2019

County of San Luis Obispo Employee Benefits Brochure

2019 OPEN ENROLLMENT:
OCTOBER 1 – OCTOBER 18, 2018

www.slocounty.ca.gov/2019OE

www.BenXcel.net

COUNTY OF SAN LUIS OBISPO

2019 Open Enrollment Checklist

Check When Completed	Action Item	Due Date
☐	Attend the Benefits Fair to Get Your Questions Answered by the Carriers	September 12th (Vets Hall)
☐	Attend an Open Enrollment Educational Workshop (Optional)	October 3 or October 4 Webinar: October 10th
☐	Review Benefits and Select a New Medical Plan or Decide to Continue with Your Current Plan	October 1- 18
☐	Edit or Verify Dependent Information	October 1- 18
☐	Make Benefits Elections Online at BenXcel.net	October 1- 18
☐	Upload Any Required Documentation for new coverage or new dependents (ex. Birth or Marriage Certificate, etc.)	October 1- 18
☐	Print Confirmation Statement from BenXcel and Save for Your Records	October 1- 18
☐	Check Your First Paystub of 2019 to Ensure Your Deductions Match What You Intended to Enrolled In.	January 2019
☐	Receive new Anthem ID cards: All employees enrolled in medical will receive new ID cards, even if no changes are made, plan names will be added to them for 2019.	December

What Do I Do If…?	You Can:
Enrollment Issues/Questions ▪ I can't remember my password for BenXcel ▪ I'm in BenXcel to change my benefits during Open Enrollment but I am having system issues	Call BCC at 1-800-685-6100.
Medical Issues/Questions ▪ I want to check if my provider is in Anthem's network ▪ I have a question about how my plan covers a certain service or procedure ▪ I lost my medical ID card and need a new one ▪ I received a bill from medical provider and I don't think it's right	Call Anthem at 1-800-967-3015 *or* Create an online Anthem account to print a copy of your ID card, view your recent claims or plan documents, estimate a cost for a procedure, and so much more!
Pharmacy Issues/Questions ▪ I have questions on the cost of my medication ▪ I want to check if my medication is on the formulary ▪ I lost my pharmacy card and need a new one ▪ I want to refill a medication ▪ I want to learn more about the mail-order pharmacy option	Call Express Scripts at 1-877-554-3091 *or* Create an online Express Scripts account to print a copy of your ID card, price a medication, order a refill, set up mail-order, find a pharmacy, and so much more!
Dental Issues/Questions ▪ I want to check if there are any dentists in my area ▪ I have questions about my dental coverage ▪ I have a billing question	Call Aetna at 1-877-238-6200 *or* Call Delta Dental at 1-888-335-8227
Vision Issues/Questions ▪ I want to know which providers near me accept VSP ▪ I have questions about my vision coverage	Call VSP at 1-800-877-7195
Carrum Health Surgical Benefit Questions ▪ I want to learn more about the Carrum Health surgical benefit program. ▪ I want to know if a certain procedure is covered	Call Carrum at 1-888-855-7806 *or* Create an account at www.carrum.me/EIAHEALTH
Medicare Transition Questions ▪ I am an employee turning 65 and I want to know what I need to do in regard to Medicare and Social Security.	As long as you are employed, you are not eligible to enroll in a County Medicare plan or a private market Medicare supplement. You are eligible to enroll in a group Medicare supplement through a spouse. For general information on what to do when you turn 65 in regard to Social Security & Medicare, you can call the Central Coast Commission for Senior Citizens at 805-928-5663 to speak to a Medicare Counselor from their Health Insurance Counseling & Advocacy Program (HICAP).

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2019 OPEN ENROLLMENT

LET'S TALK BENEFITS

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to the Evidence of Converges (EOCs) available at www.slocounty.ca.gov/2018EOCs. The plan benefit booklets determine how all benefits are paid. A list of plan contacts is included at the back of this guide.

No action is required this Open Enrollment if you do not wish to make any changes to your benefit elections or your dependents.

(You must take action if you waive medical or would like to contribute to an FSA account.)

Important Eligibility Information

- Employees that waive County medical insurance will be required to upload proof of other group coverage online by October 18th.

BENEFITS EFFECTIVE DATE:

January 1, 2019 - December 31, 2019

2018 OPEN ENROLLMENT PERIOD:

October 1 – October 18, 2018

WHAT IS NEW IN 2019?

No Action Required This Open Enrollment

Employees who do not want to change benefits or add dependents do not need to re-enroll in 2019 benefits. Your current election will roll over to 2019 Plan Year. If you want to continue your Health FSA or Dependent FSA, you must re-enroll in that plan. The FSA plans will not roll over.

Coverage	Benefit Plan Changes
Medical	**New Plan Available**: A High Deductible Health Plan (HDHP) will now be offered along with a corresponding Health Savings Account (HSA). A limited purpose dental and vision FSA will be available for employees who elect the option for an HSA. They are still eligible for the full Dependent Care FSA. **Peace Officer:** Due to low enrollment, similar premiums, and richer benefits offered on other plans, the Anthem Peace Officer plan will not be offered in 2019. Participants in this plan will be automatically transitioned to the plan offering at least equal, and greater benefits, Anthem Care, effective 1/1/2019. No action is required during Open Enrollment for medical unless employees want to elect a plan other than Anthem Care.
Pharmacy	**Anthem EPO Benefit Enhancement**: All employees, excluding those enrolled in the HDHP, will now have the same pharmacy benefit. This change will reduce out of pocket maximum for those enrolled in the Anthem EPO plan. **HDHP:** Pharmacy expenses are included as a part of the annual deductible and out of pocket maximum for the HDHP. **All Plans:** Express Scripts will continue to update their formulary on January 1 and July 1 of each year.
Dental	**Delta Dental Benefit Enhancement**: Diagnostic & Preventative service charges will be excluded from the maximum annual benefit. This will provide employees with more dollars to spend, should they need services that apply to their maximum benefit, even if they receive their routine cleanings. **Aetna Dental**: No plan changes.
Vision	**VSP Benefit Enhancements:** Standard progressive lenses will now be covered in full for no additional cost. In addition, an extra $20 will be added to employees' frame allowance for select name brands.
FSA	**Benefit Enhancements:** Employees will be able to roll over $500 per year of their 2019 FSA account balance, effective 1/1/2020. Contribution limits will be increased to the 2019 IRS maximum contributions. Prior year contribution amounts will NOT automatically roll over, employees must elect a specific amount of dollars to contribute to their FSA annually during Open Enrollment.
Voya & Aflac	**Rule Change**: Employees will only be able to enroll in or drop voluntary Voya & Aflac coverages during Open Enrollment or when select qualifying events occur.

YOUR OPEN ENROLLMENT RESOURCES

Visit Your 2019 Open Enrollment Webpage

Visit www.slocounty.ca.gov/2019OE for the latest information available. This page will be updated regularly and is your best source of information. You will be able to view copies of all presentations given throughout Open Enrollment on this page if you are unable to attend in-person.

Attend the Benefits Fair (September 12th)

The Benefits Fair will be held on September 12th from 10:0am-4:00pm at the Vets Hall in SLO. This is your best chance to get your questions answered directly by the carriers. Shuttles will run from the Health Agency Campus, SLO Department of Social Services, & the New Government Center to the Vets Hall throughout the day. There will be raffles, free flu shots with your Anthem ID Card, health screenings, etc. We also encourage you to check out the workshops we have scheduled throughout the day on the High Deductible Health Plan/Health Savings Account, How to Maximize Your PPO, 2019 Benefits Review, Express Scripts, and Voluntary Coverage (Aflac & Voya) that will contain a lot of great information.

Contact Your Insurance Carriers for Plan Benefit Questions

Contact information for carriers like Anthem, Aetna and VSP is available on the back of this brochure. We encourage you to reach out to them with your personal questions for the quickest response.

Watch the Benefits Overview Webinar

An online webinar will be posted on October 10th for those unable to attend any of the in-person opportunities. You can view this webinar at www.slocounty.ca.gov/20190E.

Educational Workshops: 2019 Benefits Overview

The Benefits team will also hold Educational Workshops to review the County Benefits and take questions. To register for a workshop please visit NeoGov Learn. Registration for each workshop will be closed when capacity is filled. A copy of the presentation will also be available on our Open Enrollment webpage.

Date	Time	Location	Room
10/3	**9:30-10:30am**	**Atascadero Library:** 6555 Capistrano Ave, Atascadero	**Conference Room**
10/3	**11:00am-12:00pm**	**Atascadero Library:** 6555 Capistrano Ave, Atascadero	**Conference Room**
10/3	**1:00-2:00pm**	**Atascadero Library:** 6555 Capistrano Ave, Atascadero	**Conference Room**
10/3	**3:00-4:00pm**	**Atascadero Library:** 6555 Capistrano Ave, Atascadero	**Conference Room**
10/4	**9:00-10:00am**	**New Government Center:** 1055 Monterey St. SLO	**BOS Chambers**
10/4	**10:30-11:30am**	**New Government Center:** 1055 Monterey St. SLO	**BOS Chambers**
10/4	**12:00-1:00pm**	**New Government Center:** 1055 Monterey St. SLO	**BOS Chambers**
10/4	**3:00-4:00pm**	**New Government Center:** 1055 Monterey St. SLO	**BOS Chambers**

ENROLLMENT TIPS

REMEMBER

Open Enrollment will take place from **October 1 – October 18, 2018.** During this time, you are able to enroll in new programs, edit dependents, and make changes to your current benefits. Remember, this year the County will be having a **passive enrollment**, meaning you **do not need to take action**. If you want to **continue** your Health FSA or Dependent FSA **you must re-enroll** in that plan. The FSA contribution **will not automatically roll over.**

What Actions Can I Take?

