COUNTY of SAN LUIS OBISPO

The Newbie Guide to Employer Medical Coverage

Getting Started

First time? We want you to feel confident that you're choosing the right plan to fit your healthcare needs and budget. This guide will help you choose an employer-provided plan and answer some frequently asked questions.

The Basics

- Key things to know
- Understanding plan types
- Choose the right plan for you

Maximize Your Benefits

- Managing out-of-pocket expenses
- Preventive care screening benefits
- Get the most from your prescription plan

Resources

- Where do I go from here?
- Medical plan contacts
- Enrollment website

The Basics

Key Things to Know

Picking a health insurance plan for the first time can be… a lot. But armed with some foundational knowledge about health coverage, it'll be a breeze.

Read on for an explanation of the following healthcare terminology. If you still have questions, take a look at the plan information at the end of this guide.

- Eligibility
- Enrollment
- Premiums
- Out-of-pocket costs
- Plan options

Eligibility

U.S. companies with 50 or more full-time employees are required by law to offer medical coverage to employees working 30 or more hours per week.

These companies must also offer benefits to those employees' dependent children and stepchildren up to age 26.

Some employers also extend health benefits to part-time employees, spouses, domestic partners, and children older than 26.

I'm new to the U.S. and this is all very weird.

Unlike many other countries, the U.S. does not have a national healthcare system. The government does fund two public health plans, Medicare for people 65 and older, and Medicaid for specific disadvantaged populations. More than half of Americans under age 65 get medical insurance through their employers. The remainder purchase an individual insurance policy or go without insurance.

Enrollment

You can enroll in or change your employer-provided health insurance plan only at certain times.

Your first opportunity to enroll is when you are first hired. If you do not enroll at that time, you will have to wait until the company's annual open enrollment period.

During open enrollment, you can enroll, change your plan, or add or remove dependents.

The only other time you can enroll or change your insurance plan is when a special enrollment period is triggered by a "life event," such as marriage, divorce, turning 26, or having or adopting a child.

Why is turning 26 a life event?

Under the Affordable Care Act (ACA), dependent children and stepchildren can stay on their parents' health insurance until age 26. If you are within a few months of your 26th birthday, talk to your parents to find out when your coverage ends on their plan.

Premiums

The premium is the monthly cost for your insurance plan.

Most employers cover a large portion of the premium. The remainder (your contribution) will be deducted from your paycheck.

Most employers offer pre-tax benefit contributions, which means the money you spend on premiums are not taxed.

Out-of-pocket costs

Everything you pay for that your insurance won’t cover, split into four categories:

Deductible

The amount of money you pay for healthcare services before your insurance benefits kick in.

Coinsurance

The split between what you pay and what your insurance pays for healthcare services after you meet your deductible.

Copay

A fixed amount you pay for certain services, like doctor visits, which may apply even if you haven’t met your deductible.

Services not covered

Health insurance doesn’t pay for every possible healthcare service. Contact your insurance company if you aren’t sure whether a service is covered.

See more about how to manage your out-of-pocket costs on page 13 of this guide

Plan Options

Employers may offer just one health insurance plan or several options so employees can pick the plan that best fits their budget and healthcare needs.

Some plans (like HMOs) restrict you to in-network doctors. Other plans (like PPOs) allow you to see any doctor, but you will pay a higher coinsurance percentage if the doctor is out of network.

During enrollment, you will be able to look at the plan details to decide if it's right for you.

Understanding Plan Types

	Pros	Cons	Must Pay Deductible	Out-of-network Care Covered	Referral Needed to See Specialist	Must Select Primary Care Physician
HMO Health Maintenance Organization	• More predictable costs	• Less flexibility • No out-of-network coverage • May have to select Primary Care Physician	○		●	○
PPO Preferred Provider Organization	• You can go anywhere, whether in-network or out-of-network	• You pay more for out-of-network providers	●	●		
POS Point of Service	• Combines HMO and PPO • You choose how you want to use the plan	• Must pay deductible for out-of-network care	○	●	●	●
EPO Exclusive Provider Organization	• Fewer restrictions than an HMO	• No out-of-network coverage	○			
HDHP High Deductible Health Plan	• An HMO, EPO, PPO or POS with a high deductible, but with the advantage of a tax-free Health Savings Account	• More responsibility for out-of-pocket costs until the deductible is met	●	●		

Key: ● = Yes ○ = Maybe

Choose the Right Plan for You

How do you know which type of plan is right for you?

