PENNSYLVANIA PROFESSIONAL FIRE FIGHTERS ASSOCIATION

240 North Third Street – Suite 403 – Harrisburg, PA 17101

Affiliated with: – International Association of Fire Fighters, American Federation of Labor, Congress of Industrial Organizations, Pennsylvania AFL-CIO, Local Labor Union

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General Counsel

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Legislative Counsel

May 12, 2016

Brothers and Sisters:

The Pennsylvania Professional Fire Fighters Association is pleased to present you and your families with more value added benefits.

After surveying our membership we found a need for affordable dental and eye and prescription insurance programs that our members, **both** active and retired could take advantage of.

The PPFFA has partnered with Millennium Administrators to offer you and your families these great plans at a good price.

In this packet you will find everything you need to help you choose a plan that fits your needs.

You can choose either Delta Dental or United Concordia for your dental plan, Eyemed Select for eye care and PBM: CVS/Caremark for your prescription needs.

To check and see what providers accept these plans and what locations have providers you can check the following web sites:

Delta Dental: http://www.deltadental.com/Public/index.jsp

United Concordia: https://www.unitedconcordia.com/dental-insurance/

Eyemed: https://www.eyemedvisioncare.com/locator/captcha.emvc

PBM: CVS https://www.caremark.com/wps/portal

By taking advantage of these programs you can make sure that you and your family are well protected.

If you need further information on these programs you may call toll free, Millennium Administrators directly at: 866-644-2489.

Fraternally:

Art Martynuska
President

Millennium ADMINISTRATORS

Pennsylvania Professional Firefighters
Benefit Options

900 Ashbourne Way, Suite B
Schwenksville, PA 19473
866.644.2489

DENTAL COVERAGE
DELTA DENTAL - PPO PLAN 4

BENEFIT HIGHLIGHTS

WHO'S ELIGIBLE	Primary enrollee, spouse and eligible dependent children to age 19 or to age 25 if dependent is full-time student		
DEDUCTIBLES	In-PPO Network:	$50 per person, $150 per family, per calendar year	
	Out-Of-PPO Network:	$50 per person, $150 per family, per calendar year	
DEDUCTIBLE WAIVED FOR DIAGNOSTIC & PREVENTIVE?	In-PPO Network:	Yes [X]	No [ ]
	Out-Of-PPO Network:	Yes [X]	No [ ]
ANNUAL MAXIMUM	The maximum benefit paid per calendar year is $1500 per person In-PPO Network		
	The maximum benefit paid per calendar year is $1500 per person Out-Of-PPO Network		

BENEFITS AND COVERED SERVICES*	In-PPO Network**	Out-Of-PPO Network**
DIAGNOSTIC & PREVENTIVE BENEFITS Oral examinations, routine cleanings, x-rays, fluoride treatment, space maintainers, sealants	100%	100%
BASIC BENEFITS Fillings	80%	80%
MAJOR BENEFITS Crowns, inlays, onlays and cast restorations	50%	50%
ENDODONTICS Root canals	80%	80%
PERIODONTICS Gum treatment	80%	80%
ORAL SURGERY Incisions, excisions, surgical removal of tooth including simple extractions	80%	80%
PROSTHODONTICS Bridges, dentures, implants	50%	50%
ORTHODONTIC BENEFIT children only	50%	50%
ORTHODONTIC MAXIMUM	$1000 Lifetime	$1000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded. Please refer to you Evidence of Coverage or Summary Plan Description for waiting periods and a list of benefit limitations and exclusions.

** Fees are based on PPO fees for In-PPO Network dentists and PPO fees for Out-Of-PPO Network dentists. Reimbursement is paid on Delta Dental contract allowances and not necessarily each dentist's actual fees.