- **Enroll** in any of the County-sponsored plans and voluntary benefits;
- **Add** dependent coverage
- **Add, change, or cancel** your voluntary Life, Disability, Critical Illness, and/or Accident Insurance;
- **Participate** for the first time or continue to participate in FSA Healthcare or Dependent Care or Limited FSA if enrolled in HDHP & HSA plan;
- **Opt out or waive** participation in County sponsored medical benefits. If you opt out of medical insurance you will be required to provide proof of other group coverage. You will not be eligible to participate in benefits until the next open enrollment period unless you have a qualifying event.
- **Combine coverage** with a spouse or registered domestic partner who is also a benefit eligible County employee.

How do I Enroll?

You must **go online** to the County's eBenefits website, www.benxcel.net, to enroll, add dependent, FSA or Dependent Care enrollment, address changes and personal information updates. To access the online enrollment following the steps below:

1. Website: https://www.benxcel.net
2. Enter your user information:
    a. **USER ID:** First letter of first name, full last name, entire DOB
        i. EX: Judy Smith-Doe DOB:01/25/1973 USER ID: jsmithdoe01251973
    b. **PASSWORD:** Your password will be what you set it to last Open Enrollment. If you cannot remember it, you can click the Reset Password button on the login page or call BCC at 1-800-685-6100 for a reset.
3. For Company Name Type: SLO
4. Click the Sign In button to enter the system
5. Follow the system prompts to review the benefit options and begin making elections
6. Note: A confirmation statement will appear when the enrollment is complete. Please save or print for your records.

If you do not have the Employee Guide to BenXcel you can get a copy at www.slocounty.ca.gov/2019OE.
If you are having system issues or have forgotten your username and/or password, you must call BCC at 1-800-685-6100 for assistance. If you enter wrong username or password more than 5 times, you will be locked out and will need to call BCC.

WHO CAN YOU COVER?

WHO IS ELIGIBLE?

Permanent, Part-time and Full-time employees working 20 or more hours per week are eligible for the benefits as outlined in your respective labor agreements. You can enroll the following family members in medical, dental and vision plans.

1. Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
2. Your domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit.
3. Your children (including stepchildren or domestic partner's children):
    - Children under age 26 are eligible to enroll in health coverage. They do not have to live with you or be enrolled in school.
    - Children you have legal guardianship of or those named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.
    - Children over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

1. Parents, grandparents, siblings and former spouses.
2. Employees who work fewer than 20 hours per week, temporary employees, contract employees, or employees residing outside the United States.
3. Stepchildren of former spouses or dependents without a legal arrangement.

ENROLLMENT PERIODS AND QUALIFYING EVENTS

Coverage for new permanent employees begins on the 1st of the month following date of hire. After that, Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying event.

It is your responsibility to login online at www.benxcel.net **within 31 days if you have a qualifying event outside of Open Enrollment and you would like to make changes. Click here to watch an instructional video on how to initiate a Qualifying Event.**

Qualifying Events Include:

- Marriage, divorce or death
- Birth or adoption of a baby or child
- Loss of other group healthcare coverage
- New eligibility for other group healthcare coverage
- Status change from Temporary to Permanent
- Retirement
- Returning to work from non-pay status/leave

DEPENDENT ELIBIGILITY DOCUMENTATION

Dependent Type	Required Documentation	Resources to Obtain Documentation
Dependent Spouse (same or opposite gender)	Add: Marriage Certificate Remove: Divorce Decree	• County office that issued original marriage Certificate • **www.vitalchek.com**
Registered Domestic Partner	Add: State of California, County or City issued Declaration/Certificate of Domestic partnership Remove: Termination of Domestic Partnership	• County/City office that issued original certificate • **http://www.sos.ca.gov/dpregistry/**
Dependent child by birth	Birth Certificate (must include parents name), **and/or** copies of any court orders, divorce decrees **or** other legal documents relating to custody or health coverage.	• County office that issued original birth certificate • Hospital in which child was born • U.S. Department of State (for children born outside of the U.S) • Social Security Administration • **www.vitalchek.com**
Dependent child by adoption	Final Adoption Papers **and/or** copies of any court orders, divorce decrees or other legal documents relating to custody or health coverage	• State agency that issued final adoption papers • Adoption agency that issued placement papers • Social Security Administration
Dependent stepchild(ren)	Marriage Certificate **and** Birth Certificate (must include parents name), and/or copies of any court orders, divorce decrees or other legal documents relating to custody, health coverage or income tax exemptions	• County office that issued original birth certificate • Hospital in which child was born • U.S. Department of State (for children born outside of the U.S) • Social Security Administration • **www.vitalchek.com**
Dependent child Legal Guardianship	Birth Certificate (must include parents name), **and** copies of any court orders or other legal documents relating to custody or health coverage	• County office that issued original birth certificate • Hospital in which child was born • U.S. Department of State (for children born outside of the U.S) • Social Security Administration **www.vitalchek.com**

Note: Social Security Numbers (SSN) are required to enroll all dependents. For the birth of a child, you will have 60 days to provide the SSN.

CARRUM HEALTH

Get access to the best surgeons without the worry of medical bills.

Carrum Health is specifically designed to help you find answers to your healthcare questions and deliver a superior experience for you and your family. Learning you need surgery can be stressful. That's where we can help!

ELIGIBLE PROCEDURES INCLUDE:

- Shoulder
- Ankle / Foot
- Elbow
- Spine
- Wrist / Hand
- Bariatric*
- Hip
- Cardiac
- Knee
- Pain Management

Hoag Orthopedic Institute
ORANGE COUNTY
80 NEW OUTPATIENT PROCEDURES

NEW LOCATION
PROVIDENCE Saint John's Health Center
SANTA MONICA

EXPLORE MORE
Visit: carrum.me/EIAHEALTH
Text: "EIA" to 555888
Call us: 1-888-855-7806

Carrum Health is a special surgery benefit for active employees, early retirees, COBRA participants and their dependents on EIA Health Anthem, Blue Shield or Delta Health Systems plans. *Bariatric surgery is only available through Carrum Health if it is a covered benefit under your employer's health plan.

CARRUM HEALTH FAQs

What is Carrum Health and how does it benefit me?

Carrum Health is a special surgery benefit that provides exclusive access to "Centers of Excellence". These facilities and doctors provide for an improved patient experience, high quality of care, and zero or minimal out-of-pocket costs.

Which procedures are covered?

For a full list of eligible procedures, register and log in at www.carrum.me/EIAHEALTH or contact Carrum Health.

Who is eligible for the program?

Active employees, early retirees, COBRA participants and their dependents on EIA Health Anthem, Blue Shield or Delta Health Systems plans are eligible for this program.

How do I qualify for these services?

The following criteria must be met to qualify for the Carrum Health program:

1. You have primary medical coverage through the Excess Insurance Authority PPO, EPO and HDHP plans.
2. You meet requirements of the hospital/surgical center physician(s) considering your case. Additional diagnostic or medical services may be required.
3. Your local physician agrees to assume care for you upon return home.
4. You have an adult caregiver physically able to assist you during your care and travel if needed.

What forms do I need to complete? Do I need to provide medical records?

Upon verification of eligibility, your Carrum Health Care Concierge will help you complete the acknowledgment, authorization and medical records release forms. After that, your Carrum Health Care Concierge takes care of gathering and transferring all your medical records to your chosen hospital/surgical center.

Which services and expenses are covered?

Coverage includes the following:

1. All eligible medical expenses associated with your evaluation or procedure at the facility.
2. Travel expenses for you and one adult companion including transportation, lodging, and a daily allowance.
3. Medically necessary services or equipment related to this program provided after discharge from the facility before returning home (excluding outpatient medication).

Which travel expenses are covered? The following expenses are covered for you and one companion:

1. Transportation – air, train, bus, rental car or mileage allowance (if driving your own car).
2. Lodging – one hotel room to be shared by you and one adult companion.
3. Meals – a daily allowance.
4. Parking and baggage fees – as appropriate.

Per IRS rules, a portion of the covered travel expenses will be reported as taxable income to the employee. Due to IRS regulations, on HSA plans the deductible applies but coinsurance is waived.

Who manages my travel?

Your personal Carrum Health Care Concierge will make all travel arrangements for you and one adult companion.

SOLERA HEALTH: DIABETES PREVENTION PROGRAM

86 million Americans have pre-diabetes but losing just 5-7% body weight through diet changes and increasing physical activity can help decrease the risk of it developing into Type 2 diabetes.

You may qualify for Solera Health, a *free* program offered by Anthem that matches you with an industry leading network partner based on your preferences to find the best fit for you. You can choose from a variety of options including access to a personal health coach, weekly lessons, a support group, or tools like a Fitbit or a wireless scale *at no cost to you.*

To see if you qualify for this program, you can either submit blood screen results to Solera or click here and take the confidential online quiz.

What is the Solera4me Lifestyle Change Program?

Also known as the Diabetes Prevention Program (DPP), the lifestyle change program helps participants lose weight, adopt healthy habits and significantly decrease their risk of developing type 2 diabetes. The program meets weekly for 16 weeks and then monthly for the balance of a year. The program teaches participants to make lasting changes by eating healthier, increasing physical activity, and managing the challenges that come with lifestyle change.

What's included in the program?

There are many versions of the lifestyle change program, but most include the following components:

- 16 weekly lessons followed by monthly sessions for the rest of the year
- Lifestyle health coach to help set goals and keep participants on track
- Small group for support and encouragement
- Helpful tools, like wireless scales and fitness trackers

How do members find out if they qualify?

