COBRA Benefits Enrollment Guide

2026

For former employees of Local 102 and 180

WE ARE
THE FUTURE OF ENERGY

FirstEnergy®

Benefit Plans

Medical

You have the option to enroll in medical plans sponsored through your union in addition to the Consumer HDHP plan sponsored by FirstEnergy.

Anthem Blue Cross Blue Shield (Anthem) is the carrier for all FirstEnergy medical plans and Caremark is the carrier for all FirstEnergy Rx plans.

- Anthem/Caremark Consumer HDHP

The differences between the medical options are:

- The premiums you pay
- The annual deductible amounts
- The way the deductibles work
- The way the prescription drug deductibles are satisfied
- The annual out-of-pocket maximum amounts

Anthem's Network

If you use physicians and medical facilities that are in the Anthem network, you will pay much less compared to accessing out-of-network care. You can find which doctors and medical facilities are in Anthem's network by visiting www.anthem.com or using the Sydney Health app – and entering the appropriate network name/prefix below. There are three different networks depending on where a plan member resides.

Anthem BlueCross BlueShield

1-866-236-4365

www.anthem.com

Sydney Health app

State Where You Live	Network Name	Network Prefix
NJ	Horizon Managed Care Network	104
DC MD North VA	BlueChoice Advantage Open Access	110
All others	National PPO (BlueCard PPO)	901

Prescription Drug (Rx)

FirstEnergy's medical plans include prescription drug coverage through CVS Caremark. If you enroll in a HDHP, the prescription drug deductible, coinsurance and out-of-pocket maximum are combined with the medical plan. Prescription drug charges are applied to the combined deductible before benefits are paid. Also, no coverage is provided for prescriptions when an over-the-counter medication is available.

CVS Caremark
Advanced Choice network
Group Number: 7474


1-888-202-1654


www.caremark.com


CVS Caremark app

Generic Drug Rule

All FirstEnergy prescription drug plans have a generic drug rule. If you choose a non-preferred brand-name drug and there is a generic available, you will pay the brand coinsurance and the difference in cost between the generic and brand-name drug. If a generic is not available, you will pay just the brand coinsurance.

Maintenance Choice Program

If you use maintenance prescription drugs, you have the option of obtaining up to a 90-day supply of maintenance drugs through Caremark mail order, a CVS retail pharmacy, Kroger-affiliated pharmacies and Costco pharmacies, at the same coinsurance charged for mail order prescriptions.

Check Drug Costs Tool

You can search generic, brand, specialty and alternative medications for retail and mail order options in the Check Drug Costs tool. You also can compare the options to get the best value, based on your medication dosage. To access this tool visit Caremark's site or app.

Medical & Rx Plan Options	**Anthem/Caremark Consumer HDHP**
	Medical & Prescription
Annual Deductible **Type of Family Deductible**	$3,300 individual $6,600 family Embedded
Coinsurance	20% after deductible met
Annual Out-of-Pocket Maximum (includes deductible and coinsurance)	$5,500 individual $11,000 family
Preventive www.anthem.com/preventive-care/	100% covered with no deductible
Emergency Room Visit	20% after deductible met; $250 copay if not true emergency
Savings and Spending Plans	Eligible for HSA and Limited Health Care FSA

Contact Anthem or Caremark for all plan details.

HIGHMARK. Performance Blue PPO

Utility Workers Performance Blue $3400 Plan

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Group 107105-00, 01, 02, 03, 04, 05, 06, 07