RATES EFFECTIVE 01/01/2016-12/31/2016

Application Fee:	**$**	**50.00**
Renewal Fee:	**$**	**25.00**
Monthly SINGLE Rate:	**$**	**33.89**
Monthly FAMILY Rate:	**$**	**86.25**

DENTAL COVERAGE
UNITED CONCORDIA - PREFERRED

BENEFIT HIGHLIGHTS

WHO'S ELIGIBLE	Primary enrollee, spouse and eligible dependent children to age 19 or to age 25 if dependent is full-time student		
DEDUCTIBLES	In-PPO Network:	$50 per person, $150 per family, per calendar year	
	Out-Of-PPO Network:	$50 per person, $150 per family, per calendar year	
DEDUCTIBLE WAIVED FOR DIAGNOSTIC & PREVENTIVE?	In-PPO Network:	Yes [X]	No [ ]
	Out-Of-PPO Network:	Yes [X]	No [ ]
ANNUAL MAXIMUM	The maximum benefit paid per calendar year is $1500 per person In-PPO Network		
	The maximum benefit paid per calendar year is $1500 per person Out-Of-PPO Network		

BENEFITS AND COVERED SERVICES*	In-PPO Network**	Out-Of-PPO Network**
DIAGNOSTIC & PREVENTIVE BENEFITS Oral examinations, routine cleanings, x-rays, fluoride treatment, space maintainers, sealants	100%	80%
BASIC BENEFITS Fillings	80%	60%
MAJOR BENEFITS Crowns, inlays, onlays and cast restorations	50%	50%
ENDODONTICS Root canals	80%	60%
PERIODONTICS Gum treatment	80%	60%
ORAL SURGERY Incisions, excisions, surgical removal of tooth including simple extractions	80%	60%
PROSTHODONTICS Bridges, dentures, implants	50%	50%
ORTHODONTIC BENEFIT children only	50%	50%
ORTHODONTIC MAXIMUM	$1000 Lifetime	$1000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded. Please refer to you Evidence of Coverage or Summary Plan Description for waiting periods and

** Fees are based on PPO fees for In-PPO Network dentists and PPO fees for Out-Of-PPO Network dentists. Reimbursement is paid on Delta Dental contract allowances and not necessarily

RATES EFFECTIVE 01/01/2016-12/31/2016

Application Fee:	**$**	**50.00**
Renewal Fee:	**$**	**25.00**
Monthly SINGLE Rate:	**$**	**39.96**
Monthly FAMILY Rate:	**$**	**118.24**

Millennium ADMINISTRATORS

Pennsylvania Professional Firefighters
Benefit Options

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Schwenksville, PA 19473
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VISION COVERAGE
EYEMED SELECT PLAN H, FIXED FEE

Vision Care Services	Member Cost	Out-of-Network Allowance
Exam with Dilation as Necessary	$10 Copay	$30
Exam Options:		
Standard Contact Lens Fit and Follow-up	Up to $40	N/A
Premium Contact Lens Fit and Follow-up	10% off Retail	N/A
Frames:	$0 Copay; $200 Allowance, 20% off	
Any available frame at provider location	balance over $200	$100
Standard Plastic Lenses:		
Single Vision	$25 Copay	$25
Bifocal	$25 Copay	$40
Trifocal	$25 Copay	$60
Lenticular	$25 Copay	$60
Standard Progressive Lens**	$25 Copay	$55
Premium Progressive Lens**	$25, 80% of Charge less $120 Allowance	$55
Lens Options:		
UV Treatment; Tint (Solid and Gradient); Standard Plastic Scratch Coating; Standard Polycarbonate		
- Kids under 19; Standard Anti-Reflective Coating	$0	$5
Standard Polycarbonate - Adults	$40	N/A
Polarized; Other Add-Ons	20% off Retail Price	N/A
Contact Lenses (Contact lens allowance includes materials only)		80%
Conventional	$0 Copay; $200 Allowance, 15% off balance over $200	$160
Disposable	$0 Copay; $200 allowance, plus balance over $200	$160
Medically Necessary	$0 Copay, Paid-in-Full	$200
Laser Vision Correction	15% off retail price or 5% off	
Lasik or PRK from U.S. Laser Network	promotional price	N/A
Additional Pairs Benefit:	$1000 Lifetime	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	
** Standard Progressive Lens covered - fund Premium Progressive as a Standard		

