2022 EMPLOYEE BENEFITS GUIDE

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Important Contacts

COVERAGE	CONTACT	PHONE	WEBSITE
Medical	Independence Blue Cross	800-275-2583	www.ibx.com
Dental	Aetna	877-238-6200	www.aetna.com
Vision	VBA	800-432-4966	www.vbaplans.com
Health & Welfare Benefits	Health & Welfare Office	215-895-3346	afscme33.org

Welcome

We are pleased to provide you with medical, dental and vision benefits that are a vital part of your total compensation. You have the flexibility to select from benefits to keep you and your family healthy, provide financial protection in the event of an unforeseen event. This brochure was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this brochure to make sure you understand the benefits that are available to you and your family — then be sure to take action.

Eligibility

If you work at least 30 hours per week, you are eligible for benefits. If you were hired between the 1st and the 15th of the month, your benefits are effective immediately. If you were hired between the 16th and the end of month, your benefits will be effective on the first of the following month. You may also enroll your eligible dependents for coverage. This includes the following:

- Your legal spouse or qualified domestic partner
- Children under the age of 26, regardless of student, dependency or marital status
- Children who are past the age of 26 and are fully dependent on you for support due to a mental or physical disability, and who are indicated as such on your federal tax return

Qualified Life Events

Generally, you may only change your benefit elections during the Open Enrollment period. However, since life happens, you also may change your benefit elections during the year if you experience a Qualified Life Event.

QUALIFIED LIFE EVENT DOCUMENTATION	
Change in marital status	
Marriage	Copy of marriage certificate
Divorce/Legal Separation	Copy of divorce decree
Death	Copy of death certificate
Change in number of dependents	
Birth or adoption	Copy of birth certificate or copy of legal adoption papers
Step-child	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
Death	Copy of death certificate
Change in employment	
Change in your eligibility status (i.e., full-time to part-time)	Notification of increase or reduction of hours that changes coverage status
Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

Medical

Medical insurance is essential to your well-being and our medical coverage provides you and your family the protection you need for everyday health issues or when the unexpected happens.

How a Health Plan Works

Preventive Care – like physical exams, flu shots and screenings – is always covered 100% when you use in-network providers. The key difference between the plans is the amount of money you'll pay each pay period and when you need care. The plans have different:

Annual deductible amount – the amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay

Out-of-pocket maximums – the most you will pay each year for eligible network services including prescriptions. After you reach your out-of-pocket maximum, the plan picks up the full cost of covered medical care for the remainder of the year.

Copays – A copay is a fixed amount you pay for a health care service. Copays do not count toward your deductible but do count toward your annual out-of-pocket maximum.

Coinsurance – Once you've met your deductible, you and the plan share the cost of care, called coinsurance. For example, you pay 20% for services and the plan will pay 80% of the cost until you have reached your out-of-pocket maximum.

Medical Plan Comparison

	DC 33 HMO	DC 33 HMO S	DC 33 PERSONAL CHOICE PPO	
	IN-NETWORK ONLY	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible				
Individual	$0	$0	$300	$750
Family	$0	$0	$600	$1,500
Calendar Year Out-of-Pocket Maximum (Includes Deductible)				
Individual	$1,500	$3,000	$2,000	$4,500
Family	$3,000	$6,000	$4,000	$9,000
	You pay	You pay	You pay	
Coinsurance				
Preventive Care	$0	$0	$0	30% No Deductible
Primary Care Physician	$20	$40	$20	30% After Deductible
Specialist	$25	$60	$30	30% After Deductible
Urgent Care	$50	$50	$40	30% After Deductible
Emergency Room	$200	$200	$200	
Pharmacy				
Retail Rx (up to 30-day supply), Mail Order Rx (up to 90-day supply)				
Tier 1	$10	$10	$10	
Tier 2	$25	$25	$25	
Tier 3	$40	$40	$40	

