New York State Professional Fire Fighters Association, Inc.

174 Washington Avenue, Albany, NY 12210
Phone: 518-436-8827 • 1-800-238-8827 • Fax: 518-436-8830
E Mail: profire@nyspffa.org
www.nyspffa.org

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REV. JOHN TALLMAN
40 Collins Place
Albany, NY 12208

Dear Local President,

As you are now aware, The NYSPFFA has been successful in replacing our old Delta Dental Plan, in favor of a more affordable, and enhanced benefit, Emblem Health Dental Plan. At the same time, a new Vision Plan, is now also available.

The new plan with EmblemHealth contains many improvements over the old plan, including $2,000.00 in orthodontic care, where no benefit for orthodontia existed before.

We are happy to report that nearly every NYSFPPA members, formally covered under the old plan, has opted for the new coverage.

We are now requesting that all NYSPFFA members take a few moments to look at this valuable coverage.

- If your Local is currently without Dental Coverage, this is a cost-effective solution to your problem.
- If you already have a Dental plan, take some time and compare the cost and benefit of your existing plan to that of the NYSPFFA EmblemHealth Plan.(if you would like us to do a side-by-side comparison for you, simply send us your existing plan)
- For Locals with existing plans who want to switch, you can continue to bill your membership the same way you do currently (simply subtract the $3.00 TPA fee from the attached rete sheet) or allow our TPA to do the billing for members directly (current rates apply)

Please see the enclosed Rate Sheet for both the Dental Plan and the Vision plan, that can be applied for together, or separately.

Any questions, please call our office or our Insurance Broker-of Record: Michael B. Murphy, President, MBM Insurance Services, Inc. at 516-795-8248.

Fraternally,

Sam Fresina
President

James McGowan
Secretary Treasurer

EmblemHealth®

High and Standard Dental Option Benefits

For the New York State Professional Fire Fighters Association

Dental care is an important part of your overall health. We're happy to offer you high-quality, preferred dental care with the New York State Professional Fire Fighters Association.

As a member of EmblemHealth's High or Standard Option plans, you will:

- Have access to over 10,000 providers in New York and New Jersey, plus 160,000 providers nationwide on an in-network basis.
- Be covered for preventive services like cleanings, x-rays, and exams.
- Be covered for basic and major dental services. Basic services include fillings and root canals; major services include restorations and prosthetics.

Here are some important things to know about your benefits:

- Dependents are covered until the end of the year they turn 19, or 23 for students.
- Both plans have a **$1,000 annual maximum** per person. This is the most your dental plan will pay toward the cost of dental care during your plan year. You are responsible for paying costs above the annual maximum. Orthodontia is not subject to the annual maximum.
- Both plans have a **$2,000 lifetime orthodontic maximum** per person. This is the maximum dollar amount your dental plan will pay toward the cost of orthodontic dental care for you and your child. Adult orthodontia is covered. We will cover up to 20 months of treatment. Beyond that, you must pay the provider's fees.
- Both plans have a **$50 individual, or $150 family deductible** for certain types of services. This is the amount you pay for services before your plan starts to pay.
- Some services, like prescription drugs, certain surgeries, and dental implants, are not covered by these plans.

Monthly rates

continued on the other side

Here are the monthly rates* you will pay if you choose one of these plans:

Standard Option	Rates	High Option	Rates
Single	$32.79	Single	$38.55
Employee & children	$66.53	Employee & children	$79.68
Employee & spouse	$63.97	Employee & spouse	$75.76
Family	$108.01	Family	$129.39

*Rates include a $3.00 TPA administration fee.