That will depend on your personal preferences, family situation, and budget. Take the following factors into consideration.

Healthcare Costs

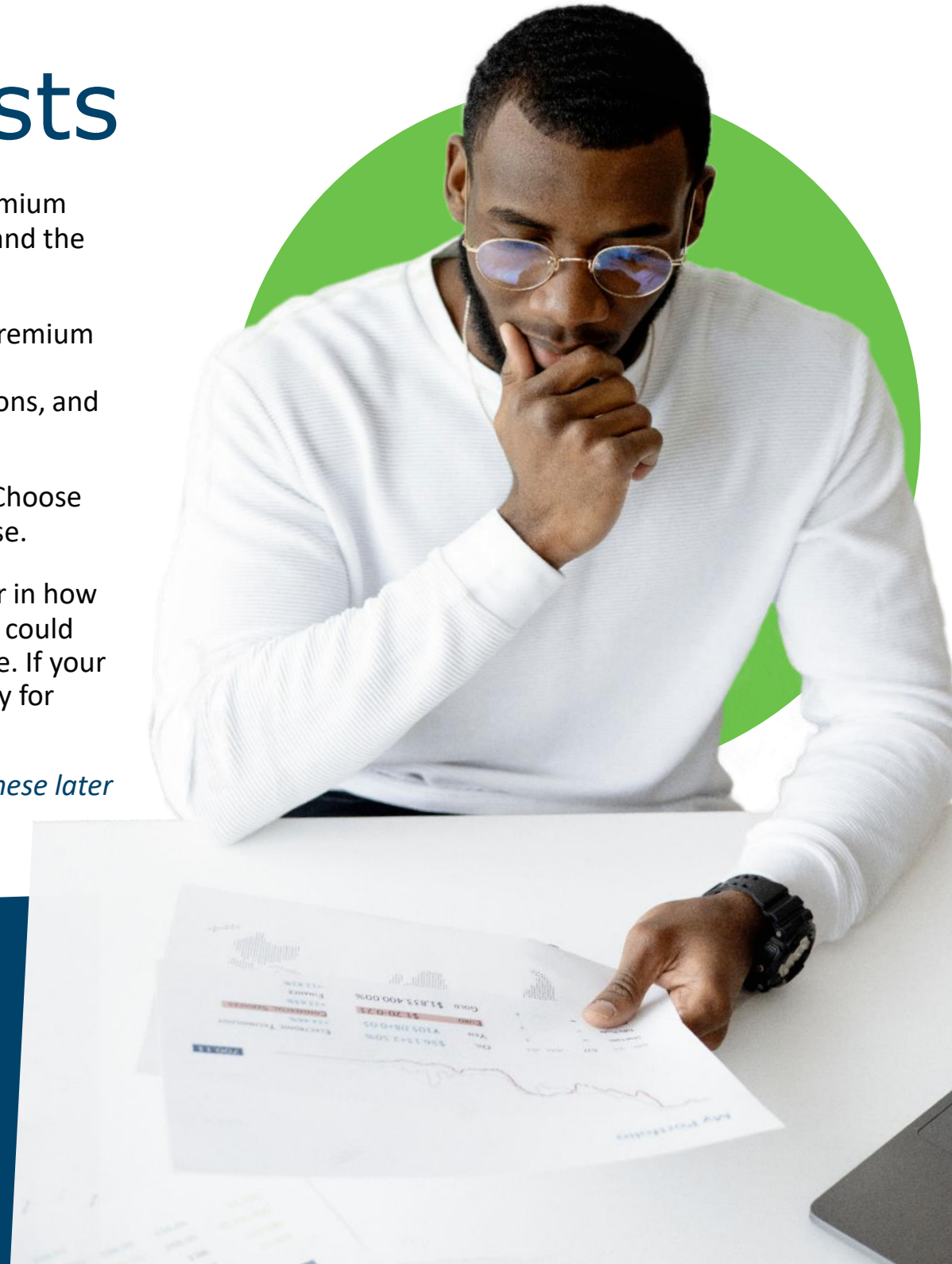
What are your specific needs? The lowest-premium plan may not be the least expensive option for you, and the highest-premium plan may not fit your situation.