Benefit	In Network	Out of Network
General Provisions		
Effective Date	January 1, 2026	
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $3,400 $6,800	 $9,200 $18,400
Plan Pays – payment based on the plan allowance	80% after deductible	50% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 $3,500 $7,000	 $8,000 $16,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $8,050 $16,100	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	80% after deductible	50% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	80% after deductible	50% after deductible
Specialist Office Visits & Virtual Visits	80% after deductible	50% after deductible
Virtual Visit Provider Originating Site Fee	80% after deductible	50% after deductible
Urgent Care Center Visits	80% after deductible	50% after deductible
Telemedicine Services (3)	80% after deductible	not covered
Preventive Care (4)		
Routine Adult Physical Exams	100% (deductible does not apply)	50% after deductible
Adult Immunizations	100% (deductible does not apply)	50% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	50% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	50% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible
Routine Pediatric Physical Exams	100% (deductible does not apply)	50% after deductible
Pediatric Immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible
Emergency Services		
Emergency Room Services (5)	$175 copay (waived if admitted) after deductible is met, 100% thereafter	
Ambulance - Emergency (6)	100% after deductible	100% after in-network deductible
Ambulance - Non-Emergency (6)	100% after deductible	100% after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	80% after deductible	50% after deductible
Hospital Outpatient	80% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	80% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	80% after deductible	50% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	80% after deductible	50% after deductible
	Limit: 20 visits/benefit period limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	

Benefit	In Network	Out of Network
Respiratory Therapy	80% after deductible	100% after in-network deductible
Speech Therapy	80% after deductible	50% after deductible
	Limit: 20 visits/benefit period limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Occupational Therapy	80% after deductible	50% after deductible
	Limit: 20 visits/benefit period limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Spinal Manipulations	80% after deductible	50% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	50% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	80% after deductible	50% after deductible
Inpatient Detoxification / Rehabilitation	80% afer deductible	50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	80% after deductible	50% after deductible
Outpatient Substance Abuse Services	80% after deductible	50% after deductible
Other Services		
Allergy Extracts and Injections	80% after deductible	50% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (7)	80% after deductible	50% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	80% after deductible	50% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	50% after deductible
Home Health Care	80% after deductible	50% after deductible
	limit: 90 visits/benefit period	
Hospice	80% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (8)	80% after deductible	50% after deductible
Private Duty Nursing	80% after deductible	50% after deductible
	240 hours per benefit period	
Skilled Nursing Facility Care	80% after deductible	50% after deductible
	100 days per benefit period	
Transplant Services	80% after deductible	50% after deductible
Precertification/Authorization Requirements (9)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	None None	
Prescription Drug Program (10) Hard Mandatory Generic *National Plus* *Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary with an Incentive Benefit Design*	**Retail Drugs (31/60/90-day Supply)** $0 generic copay $0 brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $0 generic copay $0 brand copay	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.
(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7), must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).

HIGHMARK. Performance Blue PPO

Utility Workers Performance Blue $9200 Plan

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Group # 107105-08, 09, 10, 11, 12, 13, 14, 15

Benefit	In Network	Out of Network
General Provisions		
Effective Date	January 1, 2026	
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $9,200 $18,400	 $18,400 $36,800
Plan Pays – payment based on the plan allowance	100%	80% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 None None
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $9,200 $18,400	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $10 copay	80% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $10 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after $10 copay	80% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $10 copay	80% after deductible
Telemedicine Services (3)	100% after $10 copay	not covered
Preventive Care (4)		
Routine Adult Physical Exams	100% (deductible does not apply)	80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	80% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	80% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric Physical Exams	100% (deductible does not apply)	80% after deductible
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services (5)	100% after $100 copay (waived if admitted)	
Ambulance - Emergency (6)	100% after deductible	100% after in-network deductible
Ambulance - Non-Emergency (6)	100% after deductible	80% after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $10 copay	80% after deductible
	Limit: 20 visits/benefit period limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Respiratory Therapy	100% after deductible	100% after in-network deductible

Benefit	In Network	Out of Network
Speech Therapy	100% after $10 copay	80% after deductible
	Limit: 20 visits/benefit period limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Occupational Therapy	100% after $10 copay	80% after deductible
	Limit: 20 visits/benefit period limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Spinal Manipulations	100% after $10 copay	80% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	80% after deductible
Inpatient Detoxification / Rehabilitation	100% afer deductible	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $10 copay	80% after deductible
Outpatient Substance Abuse Services	100% after $10 copay	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (7)	100% after deductible	80% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
	limit: 90 visits/benefit period	
Hospice	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment (8)	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible	80% after deductible
	240 hours per benefit period	
Skilled Nursing Facility Care	100% after deductible	80% after deductible
	100 days per benefit period	
Transplant Services	100% after deductible	80% after deductible
Precertification/Authorization Requirements (9)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	
Prescription Drug Program (10) Hard Mandatory Generic *National Plus* *Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary with an Incentive Benefit Design*	**Retail Drugs 31/60/90-day Supply** Tier One: $8/$10/$15 Generic Copayment Tier Two: $20/$40/$60 Formulary Brand Copayment Tier Three: $50/$100/$150 Non-Formulary Copayment **Specialty Drugs (31 day supply only)** 25% Coinsurance non-formulary Specialty Drugs with a $200 Max Copay $50 specialty drug formulary generic copay $50 specialty drug formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $10 formulary generic copayment $40 formulary brand copayment $100 non formulary brand copayment	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.
(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.