Members who are identified as having prediabetes or who score as high risk for developing type 2 diabetes can qualify for the program. Members should visit solera4me.com/eia and take a 1-minute quiz to see if they qualify.

If they're qualified, how do members enroll for the lifestyle change program?

Members should visit solera4me.com/eia to learn more about the program and to enroll; or they can call 1-877–486–0141 to enroll over the phone. Once enrolled, members will receive a Welcome Email from Solera with instructions on how to complete the registration process with their matched DPP provider. Members must complete the registration process with their DPP provider to begin the program.

If they're qualified, how do members enroll for the lifestyle change program?

This program is at no cost to members if they are covered by a participating health plan. Once a member enrolls in the program on Solera4Me.com, their health plan provider will receive a claim from Solera to cover the program services for this preventive benefit. Members may receive an Explanation of Benefits (EOB) from their health plan for this benefit. No action is necessary if a member receives an EOB. DPP is a covered preventive benefit.

2019 FREQUENTLY ASKED QUESTIONS

Do I need to re-enroll in 2019 benefits?

No. This year is a passive enrollment. If you do not wish to make changes your current benefits will rollover to 2019 plan year. If you waive County medical, you will be required to login in, elect to waive again, and upload your poof of other coverage. If you want to continue your Health FSA or Dependent FSA **you must re-enroll** in that plan. **The FSA plans will not roll over.**

What happens if I am currently enrolled in Anthem Peace Officer PPO plan?

Effective January 1, 2019, this plan will no longer be offered due to low enrollment, similar premiums and enriched benefits offered on other plans. You will be automatically transitioned to Anthem Care effective 1/1/2019. Anthem Care provides a potential savings of $2,500 for an individual or $5,000 for a family due to a lower Out of Pocket Maximum. Care also provides access to the same network of providers & pharmacy benefit and comparable medical benefits coverage including copays and insurance at a similar monthly premium. No action is required unless you want to enroll in a medical plan other than Anthem Care.

2018 PLAN	2019 EQUIVALENT PLAN
N/A	***NEW*** **Anthem High Deductible Health Plan (HDHP) with Health Savings Account (HSA)**
Anthem Peace Officer PPO	Anthem Care PPO
Anthem Select PPO	Anthem Select PPO
Anthem Care PPO	Anthem Care PPO
Anthem Choice PPO	Anthem Choice PPO
Anthem EPO	Anthem EPO

What is the difference between the High Deductible Health Plan (HDHP) and PPO plans?

Click here to watch a video about the differences between HDHP and PPO plans.

Will my dependent(s) coverage automatically transfer over for medical, dental and vision insurance?

Yes, if you are not making changes to your benefits, then you do not need to login to BenXcel online. However, it is encouraged you logon to verify your dependents and elections.

Will I receive a new pharmacy and medical ID card?

All employees will receive a new medical ID card, even if you do not change your benefits, because we will be adding plan names on to them. You will not receive a new pharmacy ID card unless you are changing plans. The County does not receive a copy of your ID card or your member ID numbers.

Where can I get more information on the 2019 Benefits?

The 2019 Open Enrollment webpage contains the most up to date information including valuable resources such as plan documents, other resources, and contact information for all the carriers.

GENERAL FREQUENTLY ASKED QUESTIONS

I waive medical coverage, what documents are acceptable for proof of other coverage?

In order to opt-out of County medical coverage you must submit proof of other group coverage. Proof of other coverage documents should contain the insurance carrier name, group/employer name, member name and covered dependent names, plan name and plan effective date.

Example of acceptable documents include:

a. A copy of your medical insurance ID card indicating you are a covered member and that coverage is effective for the upcoming plan year
b. A letter from your insurance carrier stating your name as a covered member and your coverage effective date
c. A letter from the employer that states that plan name and that you are a covered member for the upcoming plan year
d. A recent open enrollment confirmation statement from an employer stating the plan name, covered members and coverage effective dates

Documents that are not acceptable include:

a. COBRA documentation
b. Medical ID cards without your name or a coverage tier (ex: family) listed on them or a plan effective date
c. Medi-Cal Paperwork (Employees are not eligible for Medi-Cal)

I have a claims question, what should I do?

Claims questions should first be addressed with your provider. Always verify that you are utilizing your newest ID card and that the provider HSA billed the correct group number and member ID. If your provider is having an issue verifying your eligibility they are able to contact Anthem directly to resolve any billing issues. When your provider bills Anthem an Explanation of Benefits (EOB) will be generated outlying the amount that you owe. If your provider bills you a different amount than what is on your EOB, contact your provider to resolve. If you believe there is an error on your EOB, contact Anthem. Click here to learn about balance billing and how to prevent this.

What is Ben-IQ?

Take a tour of Ben-IQ. It will walk you through all of the features that are available to you by downloading the app. You will learn how to review the plan summaries and where to find important contacts like our nurse line. You can store and organize ID cards by using your phone's camera, and much more! Be sure to share Ben-IQ with your covered family members too. The access code is **SLO**

Is COBRA coverage available to my dependent who is turning 26 and no longer eligible to be on my plan?

Yes. COBRA coverage will normally be available for a maximum of 36 months for your dependent aging out of eligibility (age 26). The cost for coverage is the monthly cost of insurance plus a 2% administrative fee. For more information on COBRA coverage, please contact our Benefits third party administrator, BCC at 1-800-685-6100.

Do we have dental & vision ID Cards?

Aetna, Delta, and VSP do not issue ID cards. You can download and print an ID card by logging into their website. To utilize these benefits, provide the plan group number along with the Social Security Number (SSN) of the member. Plan group numbers can be found on page 34 of this brochure.

2019 HEALTH PREMIUM RATES (EFFECTIVE 1/1/2019)

MEDICAL

Plan/Coverage Type	Semi-Monthly Premium	Monthly Premium	Plan/Coverage Type	Semi-Monthly Premium	Monthly Premium
EIA Anthem Select			**EIA Anthem EPO**		
Employee Only	$269.70	$539.40	Employee Only	$374.20	$748.40
Employee + 1	$532.20	$1,064.40	Employee + 1	$744.20	$1,488.40
Family	$693.70	$1,387.40	Family	$971.20	$1,942.40
EIA Anthem Choice			**EIA Anthem High Deductible Health Plan (HDHP)**		
Employee Only	$303.70	$607.40	Employee Only	$254.83	$509.65
Employee + 1	$600.20	$1,200.40	Employee + 1	$502.83	$1,005.65
Family	$782.20	$1,564.40	Family	$654.83	$1,309.65
EIA Anthem Care					
Employee Only	$316.20	$632.40			
Employee + 1	$626.20	$1,252.40			
Family	$816.70	$1,633.40			

DENTAL & VISION

Plan/Coverage Type	Bi-Monthly Premium	Monthly Premium	Plan/Coverage Type	Bi-Monthly Premium	Monthly Premium
Aetna Dental DMO			**Delta Dental**		
Employee Only	$15.94	$31.88	Employee Only	$25.12	$50.24
Employee + 1	$26.36	$52.72	Employee + 1	$42.70	$85.40
Family	$38.94	$77.88	Family	$65.30	$130.60
VSP Vision					
Employee Only	$4.77	$9.54			
Employee + 1	$7.27	$14.54			
Family	$11.76	$23.52			

NEW! HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

	Anthem HDHP & HSA	
	In-Network	**Out-of-Network**
Calendar Year Deductible		
Individual/Family	$2,000 / $6,000 Aggregate	$2,000 / $6,000 Aggregate
Annual Out-of-Pocket Maximum		
Individual / Family	$6,350 / $12,700 Embedded	$6,600 / $15,000 Embedded
Physician Office Visit	20%	40%
Specialist Copay	20%	40%
Preventative Care	No Charge (Deductible Waived)	10%
Lab and X-Ray		
CT, MRI, PET scans	20%	40%
Other lab and x-ray tests	20%	40%
Hospitalization		
Inpatient	20%	40%
Outpatient	20%	40%
Emergency Room	20%	40%
Urgent Care Services	20%	40%
Durable Medical Equipment	20%	40%
Chiropractic / Acupuncture Care	20%	40%
	PREMIUMS	
Plan/Coverage Type	**Anthem HDHP & HSA Monthly Cost**	
Single	$509.65	
Two Party	$1,005.65	
Family	$1,309.65	
Provider Network	Blue Cross PPO (Prudent Buyer) - Large Group	

Please watch the below video for an overview of how a High Deductible Health Plan (HDHP) works with a Health Savings Account (HSA):

UNDERSTANDING HIGH DEDUCTIBLE HEALTH PLANS & HEALTH SAVINGS ACCOUNTS (HSA)

HDHP: HOW DOES IT WORK?

A High Deductible Health Plan (HDHP) is a health plan product that combines a Health Savings Account (HSA) with traditional medical coverage. It provides insurance coverage and a tax-advantaged way to help save for future medical expenses. HDHPs have higher annual deductibles and out-of-pocket maximum limits than other PPO plans.

- With a HDHP, the annual deductible must be met *before* plan benefits are paid for services other than in-network preventive care services, which are covered 100%. Once your annual out-of-pocket expenses for covered services from in-network providers, including deductibles, copayments and coinsurance, reaches the pre-determined out-of-pocket limit, the plan pays 100% of the allowable amount for the remainder of the calendar year.
- One key difference to note is that you are required to meet your medical annual deductible for both medical expenses *and* prescription drugs before the plan's coinsurance cost sharing begins. Please see page 19 for more information on pharmacy coverage under a HDHP.

HSA: HOW DOES IT WORK?

A Health Savings Account allows employees to pay for current health expenses and save for future qualified medical expenses on a pre-tax basis. Funds deposited into an HSA are not taxed, the balance in the HSA grows tax free, and that amount is available on a tax-free basis to pay medical costs.