Plan Exclusions:

1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical) treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses and/or contract lenses; 6) Non-prescription sunglasses; 7) Two Pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care; 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contract lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Additional Discounts:

Member receives a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contract lenses. Plan discounts cannot be combined with any other discounts or promotional offers.; Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.; After initial purchase, replacement contract lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.; The contract lens benefit allowance is not applicable to this service.; Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.; Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

RATES EFFECTIVE 01/01/2016-12/31/2019

Application Fee for VISION COVERAGE Only:	**$**	**25.00**
Renewal Fee:	**$**	**15.00**
Monthly SINGLE Rate:	**$**	**6.55**
Monthly TWO ADULTS Rate:	**$**	**12.45**
Monthly ADULT + CHILD(REN) Rate:	**$**	**13.11**
Monthly FAMILY Rate:	**$**	**19.27**

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PRESCRIPTION DRUG COVERAGE

PBM: CVS/CAREMARK 60,000+ PHARMACY NETWORK

BENEFIT HIGHLIGHTS

COPAYMENTS:	RETAIL: $20/$40/$60 -- MAILORDER $40/$80/$120
ANNUAL MAXIMUM BENEFIT:	The maximum benefit paid per calendar year is $1,200 per Individual; $2,400 per Individual + 1; $3,600 per Family
GENERIC DISPENSING RULES:	When a generic is available but the pharmacy dispenses the brand per the member's request, the member will pay the difference between the brand discount and the generic discount when available. If the drug pricing discount is not available there will not be a generic incentive charged. The plan member will be charged the Brand copay.
MAINTENANCE CHOICE:	Maintenance Medications are required to be filled through Mail Order or at a CVS Pharmacy. You will be allowed 2 Fills at Retail prior the mandate.
DEPENDENT AGE LIMITS:	Children will be covered through age 25 and will be terminated at the end of the month following their 25th birthday.
ENROLLMENT TERMS:	Must Sign One (1) Year Contract

BENEFITS AND COVERED SERVICES

DRUG CATEGORIES (ALL DOSAGE FORMS)	COVERED (YES OR NO)	COMMENTS
ADD and Narcolepsy Drugs	Yes	
Anabolic Steroids	No	
Anorexients (Diet Aids)	No	
Anti-rejection Drugs (Immunosuppressants)	No	
Anti-Smoking Aids (Requiring a prescription)	No	
Tretinoin (Retin-A, Retin-A Micro, Avita, Ziana, Atralin)	Yes	Coverd to Age 35
Differin	Yes	Coverd to Age 35
Tazorac	Yes	Coverd to Age 35
Compounds	Yes	
Contraceptives Oral	Yes	
Extended Cycle Contraceptives Oral (Seasonale, Seasonique, Loseasonique, Quasense, Joiessa)-The minimum number of days supply per fill will be 84 days with maximum of 91-days supply.	Yes	3x's the retail copay
Contraceptive Emergency (i.e., Plan B and Next Choice)	Yes	
Contraceptive Devices (i.e., IUD, Diaphragm)	Yes	
Contraceptive Injectible - Depo-Provera - 90-day supply per fill	Yes	3x's the retail copay
Contraceptive Implants	Yes	
Contraceptives Transdermal (i.e., Ortho-Evra)	Yes	
Contraceptive vaginal ring (i.e., Nuvaring)	Yes	
Cosmetic Drugs - including hair loss drugs, anti-wrinkle creams, hair removal creams and others (requiring a prescription)	No	
Amylin Analogs (Symlin)	Yes	
Incretin Mimetics (Byetta, Victoza)	Yes	
Insulin	Yes	
Insulin - Needles and Syringes	Yes	
Insulin injection devices	Yes	
Inhaled Insulin Supplies	Yes	
Lancets	Yes	
Lancet Devices	Yes	
Alcohol Swabs	Yes	
Blood Testing Strips: Glucose	Yes	
Urine Testing Strips: Glucose	Yes	
Acetone Testing Strips	Yes	
Keytone Testing Strips	Yes	
Glucagon Emergency Injection Kit	Yes	
Glucose (Oral)	Yes	
Blood Glucose Monitoring Units	No	
Blood Glucose Monitoring Units Disposable	No	
Blood Glucose Monitoring Units Continuous	No	
Blood Glucose Monitoring Watch	No	
Emergency Allergic Reaction Kits (Bee Sting Kits, Epi-pen, Epi-pen Jr, Twinject, Epinephrine Inj, Adrenaclick)	Yes	
Fertility Agents - Oral	No	
Fertility Agents - Injectible	No	
Fluoride (Topical Fluoride dental products - requiring a prescription)	No	
Growth Hormone	No	
Impotency Drugs - (Inectible, Oral, Suppository, Kits)	No	
Injectibles (All injectibles, unless otherwise noted on this form)	No	
IV Injectibles (unless otherwise noted on this form)	No	
Migraine Medicines (kit, nasal spray, tablet, injectibles)	Yes	
Multiple Sclerosis Meds (examples Betaseron, Avonex, Copaxone, Rebif, Novantrone)	Yes	
Multiple Vitamins (that require a prescription)	Yes	
Prenatal Vitamins (that require a prescription)	Yes	
Pediatric Vitamins (that require a prescription)	Yes	
DTC Coverage Plan - PPI (Proton Pump Inhibitor)	Yes	
DTC Coverage Plan - NSA (non-sedating antihistamine)	Yes	