Dental

You can choose from two dental options, the Basic Plan and the Plus Plan, administered through Delta Dental. You will be responsible for the full cost of coverage and contributions are deducted pre-tax.

Delta Dental offers two networks that you can use: PPO and Premier. You will receive the best discount if you use PPO dentists. You can search for in-network dentists by calling Delta Dental or visiting its website.

Delta Dental

1-800-524-0149

www.deltadentaloh.com

Delta Dental Mobile app

	Basic Plan		Plus Plan	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (Individual/Family)	$100 / $300	$200 / $600	$50 / $150	$100 / $300
Calendar Year Maximum Benefit (excludes orthodontics)	$1,000 per person	$1,000 per person	$2,000 per person	$2,000 per person
Orthodontics (up to age 19)	Not covered	Not covered	50% ($1,500 lifetime max.)	50% ($1,500 lifetime max.)
Diagnostic & Preventive Services (Your Coinsurance Only – Annual deductible does not apply)				
Dental Examination (Twice per calendar year)	0%	20%	0%	20%
Oral Prophylaxis (Twice per calendar year)				
Bitewing X-rays (Once per calendar year)				
Full-Mouth X-rays (Once every 60 months)				
Basic Restorative Services (Your Coinsurance after deductible)				
Amalgam Fillings (under local anesthesia)	50%	70%	20%	40%
Resin Fillings (under local anesthesia)				
Denture Reline and Repair				
Major Restorative Services (Your Coinsurance after deductible)				
Crowns*, Caps, Implants	75%	Not Covered	50%	70%
Fixed Bridgework				
Full or Partial Dentures				

* Porcelain crowns are not covered on posterior teeth.

Contact Delta Dental with any questions.

Vision

FirstEnergy offers two levels of vision coverage – Basic Vision and Supplemental Vision, provided by VSP.

You can find participating providers by calling VSP or visiting its website. Your provider will use your Person Number to verify eligibility. To register on VSP.com use your Person Number, preceded by zeros to make a 9-digit number.

VSP
Choice Network

1-800-877-7195

www.vsp.com

VSP.com mobile site

	Basic Vision		Supplemental Vision*	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Eye Exam (per calendar year)	$50 copay with purchase of complete pair of glasses or 20% savings without purchase	Not covered	$10 copay	Reimbursed up to $45
Prescription Lenses (per calendar year)	Single – $40 copay Bifocal – $60 copay Trifocal – $75 copay Lenticular – $75 copay With purchase of complete pair of glasses	Not covered	Standard progressive – $0 copay; Premium and custom Progressive – $25 copay; Anti-reflective – $25 copay	Reimbursements: Single – up to $30 Bifocal – up to $50 Trifocal – up to $65 Lenticular – up to $100
Frame (per calendar year)	25% discount With purchase of complete pair of glasses	Not covered	$200 retail frame allowance (all manufacturers)	Reimbursed up to $70
Contacts (exam, fitting & materials) (per calendar year instead of glasses)	15% discount on exam; no discount on materials	Not covered	Elective – $200 allowance; Medically necessary covered in full (must be pre-approved)	Reimbursements: Elective – up to $105; Medically necessary – up to $210
VSP LightCare	Not covered	Not covered	$200 allowance for ready-made non-prescription sunglasses or ready-made non-prescription blue light filtering glasses, in lieu of prescription glasses or contacts. $25 copay applies.	

*Under the Supplemental Vision Plan, a $25 copay applies to prescription glasses or contacts.
Contact VSP with any questions.