- You elect your annual contribution amount to your HSA up to the IRS maximum and it is deducted each pay period, pre-tax . You may change the deduction amounts at any time. The contributions are subject to CA state taxes.
- Your HSA contributions roll over year to year, they are not use it or lose it. There is an IRS limit to how much you can contribute annually, but there is no limit to how much you can accumulate over time.
- Simply use your HSA debit card to pay for qualified medical expenses through My SmartCare.
- HSA funds can be used to pay for qualified medical expenses of IRS tax dependents, even if the dependent is not enrolled in your HDHP.
- To contribute to an HSA, you may not be enrolled in any other non-HDHP coverage, including your own or a spouse's general-purpose Healthcare FSA.

The Triple Tax Savings of an HSA		
Pre-Tax Contributions Through Payroll Deductions	Tax-Free Interest & Investment Earnings	Tax-Free Deductions for Qualified Medical Expenses

Be sure to review IRS guidelines to determine if you are eligible to contribute to an HSA *before* enrolling in the HDHP.

IMPORTANT HSA ELIGIBLITY NOTE:
HDHP/HSA participants may not contribute to the Healthcare FSA, but may enroll in the Limited-Purpose Healthcare FSA, which can only be used for qualified dental & vision expenses.

2019 HSA Contribution Limits	
Individual: $3,500	**Family:** $7,000

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) FAQs

What are the advantages of enrolling in a HDHP?

a. Premiums are typically lower than PPO plans.
b. If you are a low utilizer of your medical & prescription benefit you may able to save money.
c. You can combine your HDHP with a Health Savings Account that HAS a triple tax benefit. The triple tax benefit for the HAS is 1. Pre-tax payroll deductions, no tax on any interest accrued, and tax-free withdrawals for any qualified medical expenses. You may also withdraw your funds at the normal tax rate for non-qualified medical expenses when you are 65 or older without a penalty.

Are there any risks to enrolling in a HDHP?

a. While you will never pay more than your out-of-pocket maximum, HDHPs have higher annual deductibles and out-of-pocket maximum limits than traditional health plan options. With a HDHP, you pay for all of your health expenses except preventative care until you meet your annual deductible. Once your annual deductible is met the plan will begin cost sharing until you meet the annual out-of-pocket maximum. Once you meet the out-of-pocket maximum the plan will pay 100% for the plan year.
b. One key difference to note from a traditional PPO health plan is that you are required to meet your medical annual deductible before prescription drugs are covered under a coinsurance cost sharing. You are likely to pay more for your prescription drugs with a HDHP than a traditional PPO health plan.

Is my pharmacy and prescription drug benefit the same as other County plans?

No, your pharmacy benefit is not the same as the other County plans. Under the HDHP you are responsible for the full cost of your medications until you reach your annual deductible, there are no co-pays. Please see page 19 for more information on the pharmacy benefit for the HDHP.

How does the annual deductible and out-of-pocket maximum (OOPM) work for the HDHP?

a. The HDHP Plan has an aggregate deductible and embedded out-of-pocket maximum.
b. For Employee only coverage this means you will have to pay for medical and pharmacy expenses up to the individual deductible amount until the plan co-insurance, or cost sharing, benefits begin. You will pay no more than the plans individual out-of-pocket maximum.
c. For employees with dependents, your family will have to pay for medical and pharmacy expenses up to the family deductible amount anytime anyone utilizes services. You can meet the family deductible because of medical care to one person or from expenses incurred by the entire family. Once the family deductible is met, the co-insurance or cost sharing benefits of the plan begin until the out-of-pocket maximum limits are met. Once an individual meets the individual OOPM, the plan will pay 100% of all covered expenses for that person, even if the family OOPM has not been met. Once the family OOPM is reached the plan must pay 100% of all covered expenses for everyone — regardless of whether each family member has reached the individual maximum.

Is a HDHP right for me?

HDHPs are not right for everyone and there are many factors to consider before enrolling in this plan type. While many people may initially be skeptical of HDHPs, they can be a reasonable choice for many and can be particularly valuable if you know how to use them effectively. For individuals covered by a HDHP, an HSA offers several benefits. Money that may otherwise be lost to high premiums could be invested in a tax-free, interest-bearing HSA and withdrawn tax-free for qualified medical expenses, resulting in a triple-tax savings. For those with higher medical expenses who are also financial planners, a HDHP combined with an HSA still may provide overall cost savings as compared to a traditional plan with higher premiums and out of pocket maximums. A HDHP can also be a good option for a healthy young employee with few anticipated medical needs.

HEALTH SAVINGS ACCOUNT (HSA) FAQs

Do my HSA contributions roll over?

Yes, HSA contributions roll over year to year and you can invest some your savings once you have accumulated over $1,000 in the account. There is a limit to how much you can contribute annually, but there is no limit to how much you can rollover year to year.

Am I required to enroll in the HSA if I enroll in the High Deductible Health Plan?

You are not required to enroll in an HSA when you enroll in a HDHP, but it is highly recommended you do & contribute at least the amount of your deductible in the event you have an unexpected medical expense. You cannot enroll in the HSA if you are not enrolled in the HDHP.

Do my medical expenses have to occur in the same year as the contribution like an FSA?

No, because your contributions roll over year to year, your medical expenses do not have to occur in the same year as your contributions. You can build up your HSA during the years you have low medical expenses to help you out during the years you have a high volume of medical expenses.

Can I contribute both to a Healthcare FSA and an HSA if I am enrolled in the HDHP?

No, the IRS does not allow you to contribute to both an HSA and a full Healthcare FSA. However, you do have the option to pair your HSA with a Limited Purpose Dental & Vision FSA. Please see page 24 for more information on the limited Purpose FSA. You can enroll in the regular Dependent Care FSA even if you are enrolled in the HSA.

What are my options for withdrawing from my HSA?

1. You can always withdraw tax-free from your HSA for qualified medical expenses.
2. If you are under age 65 you can withdraw from your HSA for non-medical expenses, but you will be subject to regualr tax rates and a 20% penalty.
3. If you are over age 65 you can withdraw from your HSA for non-medical expenses, but it will be subject to regular tax rates. There will be no penalty.

What happens to my HSA if I separate or retire from the County?

The HSA is portable; it goes with you if you leave employment.

Are there any eligibility requirements to contribute to an HSA?

Yes. IRS requirements include; you must be enrolled in a HDHP, you cannot be covered by another medical plan that is not a HDHP, you cannot be enrolled in Medicare, you cannot be claimed on another person's tax return (other than a spouse), and you cannot be covered by a spouse's Healthcare FSA. For more information on HSA eligibility, contact your tax advisor or review the IRS' guidelines here. It is your responsibility to determine your eligibility before enrolling in the HSA.

How do I access my HSA funds when I have a qualified medical expense?

When you enroll in the HDHP, an account will be set up for you with the County's HSA administrator, SmartCare. You will receive a welcome email and packet from SmartCare with information on how to access your account. You will have access to a convenient debit card that you can just swipe for qualified medical expenses. If you pair your HSA with a Limited-Purpose Dental & Vision FSA, you can use the same debit card for both accounts and it will know which account to withdraw the funds from based off of what you are purchasing. You can also submit claims through the My SmartCare app or the website if you do not wish to use the debit card.

2019 MEDICAL PPOs & EPO

2019 Plans	Anthem Select PPO		Anthem Choice PPO		Anthem Care PPO		Anthem EPO
2018 Plan Migration	Anthem Select PPO		Anthem Choice PPO		Anthem Peace Officer		Anthem EPO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Calendar Year Deductible							
Individual Family	$500 $1,000		$500 $1,000		$500 $1,000		
Annual Out-of-Pocket Maximum							
Individual Family	$3,000 $6,000	None	$3,000 $6,000	None	$2,000 $4,000	None	$1,500 / $3,000
Physician Office Visit Deductible Waived	$20 (deductible waived)	40%	$20 (deductible waived)	40%	$20 (deductible waived)	40%	$15 / visit
Specialist Copay Deductible Waived	$20 (deductible waived)	40%	$20 (deductible waived)	40%	$20 (deductible waived)	40%	$15 / visit
Preventative Care	No Charge	40%	No Charge	40%	No Charge	40%	No Charge
Lab and X-Ray							No Charge
CT, MRI, PET scans	20%	40%	20%	40%	10%	40%	No charge
Other lab and x-ray tests	20%	40%	20%	40%	10%	40%	No Charge
Hospitalization							
Inpatient	20%	40%	20%	40%	$250 + 10%	$250 + 40%	No Charge
Outpatient		40%	20%	40%	10%	40%	$15 / Surgery
Emergency Room	$50+ 20% (waived if admitted)	$50 + 20% (waived if admitted)	$50 + 20% (waived if admitted)	$50 + 20% (waived if admitted)	$50 + 10% (waived if admitted)		$50 / Visit (waived if admitted)
Urgent Care Services	$20	40%	$20	40%	$20	40%	$15 / visit
Durable Medical Equipment	20%	40%	20%	40%	10%	40%	No Charge
Chiropractic/ Acupuncture Care	$15 (20 visits combined with acupuncture / calendar year)	40%	$15 (20 visits combined with acupuncture / calendar year)	40%	$15 (20 visits combined with acupuncture / calendar year)	40%	$15 / visit (20 visits per calendar year combined with acupuncture)
	PREMIUMS						
Plan/Coverage Type	Anthem Select PPO Monthly Cost		Anthem Choice PPO Monthly Cost		Anthem Care PPO Monthly Cost		Anthem EPO Monthly Cost
Single	$539.40		$607.40		$632.40		$748.40
Two Party	$1,064.40		$1,200.40		$1,252.40		$1,488.40
Family	$1,387.40		$1,564.40		$1,633.40		$1,942.40
Provider Network	Select PPO – This is a narrow network.		Blue Cross PPO (Prudent Buyer) - Large Group		Blue Cross PPO (Prudent Buyer) - Large Group		Blue Cross PPO (Prudent Buyer) - Large Group