Application Fee:	**$ 50.00**
Renewal Fee:	**$ 25.00**

RATES EFFECTIVE 01/01/2016-12/31/2016

INDIVIDUAL:	**$ 110.00**
INDIVIDUAL + 1:	**$ 210.00**
FAMILY:	**$ 310.00**

Millennium ADMINISTRATORS
900 Ashbourne Way, Suite B
Schwenksville, PA 19473
(610) 222-9400

ACH Recurring Payment Authorization Form

Schedule your payment to be automatically deducted from your checking or savings account. Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating termination due to due to non-payment.

Here's How Recurring Payments Work:

You authorize regularly scheduled charges to your checking or savings account. You will be charged the amount indicated on your invoice each billing period. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I _____ authorize Millennium Administrators, Inc. to charge my bank
(full individual name or full company name)
account indicated below each quarter for payment of my AFLAC, Dental, Telemedicine, and/or Vision Insurance Premium(s) as well as annual fees if applicable.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Checking ☐ Savings

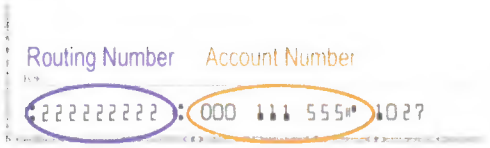
Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____



SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Millennium Administrators, Inc. in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted periodic payment dates fall on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Millennium Administrators, Inc. may at its discretion attempt to process the charge again within 30 days, and agree to an additional $100 charge for each attempt returned NSF, which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I agree not to dispute this recurring billing with my bank so long as the transactions correspond to the terms indicated in this authorization form.

Millennium ADMINISTRATORS
900 Ashbourne Way, Suite B
Schwenksville, PA 19473
(610) 222-9400

Credit Card Recurring Payment Authorization Form

Schedule your payment to be automatically charged to your Visa or MasterCard.
Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating termination due to due to non-payment.

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to be charged to your Visa or MasterCard. You will be charged the amount indicated on your invoice each billing period plus a 4% credit card transaction fee. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I _____ authorize Millennium Administrators, Inc. to charge my credit
(full individual name or full company name)
card indicated below each quarter for payment of my AFLAC, Dental, Telemedicine, and/or Vision Insurance Premium(s) as well as annual fees if applicable.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Credit Card

☐ Visa ☐ MasterCard

Cardholder Name _____

Account Number _____

Exp. Date _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Millennium Administrators, Inc. in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted periodic payment dates fall on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. I agree not to dispute this recurring billing with my credit card company so long as the transactions correspond to the terms indicated in this authorization form.