Compare total costs. Look at the plan's annual premium and your out-of-pocket costs for the deductible and copayment or coinsurance for office visits, prescriptions, and hospital stays.

What does a typical year look like for you? Choose the plan that best covers the services you typically use.

Think about opening special accounts. Factor in how an HSA, HRA or FSA* could help you offset costs. You could get a tax break on money you set aside for healthcare. If your employer contributes to an HRA or HSA, that's money for healthcare that won't affect your budget.

**more on these later*



Things to consider

- **Family size:** How many people will your insurance cover?
- **Prescriptions:** Do you take any prescription drugs for chronic or mental health conditions?
- **Frequency of doctor visits:** How often do you visit the doctor each year?
- **Specialist visits:** Do you have a health condition that require visits to a specialist?
- **Special procedures:** Do you have a health condition that may require special procedures?
- **Emergency room:** Are you involved in any high-risk sports or other activities that could lead to injury?

Provider Choice

If you already have providers you like – your favorite doctors, pharmacists, hospitals, etc. – you'll want to make sure they are in-network with the plan you choose.

You can find this information by visiting the plan website, calling the insurance company, or checking with the provider directly.

Even if your provider is out-of-network, you may get some coverage with a PPO, HDHP, or POS plan, though you will pay a higher share of the cost than you would if the provider were in network.

With an HMO, you may not have coverage at all with an out-of-network provider.

TIP: It can be a good idea to choose a PCP (Primary Care Provider) even if you are not required to. A PCP can take a holistic approach to any health issues you may have and can help coordinate care between specialists if needed. Research shows that adults with a PCP are more likely to fill their prescriptions and to receive preventive care.

Managing Out-Of-Pocket Expenses

Stay In-Network

With in-network providers, you'll pay less for healthcare services… which keeps more money in your pocket.

With out-of-network providers, you'll pay more for the same service.

Insurance plans pay a smaller share (or under some plans, no share) of the cost when you see an out-of-network provider.

Your benefits guide will include a chart of estimated costs for services. Some plans may show separate columns for "in-network" and "out-of-network" costs.

Know Where to Go

Nurseline	Online Dr. Visit	Office Visit	Urgent Care, Walk-in Clinic	Emergency Room
Included w/ plan	**$**	**$$**	**$$$**	**$$$**
24/7 answers by phone from a nurse	24/7 doctor consultation, no appointment needed	Scheduled Appointment	Conditions requiring prompt attention	Life-threatening conditions requiring immediate care
• Identify symptoms • Decide if immediate care is needed • Home treatment options and advice	• Urgent care conditions • Allergies • Insect bites • Mental health counseling • Conjunctivitis (pinkeye) • Sore throat • Rashes without fever • Sinusitis • Urinary tract infections • Sports injuries	• Preventive care • Illnesses • Injuries • Chronic conditions • Mental health concerns • Referrals to specialists	• Stitches for small cuts • Sprains/strains • Animal bites • Minor burns • Fever with no rash • Vomiting/persistent diarrhea • Abdominal pain • Wheezing/shortness of breath • Dehydration • Moderate cold/flu symptoms	• Chest pain or difficulty breathing • Weakness/numbness on one side • Severe cold or flu symptoms • Severe lacerations • Slurred speech • Severe abdominal pain • Broken bones/ dislocated joints • Serious burns • Fever with rash • Slurred speech • Fainting/seizures • Head/eye injuries • Facial lacerations • Vaginal bleeding in pregnancy

Open an HSA or FSA

Your employer may offer a special kind of savings account that lets you use tax free money on healthcare expenses.

Health savings accounts (HSA) – for participants in high deductible health plans (HDHP) – and flexible spending accounts (FSA) are savings accounts that let you set aside pre-tax money from your paycheck to pay for eligible healthcare expenses.