PHARMACY BENEFIT

	Anthem Care PPO, Anthem Choice, Anthem Select & Anthem EPO
Retail Pharmacy	**In-Network**
Annual Out-of-Pocket Limit	$2,000 individual / $4,000 family
Generic	$5 copay
Preferred Brand	$20 copay
Non-preferred Brand	$50 copay
Supply	**30 days**
Mail Order	
Annual Out-of-Pocket Limit	$1,000 Mail Order
Generic	$10 copay
Preferred Brand	$40 copay
Non-preferred Brand	$100 copay
Compound Drug	N/A
Supply	**100 days**

	Anthem HDHP
Retail Pharmacy	**In-Network**
Annual Out-of-Pocket Limit	Medical Deductible Applies
Generic	20%
Preferred Brand	20%
Non-preferred Brand	20%
Supply Limit	**30 days**
Mail Order	
Annual Out-of-Pocket Limit	Medical Deductible Applies
Generic	20%
Preferred Brand	20%
Non-preferred Brand	20%
Compound Drug	N/A
Supply	**100 days**

IMPORTANT HDHP PHARMACY NOTE:

You pay 100% of pharmacy costs until you meet the plan's deductible. This means if your prescription costs $100, you will need to pay the $100 each time you pick it up until you reach your deductible. You do NOT have a set co-pay. Once you meet your deductible, you will have co-insurance coverage, meaning you will pay 20% of your prescription's cost. If your prescription costs $100 and you have met your deductible, you will pay 20% ($20) and the plan will cover the remaining 80% ($80). Once you reach your annual out-of-pocket maximum, the plan will pay 100%.

Note for Out-of-Network benefits - member is responsible for coinsurance in addition to any charges over the allowable amount. When members use non-preferred providers, they must pay the applicable copayment/coinsurance plus any amount that exceeds Anthem's allowable amount. Charges in excess of the allowable amount do not count toward the calendar year deductible or out-of-pocket maximum.

EXPRESS SCRIPTS PHARMACY

Get Started with Home Delivery: Get up to a 90 Day Supply & Pay Lower Copays!

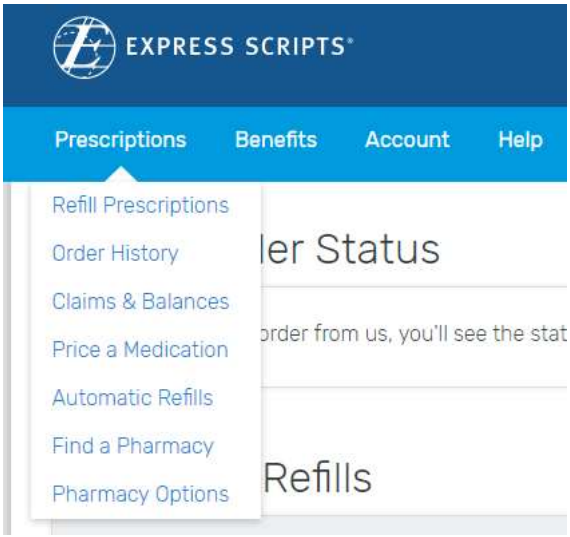
If you take prescription medicine on an ongoing basis, you can order from their convenient home delivery pharmacy. Once you start, you can refill and renew your prescriptions from the website or mobile app - and free standard shipping is included.

To review your home delivery opportunities, go to the website or mobile app and for any medicine that displays the "Transfer to Home Delivery" option, click the button, then select the item and click "add to cart". After you add your retail medicine to the cart, complete the checkout process in order to finalize the transfer to home delivery.

Create an Online Express Scripts Account or Download the App

With an online account or through the app you can access many services wherever you may be. All you need to get started is your member ID on your ID Card or your SSN.

- Set up home delivery & track your delivery
- Order refills
- Price a medication
- Find a pharmacy
- Print a copy of your ID card
- View your RX claims & balances
- View their therapeutic resource centers for information
- And so much more!



www.express-scripts.com

Did You Know?

- If you are currently enrolled in a pharmacy plan, you will not receive a new pharmacy ID card for 2019. If you are enrolling for the first time or making plan changes then you will receive a new ID card in prior to January 1st. Two ID cards are issued to the subscriber with subscriber name only. No ID cards are issued with dependent names.

- You could possibly save money switching to mail order over picking up at a retail pharmacy if you are on any maintenance medications. Your co-pay for a **1**-month supply of a generic medication at a pharmacy is $5 or you can get the same medication, but a **3**-month supply, for a $10 co-pay through mail order. Log on to your online Express Scripts account for more information.

DENTAL

San Luis Obispo County gives you a choice between two dental plans through Aetna and Delta Dental. All employees are required to enroll in a Dental plan. Please refer to the Benefit Summaries for detailed information on how the plan will pay for services. A summary of the plans available to choose from is below:

	Aetna Dental DHMO	Delta Dental DPPO	
	In-Network	In-Network	Out-Of-Network
Calendar Year Deductible	$0	$25 / per person (combined with in-network)	$25 / per person (combined with in-network)
Annual Plan Maximum	None	$1,500	$1,000
Waiting Period	None	None	None
Diagnostic and Preventive	Diagnostic pays: 100% Preventive various copays apply	Plan pays: 100% Diagnostic and Preventive to do count toward annual max	Plan pays: 100%
Basic Services			
Fillings	Plan pays: 100%	Plan pays: 90% after deductible	Plan pays: 80% after deductible
Root Canals	Various copays apply	Plan pays: 90% after deductible	Plan pays: 80% after deductible
Periodontics	Various copays apply	Plan pays: 90% after deductible	Plan pays: 80% after deductible
Major Services	Various copays apply	Plan pays: 50% after deductible	Plan pays: 50% after deductible
Orthodontic Services			
Orthodontia	Patient pays: Screening $30.00 Diagnostic Records $150.00 Treatment $1,545.00 Retention $275	Plan pays: 50% up to $1,500 Lifetime Maximum (Calendar deductible does not apply)	Plan pays: 50% up to $1,500 Lifetime Maximum (Calendar deductible does not apply)
Lifetime Maximum	None (limited to one full course of treatment)	$1,500 Child or Adult	$1,500 Child or Adult (combined with in-network)

PREMIUMS				
	Aetna Dental DHMO Premium		Delta Dental PPO Premium	
Plan/Coverage Type	Semi-Monthly	Monthly	Semi-Monthly	Monthly
Single	$15.94	$31.88	$25.12	$50.24
Two Party	$26.36	$52.72	$42.70	$85.40
Family	$38.94	$77.88	$65.30	$130.60

DENTAL CONTINUED

Aetna Provider Alert

The office of Dr. Latta, Wells, & Poblacion has notified the County they will no longer accept Aetna Dental after 12/31/18. Employees have two options:

1. If you would like to remain on Aetna you must select a new Primary Care Dentist, you can view a list of available dentists in the city of SLO here. You can also run a search of Aetna dentists by zip code at www.aetna.com or by calling Aetna at 1-877-238-6200.
2. If you would like to continue to see Dr. Latta, Wells, or Poblacion you can enroll in Delta Dental where they will continue to be Premier providers. For more information on Premier providers, please see below.

Maximize Your Savings with Delta Dental

Learn How to Save the Most with a PPO Provider

With nearly 80% of practicing dentists in Delta's networks, there is a good chance you are already visiting a Delta Dental provider. To maximize your savings, it is important to be aware of the Delta network the dentist belongs to. Delta has three different networks of providers: PPO, Premier and Non-Delta dentists.

While you can visit any licensed dentist and still receive a benefit, you will save the most by visiting a Delta PPO or Premier dentist. Delta PPO and Premier dentists accept a pre-negotiated fee as payment instead of their usual fee. See below for an illustration of these savings which are outlined below.

Delta Dental PPO: Visit a dentist in this network to maximize your savings. In general, you should expect to save about 30% on contracted services which will help reduce any out of pocket costs you may experience. PPO dentists have pre-negotiated their fees with Delta and have agreed not to balance bill Delta patients.

Delta Dental Premier: You will experience a smaller savings of 8-16% on contracted services by visiting a Premier dentist. Premier dentists have pre-negotiated their fees with Delta and have agreed not to balance bill Delta patients.

Non-Delta Dental Dentists: While you will still receive a benefit from Delta while seeing an out-of-network dentist, these dentists do not have pre-negotiated rates with Delta. In addition, an out-of-network dentist may balance bill you the remainder of the bill Delta does not pay.

Enrollee Crown Claim Payment Example	Most savings	Some savings	No savings
	Delta Dental PPO	Delta Dental Premier	Non-Delta Dental Dentists
Dentist's Charge for a Crown	$1,400	$1,400	$1,400
Plan Allowance	$650	$800	$1,100
Percentage Paid by Plan	60%	50%	50%
Plan Payment	$390	$400	$550
PATIENT PAYMENT	**$260** No balance billing	**$400** No balance billing	**$850** Balance billing

Note: Amounts listed for illustrative purposes only. Assumes no maximum or deductibles are applicable.

VISION

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions. All employees are required to enroll in a vision plan. We offer you a vision plan through Vision Service Plan (VSP).