Our Offerings	In-Network	Out-of-Network	In-Network	Out-of-Network
	High Option		Standard Option	
Preventive & Diagnostic Dental Services: Exams, cleanings, x-rays, fluoride treatments, and more.	EmblemHealth pays 100% of the Preferred Fee Schedule for covered services with a Preferred network dentist or specialist. Services are covered.*	EmblemHealth reimburses 100%, according to the Preferred Fee Schedule. You are responsible for paying any costs that are more than this amount.	EmblemHealth pays 100% of the Preferred Fee Schedule for covered services with a Preferred network dentist or specialist. Services are covered.*	EmblemHealth reimburses 100%, according to the Preferred Fee Schedule. You are responsible for paying any costs that are more than this amount.
Basic Dental Services: Fillings, root canals, surgery, and more.	After you meet the deductible, EmblemHealth pays 100% of the Preferred Fee Schedule for covered services with a Preferred network dentist or specialist. You are responsible for additional costs on any upgraded material. $50 individual, or $150 family deductible applies. Services are covered.*	After you meet the deductible, EmblemHealth reimburses 100%, according to the Preferred Fee Schedule. You are responsible for paying any costs that are more than this amount. $50 individual, or $150 family deductible applies.	After you meet the deductible, EmblemHealth pays 80% of the Preferred Fee Schedule for covered services with a Preferred network dentist or specialist. You pay 20% of the cost of covered services after you meet the $50 per person, or $150 per family deductible. You are responsible for additional costs on any upgraded material. Services are covered.*	After you meet the deductible, EmblemHealth reimburses 80%, according to the Preferred Fee Schedule. You are responsible for paying any costs that are more than this amount. $50 individual, or $150 family deductible applies.
Major Dental Services: Fixed and removable prosthetics and major restorations.			After you meet the deductible, EmblemHealth pays 50% of the Preferred Fee Schedule for covered services with a Preferred network dentist or specialist. You pay 50% of the cost of covered services after the $50 per person, or $150 per family deductible. You are responsible for additional costs on any upgraded material. Services are covered.*	After you meet the deductible, EmblemHealth reimburses 50%, according to the Preferred Fee Schedule. You are responsible for paying any costs that are more than this amount. $50 individual, or $150 family deductible applies.
Orthodontics: Available to you and your children. Adult orthodontia is covered. EmblemHealth covers up to 20 months of treatment. Beyond that, you are responsible to pay the full cost of services and must pay for any charges for missed appointments or additional cosmetic banding options.	EmblemHealth issues an initial payment of 100% for covered services to the Preferred network orthodontist upon receipt of a claim confirming the initiation of comprehensive orthodontic treatment. The balance of the available orthodontia benefit due will be issued in subsequent monthly or quarterly payments.	EmblemHealth reimburses 100%, according to the Preferred Fee Schedule. You are responsible for paying any costs that are more than this amount.	EmblemHealth issues an initial payment of 50% for covered services to the Preferred network orthodontist upon receipt of a claim confirming the initiation of comprehensive orthodontic treatment. The balance of the available orthodontia benefit due will be issued in subsequent monthly or quarterly payments.	EmblemHealth reimburses 50%, according to the Preferred Fee Schedule. You are responsible for paying any costs that are more than this amount.

*Dentists in the EmblemHealth network may offer upgraded services or materials that are not covered. You may be responsible for some or all such costs. In cases where an alternate benefit is applied, you may be responsible for the difference between the fee the dentist submits to us and how much we will cover. You and your dentist must agree in advance to Treatment Plans and payment methods for upgraded materials not covered by your plan.

Note: This is not a complete benefit comparison or a contract and should only be viewed as a summary to assist you in understanding this EmblemHealth dental benefit program. A detailed benefits description, including limitations and exclusions, is contained within the Certificate of Insurance. The terms, conditions, limits, and exclusions shown in the Certificate of Insurance shall govern. Dental plan described is underwritten by EmblemHealth Plan, Inc. Refer to policy forms EHPI-PLD-1104 and EHPI-PLD-1103.

EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC and Health Insurance Plan of Greater New York (HIP) are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

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NYSPFFA Dental Coverage Options

	Plan 1 — (Standard Plan)		Plan 2 — (High Plan)	
Brief Plan Description	100/80/50/50, 1000 max $50/$150 Ded		100/100/100/100, 1000 max $50/$150 Ded	
Dental Benefits	**In Network**	**Out-Network**	**In Network**	**Out-Network**
Annual Benefit Maximum	$1,000	$1,000	$1,000	$1,000
Maximum Carryover (Type A, B, C)	No	No	No	No
Orthodontic Lifetime Maximum	$2,000	$2,000	$2,000	$2,000
Reimbursement Schedule	Preferred	Preferred	Preferred	Preferred
Annual Deductible, Individual/Family				
Preventative	N/A	N/A	N/A	N/A
Basic	$50/150 Ded	$50/150 Ded	$50/150 Ded	$50/150 Ded
Major	$50/150 Ded	$50/150 Ded	$50/150 Ded	$50/150 Ded
Orthodontia	$50/150 Ded	$50/150 Ded	$50/150 Ded	$50/150 Ded
Coinsurance				
Preventative	100%	100%	100%	100%
Basic	80%	80%	100%	100%
Major	50%	50%	100%	100%
Orthodontia	50%	50%	100%	50%
Other Benefits				
Sealants Through	Age 17	Age 17	Age 17	Age 17
Fluoride Treatments Through	Age 19	Age 19	Age 19	Age 19
Dental Implants	Not Covered	Not Covered	Not Covered	Not Covered
Missing Tooth Coverage	Not Covered	Not Covered	Not Covered	Not Covered
Dependent Coverage				
Non-Student Through	Age 19 EOY	Age 19 EOY	Age 19 EOY	Age 19 EOY
Student Through	Age 23 EOY	Age 23 EOY	Age 23 EOY	Age 23 EOY
Monthly Premium*				
Single	**$32.79**		**$38.55**	
Member + Child	**$66.53**		**$79.68**	
Member + Spouse	**$63.97**		**$75.76**	
Family	**$108.01**		**$129.39**	