JFK MEDICAL CENTER/JEFFERSON HEALTH BENEFITS

MEDICAL & RX	DC 33 HMO	DC 33 HMO & JFK & JEFFERSON	DC 33 HMO S	DC 33 HMO S & JFK & JEFFERSON	PERSONAL CHOICE	PERSONAL CHOICE & JFK & JEFFERSON
Annual Copay Maximum	$1500/$3000	$1500/$3000	$3000/$6000	$3000/$6000	In-network: $2000/$4000 Out-of-network: $4500/$9000	$2000/$4000
Primary Care Physician	$20.00	$0.00*	$40.00	$0.00*	$20.00	$0.00*
Specialist Care Physician	$25.00	$0.00/$5.00**	$60.00	$0.00/$40.00**	$30.00	$0.00/$10.00**
Diagnostic X-ray	$40.00	$0.00***	$60.00	$20.00***	10-15%	10-15%
In-Patient Hospitalization	$500.00	$0.00***	$1,000.00	$500.00***	10%	10%
Out-Patient Hospitalization	$250.00	$0.00***	$500.00	$250***	10%	10%
Emergency Room	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00
Rx	$10/$25/$40	$10/$25/$40	$10/$25/$40	$10/$25/$40	$10/$25/$40	$10/$25/$40

* JFK only | ** $0.00 copay at JFK & at one of the approved Jefferson facilities | *** Copay at one of the approved Jefferson facilities

Bi-Weekly Member Contributions

	DC 33 HMO	DC 33 HMO S	DC 33 PERSONAL CHOICE PPO
Individual	$50.00	$25.00	$53.53
Parent/Child	$50.00	$25.00	$85.69
Parent/Children	$50.00	$25.00	$127.60
Individual/Spouse	$50.00	$25.00	$85.69
Family	$50.00	$25.00	$127.60

Dental

Taking care of your oral health is not a luxury, it is a necessity for long-term optimal health. With a focus on prevention, early diagnosis and treatment, Dental insurance can greatly reduce your costs when it comes to restorative, and emergency procedures. Preventive services are covered at no cost to you and include routine exams and cleanings. You will only pay a small deductible and coinsurance for basic and major services.

	AETNA DPPO
	IN- AND OUT-OF-NETWORK
Calendar Year Deductible	
Individual	$0
Family	$0
Calendar Year Out-of-Pocket Maximum	
Per Individual	$5,000
	You pay
Preventive Care	
Exams, Cleanings, X-rays, Fluoride Treatments	$0
Basic Services	
Fillings, Space Maintainers, Sealants, Extractions, Oral Surgery, Endodontics, Periodontics, Emergency Exams	$0
Major Procedures	
Crowns, Inlays/Onlays, Dentures and Bridgework, Repairs	20%
Orthodontia	
24-Month Treatment Fee – Additional fees will apply for pre-ortho visits and treatment, records and retention, and banding	
Adults	20% up to a lifetime maximum benefit of $5,000 per individual; deductible waived
Children (up to 19th birthday)	

Jet Dental, a professional dental team, provides quarterly onsite dental services to AFSCME District Council 33 for all staff and family members. Services include comprehensive exams, preventative cleanings and x-rays at no cost (with insurance). Patients with periodontal gum disease may need a deeper cleaning (known as scaling and root-planing), which requires a co-pay. Jet Dental's professional team will review any applicable costs before performing treatment and can offer flexible payment options as needed.

Vision

Healthy eyes and clear vision are an important part of your overall health and quality of life.

You may enroll yourself and your eligible dependents or you may waive vision coverage. You do not have to be enrolled in medical coverage to elect vision coverage or cover the same dependents under medical and vision.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

VISION BENEFITS OF AMERICA	VISION PLAN	
	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	You pay	Reimbursement
Cost		
Exam	$0	$25
Covered Services – Lenses		
Single Lenses	$0	$20
Bifocals	$0	$25
Trifocals	$0	$30
Frames	$0	$25
Covered Services – Contacts in lieu of Frames/Lenses		
Contacts – Medically Necessary	$0	$105
Contacts – Elective	$65	$65
Benefit Frequency		
Exams	Once every 24 Months	Once every 12 Months
Lenses	Once every 24 Months	Once every 12 Months
Frames	Once every 24 Months	Once every 24 Months
Contacts	Once every 24 Months	Once every 12 Months

This brochure highlights the main features of the DC 33 Employee Benefits Program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. DC 33 reserves the right to change or discontinue its employee benefits plans at any time.