	VSP Vision	
	In-Network	**Out-Of-Network**
Examination		
Benefit	$10 copay then plan pays 100%	Plan pays up to $50
Frequency	1 x every 12 months	In-network limitations apply
Materials	$10 copay then plan pays 100%	Plan pays 100% (see schedule below)
Eyeglass Lenses		
Single Vision Lens	$25 copay then plan pays 100%	Up to $50
Bifocal Lens	$25 copay then plan pays 100%	Up to $75
Trifocal Lens	$25 copay then plan pays 100%	Up to $100
Frequency	1 x every 12 months	In-network limitations apply
Frames		
Benefit	Up to $175	Up to $70
Frequency	1 x every 24 months	In-network limitations apply
Contacts (In Lieu of Glasses)		
Benefit	Up to $150	Up to $105
Frequency	1 x every 24 months	1 x every 24 months
PREMIUMS		
	Semi-Monthly	**Monthly**
Single	$4.77	$9.54
Two Party	$7.27	$14.54
Family	$11.76	$23.52

2019 VSP Benefit Enhancements:

Standard progressive lenses will now be covered in full for no additional cost.
In addition, an extra $20 will be added to employees' frame allowance for select name brands.

FLEXIBLE SPENDING ACCOUNT (FSA)

You are eligible to participate in both the General-Purpose Healthcare & the Dependent Care FSA if you are enrolled in the PPO or EPO plans. If you are enrolled in the HDHP and a HSA, you can participate in the Limited-Purpose Dental & Vision FSA and the Dependent Care FSA. All the Flexible Spending Accounts (FSAs) are administered by Benefits Coordinator Corporation (BCC).

NEW HEALTHCARE FSA ENHANCEMENT:

Beginning 1/1/2020 you can rollover up to $500 of your previous year's FSA unused balance!

General-Purpose Healthcare FSA (2018 Contribution Limit: $2,650)*	OR	Limited Purpose Dental & Vision FSA (2018 Contribution Limit: $2,650)*
Pay for eligible out-of-pocket healthcare expenses with pre-tax dollars. Eligible expenses include medical, dental, or vision costs such as plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents		Employees who enroll in the new High Deductible Health Plan and choose to contribute to an HSA *cannot* contribute to the General-Purpose Healthcare FSA, but may enroll in the Limited Purpose Healthcare FSA, which will pay for/reimburse dental & vision expenses only.

**2019 limits not yet released by IRS*

Dependent Care FSA (2018 Contribution Limit: $5,000)*
Pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are considered your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account. All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan.

**2019 limits not yet released by IRS*

Important Considerations:

- All eligible medical expense must occur before 12/31/19.
- You have until March 1, 2020 to submit approved receipts or else you will lose the funds.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status.
- FSA funds can be used for you, your spouse, and your tax dependents only.
- Claim forms may be found on the BCC website, http://www.benxcel.net
- Stops on the last day of active employment.

FLEXIBLE SPENDING ACCOUNT (FSA) IMPORTANT INFORMATION

How Do I Enroll in An FSA Plan?

You must enroll online during Open Enrollment via BenXcel.net. You will need to choose an annual contribution amount which will then be divided up and deducted per pay period. After Open Enrollment, a debit card will be mailed your home which you can begin to use to make qualified purchases.

Access Your Account Online or On the Mobile App!

- Register on the My SmartCare Online Portal
- Use your Social Security Number as your Employee ID and your FSA Benefits Debit Card number as your Registration ID when registering.
- By registering your email address, you will receive important push notifications regarding your account balance, year-end reminders, notice of debit card mailed, etc. You can change these notifications to be delivered via text message under your My SmartCare account settings.
- If you have questions regarding your account(s) or a specific claim, please contact BCC's Customer Service Center at 1-800-685-6100. Any device issues should be directed to your service provider.

Benefits Debit Card Convenience

- The Health FSA debit card allows you to avoid out-of-pocket expenses, cumbersome paperwork, and reimbursement delays
- One card can manage multiple account types, such as a Health Care Account, Dependent Care Account
- Swiping your benefits debit card at the point of service deducts the payment directly from your account, giving you instant access to your FSA dollars.
- It can be used at all eligible FSA locations where Mastercard® is accepted

Forgot Your Debit Card? No Problem!

Other Reimbursement Options		
My SmartCare Portal or App	**Other Electronic Submission**	**Paper Submission**
No Reimbursement Form required, just upload a picture of your receipt!	Fill out the Reimbursement Form & attach the receipt: • E-mail: fsa-claims@benxcel.com OR • Upload to File Transfer Portal: https://secure.benxcel.com	Fill out the Reimbursement Form & attach the receipt: • Fax: 412-276-7185 OR • Mail: BCC, Attn: Claims Two Robinson Plaza, Suite 200 Pittsburgh, PA 1520

BASIC LIFE AND AD&D INSURANCE

This is an employer paid benefit provided to Management & Confidential employees upon hire. No action is needed during Open Enrollment to maintain this benefit.

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by the company. Coverage is provided by Voya.

Class	Amount of Life Insurance	Amount of AD&D Insurance
Class 1	$50,000	$50,000
Class 2	$30,000	$30,000

Your Life Insurance plan also includes the following:

- An Accelerated Death Benefit – in the event of a terminal illness, 10% of your benefit to a maximum of 50% of your benefit, may be requested to offset medical bills, plan finances or whatever you choose.
- Conversion Privilege - you may request to take the Life and AD&D policy with you upon termination of employment with the District without Evidence of Insurability (EOI). The District policy will be converted to an individual policy.
- Extension of Death Benefit if You Become Totally Disabled - your Life Insurance policy will continue without having to pay the monthly premium if you become totally disabled while insured before you reach age 60.

On the policy anniversary after you attain age 65, the benefit amount is reduced by 35% of the original face amount. On the policy anniversary after you attain age 70, the benefit amount is reduced by 50% of the original face amount. Benefits terminate at retirement; however early retirees may continue coverage until age 65 with Board approval.

Life insurance pays a lump sum death benefit to your beneficiary while AD&D coverage provides benefits to your beneficiary if you suffer loss of life, limb, speech, hearing or sight. **Remember to review your beneficiary information during Open Enrollment and update any necessary changes.**

VOLUNTARY LIFE AND AD&D

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security. The County is offering a Supplemental Life and AD&D plan to all eligible employees and their families through Voya Financial (ReliaStar Life Insurance Company).

Employee Amount	$20,000 up to a maximum of $500,000 in $10,000 increments
Spouse Amount	$20,000 OR 50% of employee amount
Child(ren) Amount	$10,000, not to exceed 100% of employee amount
New hires who elect Voluntary Life within their first 31 days of employment receive a guaranteed issue amount without having to submit Evidence of Insurability form to Voya	
Employee Guaranteed Issue Amount	$150,000
Spouse Guaranteed Issue Amount	$50,000
Child(ren) Guaranteed Issue Amount	$10,000

NOTE: Benefit amount reduces to 65% at age 65, to 50% at age 70 and to 30% at age 75.

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

Taxes: Due to IRS regulations, a life insurance benefit of $50,000 or more is considered a taxable benefit.

Important: Evidence of Insurability (EOI)

If you are enrolling in this plan for the first time or increasing your coverage amount you will need to submit an EOI form directly to Voya. This form can be found in BenXcel's Form Library and asks for additional information about your health that Voya uses to determine whether or not to approve your coverage request. Enrolling in the plan on BenXcel does *not* mean you have been approved. You will not be deducted for premiums until you have been approved. Do *not* upload your EOI form to BenXcel, it will not be processed, you must send it to the address listed at the top of the form.

COST OF COVERAGE

Employee or Spouse's Age	Monthly Rate For Every $1,000 of Coverage	Employee or Spouse's Age	Monthly Rate For Every $1,000 of Coverage
<25	$0.07	50 - 54	$0.38
25 - 29	$0.08	55 - 59	$0.62
30 - 34	$0.10	60 - 64	$0.935
35 - 39	$0.118	65 - 69	$1.783
45 - 49	$0.23	70+	$2.885

Child (Flat Rate Not Based On Age)
$1.90 for $10,000 Coverage

VOLUNTARY DISABILITY

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability coverage can replace a portion of your income during the initial weeks of a disabling illness or accident. County employees that are not covered by another STD policy may apply for this offering through Voya Financial (ReliaStar Life Insurance Company).

SHORT-TERM DISABILITY (STD)	
Weekly Benefit Amount	Plan pays 55% covered weekly earnings
Maximum Weekly Benefit	$1,129
Minimum Weekly Benefit	$50
Benefits Begin After	
Accident or Sickness	8th day of disability
Maximum Payment Period	12 weeks
Occupational Coverage	Non-occupational coverage (off the job)

Note: *If you currently pay into CA State Disability, you are not eligible to enroll in Voluntary Short-Term Disability. You are eligible to enroll in Voluntary Long-Term Disability.*

LONG-TERM DISABILITY INSURANCE

Long-Term Disability coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security. Remember, long-term disability benefits begin after short-term disability benefits end. Coverage is provided by Voya Financial (ReliaStar Life Insurance Company).

LONG TERM DISABILITY (LTD)	
Monthly Benefit Amount	Plan pays 60% covered monthly earnings
Maximum Monthly Benefit	$10,000
Minimum Monthly Benefit	$100 / 10%
Benefits Begin After:	
Accident or Sickness	360 days of disability
Maximum Payment Period	SSNRA*
Survivor Benefit	3 months gross monthly benefit

Note: *All County employees are eligible to participate except for employees that are covered by a County or State paid long-term disability policy (Example: Safety employees in PORAC).*

*Social Security Normal Retirement Age. The premium is based on your current annual salary and age.

COST OF COVERAGE

A customized rate utilizing your salary and age will be provided for you at www.benxcel.net during open enrollment for this plan. Rates will change with salary and age throughout the life of your plan.