*All rates include $3 TPA administration fee

Coverages underwritten by EmblemHealth

Coverage effective 12/1/2019

NYSPFFA NEW Vision Coverage

In-Network	Plan A
Exam with dilation as necessary	$0 co-pay
Standard contact lens fit & follow-up	Up to $40
Any available frame at provider location	$0 co-pay/ $200 allowance 20% off balance over $200
Single vision lens	$0 co-pay
Bifocal lens	$0 co-pay
Trifocal lens	$0 co-pay
Standard Progressive lens	$65 co-pay
Premium Progressive lens	$65 co-pay, 80% of charge less $120 allowance
UV Treatment	$15 co-pay
Tint (solid & gradient)	$15 co-pay
Standard plastic scratch coating	$0 co-pay
Standard polycarbonate- adults	$40 co-pay
Standard polycarbonate- kids under 19	$0 co-pay
Standard anti-reflective coating	$45 co-pay
Other add-ons	20% off retail
Conventional Contacts	$0 co-pay/ $200 allowance 15% off balance over $200
Disposable Contacts	$0 co-pay/ $200 allowance, plus balance over $150
Medically necessary Contacts	$0 co-pay, paid in full
Examination	Once every 12 months
Lenses or contact lenses	Once every 12 months
Frame	Once every 12 months

	Monthly Premium
Member	**$9.17**
Member + Children	**$13.37**
Member + Spouse/Partner	**$16.76**
Family	**$22.56**

*All rates include $3 TPA administration fee

Coverages underwritten by EmblemHealth

Coverage effective 12/1/2019

EmblemHealth

Transaction Form for Group Accounts

I. SUBSCRIBER INFORMATION

Last Name	First Name	M.I.	Sex	Social Security Number

Street Address	Apt.	City	State	ZIP Code

Were you ever a member of EmblemHealth? ☐ NO ☐ YES
If YES, member ID _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner (DP)

Birth Date: Mo. Day Yr.

Home Tel. #: _____
Work Tel. #: _____
Cell Tel. # (see back of form*): _____

Email Address: _____

Applicant's hours worked per week:
☒ At least 20 hours ☐ Less than 20 hours ☐ COBRA
☐ Retiree (see back of form**)

Type of Coverage: ☐ Individual ☐ Family ☐ Employee & Spouse/DP ☐ Employee & Child

Note: If electing Young Adult Coverage, please submit a completed Young Adult Election Form.

Primary Care Physician Name: (Not required for EPO/PPO members) _____ ID Number: _____

OB/GYN Selection Name: (Optional) _____ ID Number: _____

Are you covered by any other health insurance or Medicare?
☐ NO ☐ YES If YES, indicate:
Insurance Co. Name: _____
Insurance Co. Telephone #: _____ Type of Coverage: _____
Policy #: _____ Effective Date: _____

Check One:
☒ New Enrollment
☐ Reinstatement
☐ Termination
☐ Change

Status:
☐ Add Dependent
☐ Remove Dep.
☐ Address Change
☐ Name Change

Transfer:
☐ To Another Carrier
☐ EmblemHealth Group Change:
From: _____
To: _____

II. ENROLLMENT INFORMATION — IF YOU ARE ENROLLING YOUR SPOUSE/DP AND/OR CHILDREN, PLEASE LIST EACH ONE BELOW — SEE ELECTION OF COVERAGE FOR ELIGIBILITY

Note: A birth/marriage certificate or 1040 Form will be required for spouse/dependents with different last name.

Last Name (if different) / First Name	Social Security Number	Sex	Relationship	Birth Date Mo.	Day	Yr.	✓ if Disabled[1]	Primary Care Physician Name/ID Number (Not required for EPO/PPO members)	OB/GYN Selection Name/ID Number (Optional)
DEPENDENT			☐ Spouse ☐ DP ☐ Child						
Current Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____									
DEPENDENT			☐ Child						
Current Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____									
DEPENDENT			☐ Child						
Current Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____									

[1]For dependent adult children incapable of self-sustaining employment, please see Section A on the back side of this form to check the appropriate "Add Dependent" box, and follow the instruction for required documentation.