A similar type of account is a health reimbursement arrangement (HRA). An HRA is an employer-funded account you can use to pay for out-of-pocket expenses, also tax free.

Because you don’t pay taxes on the money you set aside in these accounts, depending on your tax bracket, it’s like getting a 10% to 37% discount on healthcare when you use that money.

Take Advantage of Wellness Incentives

Many employers offer wellness incentives to encourage employees to get and stay healthy.

Participating in your company's wellness program means improving your wellbeing (which may reduce doctor's office visits) and may make you eligible for financial rewards.

Preventive Care Screening Benefits

Annual preventive checkups can help you and your doctor identify your baseline level of health and discover issues before they become serious.

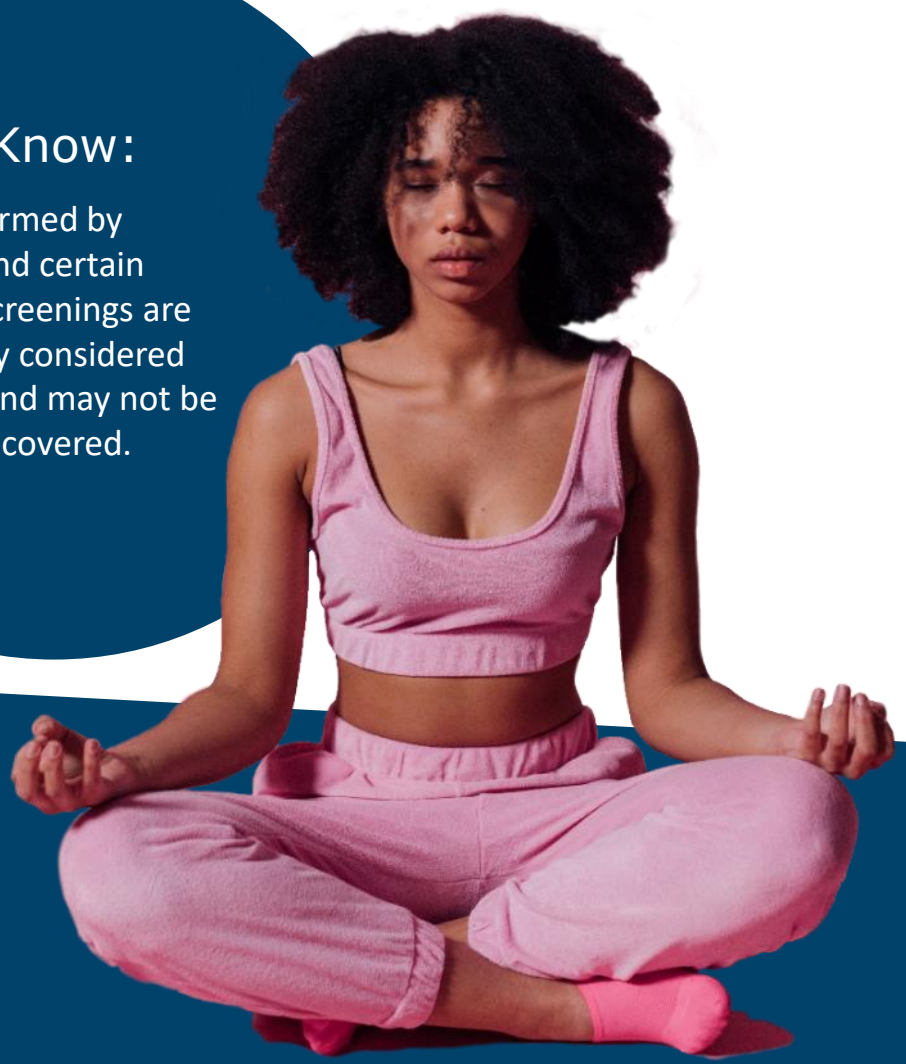
The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible.

Preventive care visits are fully covered only when obtained from an in-network provider.

The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

So You Know:

Exams performed by specialists and certain diagnostic screenings are not generally considered preventive and may not be 100 percent covered.