VOLUNTARY ACCIDENT

The Accident Insurance plan offered through Aflac provides added protection for expenses related to an accident such as ER visits, hospitalization, physical therapy or specific injuries are also eligible for benefits under this policy. Coverage is provided with no health questions and is paid in addition to your medical coverage.

Wellness Benefit - this policy includes a Wellness Benefit which gives a covered employee and each covered dependent a single standard annual benefit of $50 for completing a health screening test once every 12 months.

Employees, their spouses and dependents may apply. A partial list of benefits and benefit amounts are below:

INJURIES REQUIRING SURGERY & HOSPITAL	Lump Sum Benefit Amount
Eye Injury (treatment & surgery within 90 days)	$250
Tendons/Ligaments	$400 single / $600 multiple
Ruptured Disk	$100 during 1st year/$400 after 1st year
Torn Knee Cartilage (treatment within 60 days)	$100 during 1st year/$400 after 1st year
Hospital Admission	$1,000
Hospital Confinement (per day up to 365 days)	$200
Hospital Intensive Care (per day to 30 days)	$400
Rehabilitation Facility Confinement (per day for 60 days)	$75
FRACTURES	
Hip/Thigh	$4,000
Leg	$2,400
Foot/Ankle/Knee Cap/Forearm/Hand/Wrist	$2,000
ADDITIONAL BENEFITS	
Emergency Room Treatment (one per accident)	$125
Major Diagnostic Test (CT,CAT,MRI, EEG)	$200
Physical Therapy (up to 6 sessions per accident)	$30
Burns (2nd degree)	$100 - $1,000 (10% - more than 35%)
Complete Dislocations	Varies depending on joint affected
Family Lodging (per day if need to travel more than 100 miles for inpatient treatment up to 30 days)	$100

VOLUNTARY CRITICAL ILLNESS

The Critical Illness Insurance through Aflac Financial is a limited benefit policy and is not health insurance. The policy pays a benefit on top of any health insurance benefits you currently receive. Critical Illness insurance pays you a lump sum benefit upon initial diagnosis of a covered illness such as cancer, heart attack or stroke. Payments are made directly to you to cover copays and deductibles, at-home care or even your monthly bills.

Employees may select between either a $15,000 or $30,000 benefit amount in coverage. Spouse and child(ren) coverage is 50% of employee selected amount.

Covered Critical Illnesses and Additional Benefits	Percentage of $15,000 or $30,000 Benefit Amount
Cancer (Internal or Invasive)	100%
Heart Attack	100%
Limited Benefit Major Organ Transplant	100%
Kidney Failure (End-Stage Renal Failure)	100%
Stroke	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Sudden Cardiac Arrest	100%
Non-Invasive Cancer	25%
Coronary Artery Bypass Surgery	25%
Skin Cancer	$250 (once per calendar year/insured)

Additional Diagnosis – once benefits have been paid for a covered critical illness, Aflac will pay benefits for each different critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Reoccurrence – once benefits have been paid for a covered critical illness, benefits are payable for that same critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Wellness Benefit - this policy also offers a Wellness Benefit, which provides a $50 reimbursement for covered annual health screenings per calendar year. Covered health screenings include chest x-ray, colonoscopy, fasting glucose test, blood test for triglycerides or serum cholesterol test, CA 125 test, CA 15-3 test, CEA, cervical cancer, PSA and other screenings.

Mammography Benefit – this policy includes a Mammography Benefit of $200. Benefit pays as follows: a) a baseline mammogram for women age 35 to 39, b) mammogram for women age 40 to 49, inclusive, every two years or more frequently based on physician's recommendation, c) a yearly mammogram for age 50 and over.

Accidental Death & Dismemberment (within 90 days)			
	Employee	Spouse	Children
Accidental Death	$50,000	$25,000	$5,000
Accidental Common Carrier Death	$100,000	$50,000	$15,000
Single Dismemberment	$12,500	$5,000	$2,500
Double Dismemberment	$25,000	$10,000	$5,000

Note: An employee must enroll in Critical Illness coverage in order to enroll their spouse or child(ren).

COST OF COVERAGE

VOLUNTARY ACCIDENT INSURANCE (per month)

The rate you are quoted at enrollment for this plan is fixed and will remain with you throughout the life of your plan with a few exceptions. If you separate from the County you can take this plan and your rate with you.

Employee	$18.86
Employee and Spouse	$28.26
Employee and Dependent Child(ren)	$32.48
Family	$41.88

VOLUNTARY CRITICAL ILLNESS INSURANCE (per month)

The rate you are quoted at enrollment for this plan is fixed and will remain with you throughout the life of your plan with a few exceptions. If you separate from the County you can take this plan and your rate with you.

NON-TOBACCO: Employee or Employee + Child(ren)			NON-TOBACCO: EE + SP or FAM (50% benefit for SP/CH)		
Issue Age	**$15,000**	**$30,000**	**Issue Age**	**$15,000**	**$30,000**
18-29	$7.15	$12.77	18-29	$11.48	$19.92
30-39	$11.15	$20.78	30-39	$17.49	$31.93
40-49	$20.96	$40.40	40-49	$32.20	$61.36
50-59	$39.97	$78.41	50-59	$60.71	$118.38
60+	$75.90	$150.28	60+	$114.61	$226.18
TOBACCO: Employee or Employee + Child(ren)			**TOBACCO: EE + SP or FAM (50% benefit for SP/CH)**		
Issue Age	**$15,000**	**$30,000**	**Issue Age**	**$15,000**	**$30,000**
18-29	$9.75	$17.98	18-29	$15.38	$27.73
30-39	$17.00	$32.48	30-39	$26.26	$49.48
40-49	$32.62	$63.73	40-49	$49.69	$96.35
50-59	$64.37	$127.22	50-59	$97.32	$191.59
60+	$118.56	$235.60	60+	$178.60	$354.16

EAP PROGRAM

EMPLOYEE ASSISTANCE PROGRAM

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through Anthem can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources. Best of all, it's *free* for employees and their family members.

Help is available 24/7, 365 days a year by telephone at **800-999-7222.**

Visit their website for anthemeap.com (Company ID: San Luis Obispo) to access or learn more about a variety of resources including:

- Four *free* counselling sessions with a local therapist
- *Free* will writing services
- *Free* 30-minute consultation with an attorney
- *Free* financial management tools
- *Free* webinars and resources on a variety of topics like aging parents, career management, parenting, health tools, and self-care.

Access to Identity Theft Protection & Recovery

Turn to Employee Assistance Program for help with repairing and protecting your identity. Now more than ever your identity may be at risk. Thieves have become savvy at stealing personal and financial information no matter where you do business. So while you may think your identity is secure, the truth is, it may not be. Employee Assistance Program's ID Recovery can help you avoid the risk of identity theft. And if your identity does happen to be stolen, we can help you get back on track. Our specialists are trained to help you repair and restore your credit status. They're available 24/7 at 800-999-7222, so you can call them whenever you need help. Even better, their services come at no extra cost to you.

When you call Employee Assistance Program our ID recovery specialists will:

- Consult with you for 30 minutes
- Create an action plan based on your unique level of risk
- Fill out all necessary paperwork for you
- Notify credit agencies and negotiate with creditors
- Restore your credit to pre-theft level
- Offer you materials on credit and ID theft
- Give you guidance as often as you need it

Identity theft can hurt your credit rating, cost you money, take hours or weeks to repair and cause a lot of stress. Let us help you through it. **Call Employee Assistance Program at 800-999-7222** now. You can also log on to our website: **anthemeap.com; login ID: *San Luis Obispo***.

EAP PROGRAM

REGISTER FOR AN EAP COURSE NOW! 2018 - 2019 COURSE CALENDAR

Course	Date	Location
How to Speak to Your Physician	September 11th	Government Center-RM161/162
Financial Fitness Bootcamp	September 20th	Government Center-BOS Chambers
Communications Skills in the Workplace	November 7th	Government Center-RM161/162
Stress Management	February 6th	Government Center-RM161/162
Investment Basics	February 20th	Government Center-BOS Chambers
Eating Right For Life	March 5th	Government Center-RM161/162
Bullying: A Guide for Parents	April 2nd	Government Center-RM161/162
Getting Your Affairs in Order: 5 Essential Documents	April 10th	Government Center-BOS Chambers
Overcoming Burnout	May 15th	Government Center-BOS Chambers
Art of Listening & Giving Feedback	May 21st	Government Center-RM161/162
Getting A Good Night's Sleep	June 11th	Government Center-RM161/162

To register for any of these trainings, please visit NeoGov Learn.

- **How to Speak to Your Physician:** Time with your physician is limited, so you'll want to make the most of your visit. This seminar is designed to give patients a set of specific tools to optimize visits, including pre-appointment preparation and communication during and after an appointment.

- **Financial Fitness Bootcamp:** This comprehensive three-hour workshop puts all the pieces of the financial puzzle on the table in terms anyone can understand. Gain the knowledge and tools to move forward to relieve financial stressors created by ignorance and confusion. Leave with personal financial priorities to make smart decisions for a lifetime.

- **Communications Skills in the Workplace:** To succeed in today's workplace, you have to be an effective communicator — a skill that can be learned and refined. In this seminar, we'll discuss how to find the focus and goal of any conversation. We'll also share tips for avoiding common communication pitfalls.

- **Stress Management:** Reconciling the demands of work and home life can be a source of constant tension. As a result, you may experience sleep disturbances, appetite changes, headaches, poor concentration and irritability. Learn how to identify emotional and physical symptoms of stress, assess your own situation and discover hands-on techniques to bring balance to your work and personal life.