Your signature is required to process this form. Your signature attests that you have read the reverse side of this form.
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact associated with such application commits a fraudulent insurance act. Such act is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant must sign here: _____ **Date:** _____

III. EMPLOYER INFORMATION — THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group: New York State Professional Firefighters Association	Group Number:	Sub Group ID _____ Class ID _____ Plan ID _____	☐ HIP ☐ GHI ☐ HIPIC
	If you selected a small group metal plan, please indicate which plan you are selecting: _____		Plan Name: _____
Requested Effective Date: Medical: N/A Dental: 12/1/2019	Hire Date:	Waiting Period:	Date Submitted:	Approved By: (Group Plan Administrator)

Instructions to Benefit Administrators or Group Representatives: For groups with 100 or fewer full-time equivalent eligible employees, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Transaction Form to be processed.

IMPORTANT INFORMATION

1. The subscriber must complete sections I and II. The group plan administrator must complete section III, and if for a small group (100 or fewer full-time equivalent eligible employees) provide all necessary documentation.
2. All transactions are subject to EmblemHealth's retroactive enrollment period – members must be enrolled within 30 days (for small groups) or 90 days (for large groups) from the Qualifying Event.
3. As part of New York State's "Age 29" law, eligible young adults through age 29 may obtain coverage through a parent's group policy.
4. Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, signature, etc.) will require EmblemHealth to return this transaction form to the employer group plan administrator and may delay the requested effective date of coverage.
5. Return the completed Transaction Form along with any required documentation to: Membership, PO Box 2820, New York, NY 10116-2820.

Get more information at **www.emblemhealth.com**.

SECTION A

(To be completed by Benefits Administrator)

ACTION Check (✓)One	Qualifying Event	Documentation Required
☐ Add Subscriber	New Hire or Change in Plan	For eligible employees who work at least 30 hours per week, provide a recent Copy of NYS-45 showing this subscriber as an employee or provide copy of payroll documentation reflecting the date, employee's name and Social Security #, or the employee's current-year W-4 Form.
☐ Add Spouse	Marriage	**If last name is different** ☐ Marriage Certificate ☐ 1040 Form
☐ Add Dependent	Birth or Adoption	**If last name is different** ☐ Birth Certificate ☐ Formal Adoption Papers ☐ Court-Approved Guardianship Papers
☐ Add Young Adult	Young Adult Coverage	Young Adult Election Form
☐ Add Dependent	Dependent Adult Child Incapable of Self-Sustaining Employment	Disability Status Request Form
☐ Add Spouse ☐ Add Dependent	Loss of Coverage	Certificate of Creditable Coverage
☐ Add Domestic Partner	Domestic Partnership	Declaration of Cohabitation & Financial Interdependence Form

Note: No exceptions to our retroactive enrollment period will be allowed. Small group members must be enrolled within 30 days from the Qualifying Event/next billing date (or within 90 days for large group members).

*I understand that the phone number(s) I provided on this form may be used by EmblemHealth or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.

** Retiree option is applicable for large groups only.

Group Health Incorporated (GHI), Health Insurance Plan of Greater New York (HIP), HIP Insurance Company of New York (HIPIC), and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

100-23-TransForm (10/18)

TIMELY PAYMENT ADMINISTRATORS

Ph: 516-858-7298 | Fax: 516-795-4392

I(We) do hereby authorize Timely Payment Administrators hereafter named COMPANY, to initiate Recurring (debit) entries to (my/our) account indicated at the depository financial institution named below, hereafter named FINANCIAL INSTITUTION. I further authorize COMPANY to initiate an adjusting or correcting entry as necessary. Finally, should any such debit(s) be returned for any reason, I(we) authorize the COMPANY to collect such debt(s) electronically from the same account identified below.

What is the EFT plan?

- The EFT plan allows COMPANY to pay your policy premiums by automatically withdrawing funds from your FINANCIAL INSTITUTION account monthly.

How much will be deducted from my account?

- We will only deduct premium payments according to the payment schedule outlined in your policy plus an administrative fee.

How can I cancel the EFT plan?

- Call MBM Insurance Services, Inc at 516-795-8248 to request a cancellation form. Once we receive your request, we will cancel the plan within 7-10 business days.
- We may cancel the plan without notice if a withdrawal is not honored or 30 days after we provide written notice to you.

Please complete the information below:

Bank Name _____ Account Type: ☐ Checking ☐ Savings

Account Number _____ Bank Routing #_____

RECURRING DEBITS

Payment Start Date: _____ Amount: _____ Number of Payments: **Continuous**

*charge will appear as "**NYSPFFA**"

This Authorization is to remain in full force and effect until the COMPANY has received a written cancellation form from me (or either of us) of its termination.

SIGNATURE _____ DATE _____

PRINTED NAME _____