Typical Preventive Care Screenings for Adults

- Breast and gynecological exams
- Blood pressure
- Cholesterol
- Depression
- Diabetes
- Sexually transmitted infections
- Colorectal cancer

Getting the Most from Your Prescription Plan

If your doctor prescribes medicine, don’t forget to check your health plan’s drug formulary. It can help you make informed decisions about your medication options and identify the lowest-cost selection.

What is a Formulary?

A drug formulary is a list of prescription drugs covered by your medical plan.

The drugs listed on your health plan's formulary are Food and Drug Administration (FDA) approved and have been evaluated by an independent panel of medical experts for effectiveness and value. Drugs that are not FDA approved are not covered.

Formularies include drugs that treat most medical conditions. Some drugs may be excluded if they're overly expensive or not effective. Most formularies do not include cosmetic, weight loss, or lifestyle drugs.

The formulary often lists less expensive alternatives to your prescriptions, such as a generic or a preferred brand name.

What's the difference between generic and brand name?

Generic drugs contain the same active/key ingredients as their brand-name counterparts. But not all drugs have a generic version. Just after a new drug is created and patented, the company that made it gets to produce that drug exclusively. When that exclusivity period ends, smaller manufacturers can apply to sell generic versions.

Rx Money-Saving Tips

Your plan may require approval or step therapy (trying certain drugs before others). Specialty drugs may need to be purchased from a certain provider. Talk with your doctor about your course of treatment and confirm whether your plan requires specialty medications.

An in-network pharmacy will usually offer the best price. You can find the closest participating pharmacies on your plan's website or app. Shop around! Even within the same drugstore chain, you may find a better price at a different location. Your plan may have an online tool or app to compare prices.

You pay a different amount depending on the "tier" or class of drug, such as generic or brand name. Generic drugs are always the least expensive. Ask your doctor or pharmacist if there's a generic version.

You can get maintenance medicines by mail order, usually in a 90-day supply, and request refills through a website, app, or phone. Some plans will cover a 90-day prescription from a local pharmacy, eliminating mail order delays.

County of San Luis Obispo Resources

Blue Shield PPO Plans

Here are the basic features of our plans when you get care. Review the benefits booklet for full details.

Plan Benefits	Blue Shield Tandem PPO (Narrow Network)		Blue Shield Choice PPO		Blue Shield Care PPO	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Annual deductible	$1,250 per individual $2,500 per family		$1,000 per individual $2,000 per family		$500 per individual $1,000 per family	
Annual out-of-pocket maximum	$3,000 per individual $6,000 per family	No limit per individual No limit per family	$3,000 per individual $6,000 per family	No limit per individual No limit per family	$2,000 per individual $4,000 per family	No limit per individual No limit per family
Primary provider office visit	$35 per visit (deductible waived)	Plan pays 60% after deductible	$35 per visit (deductible waived)	Plan pays 60% after deductible	$20 per visit (deductible waived)	Plan pays 60% after deductible
Specialist office visit	$35 per visit (deductible waived)	Plan pays 60% after deductible	$35 per visit (deductible waived)	Plan pays 60% after deductible	$20 per visit (deductible waived)	Plan pays 60% after deductible
Preventive care	No Charge	Plan pays 60% after deductible	No Charge	Plan pays 60% after deductible	No Charge	Plan pays 60% after deductible

Blue Shield EPO Plan

Here are the basic features of our plans when you get care. Review the benefits booklet for full details.

Plan Benefits	In-Network Only
Annual deductible	$250 per individual $750 per family
Annual out-of-pocket maximum Embedded	$1,500 per individual $3,000 per family
Primary provider office visit	$25 per visit
Specialist office visit	$25 per visit
Preventive care	Adult exam w/ preventive test: Plan pays 100% (deductible waived; see contract for limitations), well-child. Plan pays 100% (deductible waived; see contract for limitations)

Blue Shield High Deductible Health Plan

Here are the basic features of our plans when you get care. Review the benefits booklet for full details.

