bundled Medical, RX, HIGH Dental)
☐ New Enrollment (Medical, RX and Vision)	☐ New Enrollment (Medical Only)
☐ Terminate (Bundled Medical, RX, LOW Dental & Vision)	☐ Terminate (Bundled Medical, RX, HIGH Dental & Vision)
☐ Terminate (Medical, RX, LOW Dental)	☐ Terminate (Bundled Medical, RX, HIGH Dental)
☐ Terminate (Medical, RX and Vision)	☐ Terminate (Medical Only)

By signing below you are also agreeing to the Terms and Conditions on Page 3.

7. Signature _____ Date of Signature ____ / ____ / ____
MM DD YY

❒ Terms & Conditions

Please Read the following information. The information on this form and the following conditions are part of my contract with Blue Cross® Blue Shield® of Michigan.

I am applying for coverage for myself and/or my family member identified on this application under my group's or association's contract with Blue Cross. Coverage begins on the date determined by Blue Cross. When Blue Cross accepts my application, I and covered members of my family are bound by the terms on the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my dependent's eligibility for coverage when requested by Blue Cross Blue Shield of Michigan. **Authorization:** I appoint my group or association to handle all matters of coverage. I am responsible for giving notice to Blue Cross® Blue Shield® of Michigan of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements, or death of someone covered under the policy. I authorize Blue Cross and/or my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage with Blue Cross, and for other purposes necessary for Blue Cross to fulfill its contractual and statutory obligations.

Release of Information: I acknowledge that Blue Cross requires me to provide my Social Security Number. In applying for coverage, I and my enrolled family members agree to permit providers and others to release "protected health information" (as that term is used in the Health Insurance Portability and Accountability Act of 1996, as amended) to Blue Cross for purpose of administering our coverage. Upon my request, Blue Cross will tell me where the information was sent.

Instructions for Completion and Submittal of ALL Forms

Complete form by either (a) printing a blank form and filling in all necessary information in ink or (b) open the form and complete electronically (you are able to sign your form electronically or by printing). Don't forget to save your form on your computer once you have completed.

Contact Benistar with any question 1-800-236-4782

Completed forms can be faxed or emailed to
Benistar at: memelig@benistar.com
Or if faxing send to: 1-860-408-7025

If mailing send to:
Benistar Service Center
10 Tower Lane, Suite 100
Avon, Ct. 06001