Plan Benefits	In-Network	Out-Of-Network
Annual deductible (Aggregate)	$2,000 per individual $6,000 per family	$2,000 per individual (combined with in-network) $6,000 per family (combined with in-network)
Annual out-of-pocket maximum (Embedded)	$6,350 per individual $12,700 per family	$6,600 per individual $15,000 per family
Physician office visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Specialist office visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Preventive care	Adult exam w/ preventive test: Plan pays 100% (deductible waived; see contract for limitations), Well-child visit: Plan pays 100% (deductible waived; see contract for limitations)	Adult exam w/ preventive test: Plan pays 60% after deductible (in-network limitations apply), Well-child visit: Plan pays 60% after deductible (in-network limitations apply)

Pharmacy Benefits

Express Scripts is the pharmacy program for the following medical plans:

- Blue Shield Tandem PPO
- Blue Shield Choice PPO
- Blue Shield Care PPO
- Blue Shield EPO

	Retail (in-network) (30 Day Supply)	Retail/Home Delivery (in-network) (90 Day Supply)*
Generics	$5 copay	$10 copay
	Free generics are available through Rx N Go*	
Preferred Brands	$20 copay	$40 copay
Non-preferred Brands	$50 copay	$100 copay
Specialty with SaveOnSP	$0 specialty meds with SaveOnSP	
Deductible	None	
Out-of-Pocket Maximum	$2,000 individual / $4,000 family	
Mail Order Out-of-Pocket Maximum	$1,000	

*See the benefits booklet for more information.

Pharmacy Benefits

Blue Shield coordinates the benefit for the Blue Shield HDHP medical plan.

	Retail (in-network) (30 Day Supply)	Retail/Home Delivery (in-network) (90 Day Supply)*
Generics	20% after Rx deductible Free preventive generics are available through Rx N Go *	
Preferred Brands	20% after Rx deductible	
Non-preferred Brands	20% after Rx deductible	
Specialty Drugs	20% after Rx deductible	
Deductible	Medical deductible applies	
Out-of-Pocket Maximum	Medical out-of-pocket maximum applies	
Mail Order Out-of-Pocket Maximum	Medical out-of-pocket maximum applies	

*See the benefits booklet for more information.

Medical Plan Contacts

Plan Type	Provider	Phone Number	Website	Group Number
Medical				
Medical	**Accolade for Blue Shield**	(866) 406-1275	member.accolade.com	W8002724
Pharmacy				
PPO & EPO Pharmacy	**Express Scripts for EPO/PPO plans**	(877) 554-3091	express-scripts.com	**RxBIN:** 610014 **RxGrp:** RX4EIAH
HDHP Pharmacy	**Accolade for Blue Shield Pharmacy**	(866) 406-1275	member.accolade.com	N/A
Specialty Pharmacy	**Accredo**	(800) 683-1074	express-scripts.com	N/A
Rx N Go (For Free Generic Maintenance Medications)	**Rx N Go**	(888) 697-9646	rxngo.com	N/A
NEW Amazon Rx mail order Service **for HDHP.**	**Amazon**	(855) 206-3605	pharmacy.amazon.com/pyr/blueshieldca	N/A

Other Resources

Plan Type	Provider	Phone Number	Website	Group Number
Surgical Benefit	**Carrum Health**	(888) 855-7806	carrum.me/prism	N/A
Mental Health Support	**Accolade Care**	(866) 406-1275	member.accolade.com	N/A
Virtual Health Help	**Headspace**		work.headspace.com/slo/member-enroll	N/A
MSK Benefit	**Hinge Health**	(855) 902-2777	hingehealth.com/prism	N/A
Diabetes Management	**Livongo**	(800) 945-4355	Welcome.livongo.com/prism	Company Code: PRISM
Employee Health Clinic	**Employee Health Clinic**	(805) 754-2037	1485 Kansas Avenue, San Luis Obispo, CA 83405	N/A
Employee Assistance Program	**Anthem EAP**	(833) 954-1067	anthemEAP.com	N/A
Digestive Health Program	**Cylinder**		go.cylinderhealth.com/SLO/	N/A

*** Please click below to access the 2025 Benefits Brochure for more in-depth plan and coverage information:**

2025 Benefits Brochure