- **Investment Basics:** This class will help participants understand the difference between saving and investing. Learn how to identify goals and the keys to building wealth. We'll discuss how to create a mix of investments that fit your needs and a plan to get started.

PLAN CONTACTS

If you need to reach our plan providers, below is their contact information:

	Provider	Phone Number	Website	Policy Number
Medical	Anthem	800. 967.3015	www.anthem.com/ca/EIAHealth/	175075
	Carrum Health	888.855.7806	www.carrumhealth.com/	None
Pharmacy	Express Scripts For EPO/PPO plans Medicare PDP	877-554-3091 (24/7) 844-468-0428 (24/7)	www.express-scripts.com	Issuer: 9151014609 RxBIN: 610014 RxGrp: RX4EIAH
Specialty Pharmacy	Accredo Specialty	800.803.2523	www.accredo.com	
Dental	Delta Dental DPPO	800.765.6003 888.335.8227	www.deltadentalins.com	2999-0011
	Aetna Dental DMO	877.238.6200	www.aetna.com	883524-001
Vision	VSP	800.877.7195	www.vsp.com	00105558
Life & ADD and Disability Insurance	Voya Basic Life and AD&D, Basic LTD, Voluntary Life and AD&D, Voluntary STD & LTD	1.800.955.7736 9:00am to 6:30pm ET Monday – Friday	www.voya.com Personalized plan documents are not provided for these plans. Group plan documents and claim forms are available on the Benefits Website	CSAC EIA 31640-7 Act 37
Critical Illness & Accident Insurance	AFLAC Accident Critical Illness	1.800.433.3036	www.aflacgroupinsurance.com Personalized plan documents are not provided for these plans. Group plan documents and claim forms are available on the Benefits Website	CA17800 C21000
Employee Assistance Program	Anthem EAP	1.800.999.7222	Anthem EAP Company Code: San Luis Obispo	None
FSA **COBRA**	Benefits Coordinators Corporation (BCC)	800.685.6100	www.benxcel.net	None
Human Resources	None	805.781.5959 hr@co.slo.ca.us	www.slocounty.ca.gov/hr Type, "2018 Open Enrollment" in the search box or navigate to Departments – Human Resources - Benefits	None

IMPORTANT TERMS TO LEARN

Health insurance seems to have its own language. You will get more out of your plans if understand the most common terms, explained below in plain English.

MEDICAL

OUT-OF-POCKET COST - A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

DEDUCTIBLE - The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

GENERIC DRUG - A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

DENTAL

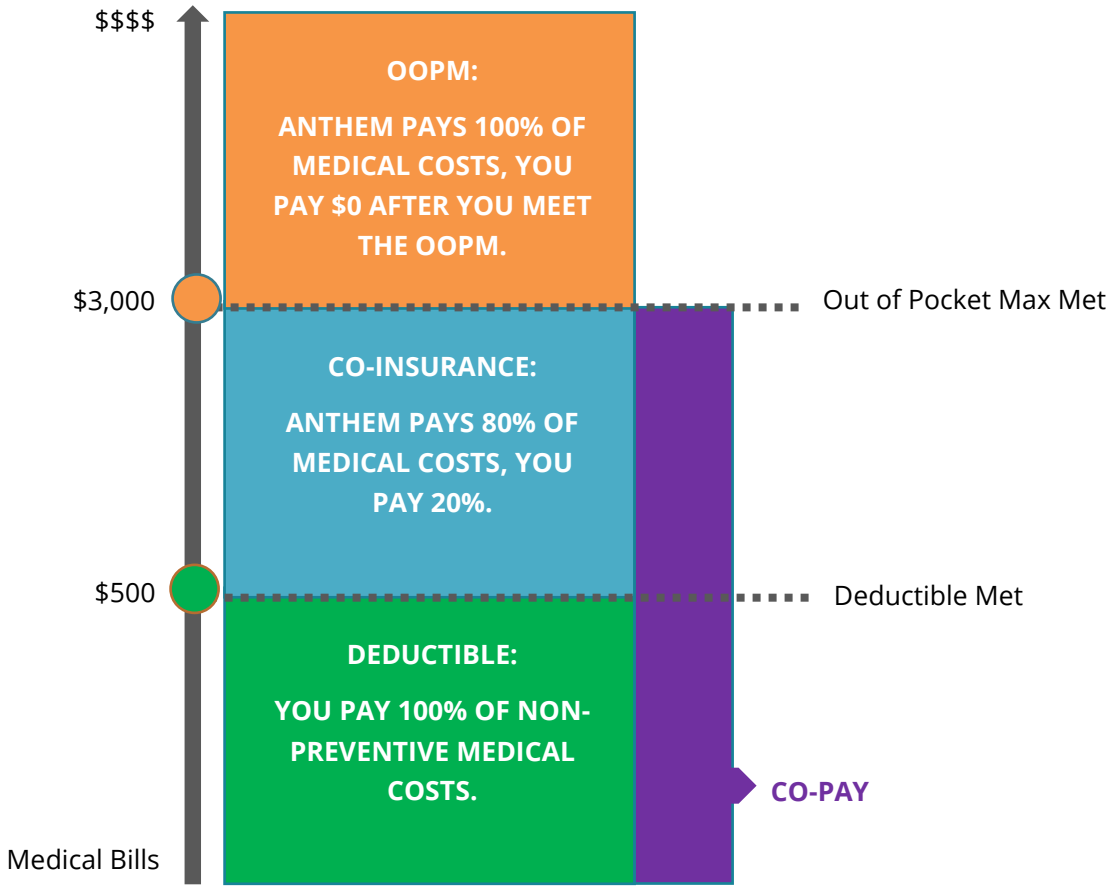
BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES - Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

PPO Terms Explained:

Co-Pays, Deductibles, Co-Insurance, & OOPMs



- **Co-Pay:** A fixed dollar amount you are required to pay for certain covered services at the time you receive care. Co-pays apply to your Out of Pocket Maximum, not your Deductible.

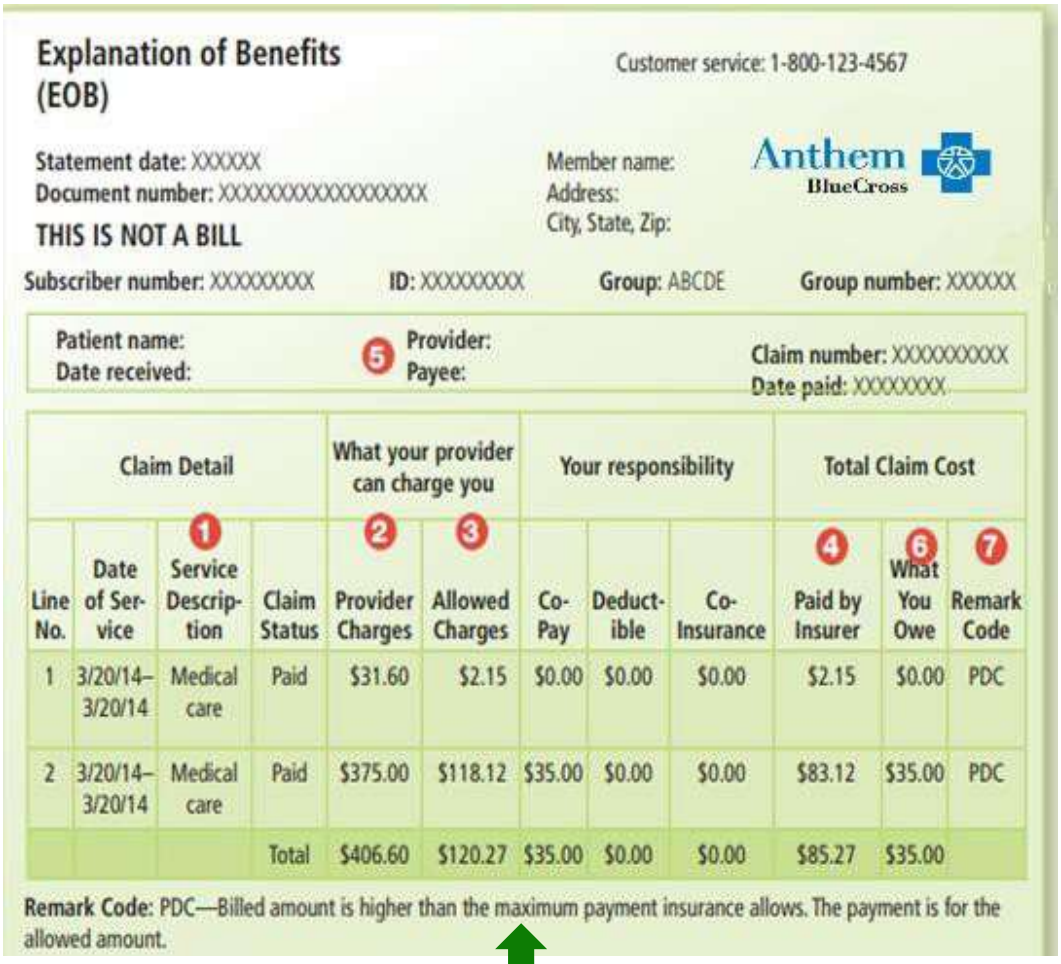
- **Deductible:** The fixed dollar amount you must pay every calendar year before your cost sharing of medical expenses. For example, if your deductible is $500, your plan won't pay anything for most services until you've met your $500 deductible. Preventive care is *not* included, meaning it is always 100% covered by Anthem, even when you have not reached your deductible or OOPM. However, you are responsible for all other medical costs up to the deductible.

- **Co-Insurance:** Your share of the costs of a covered health care service — usually a percentage of an eligible expense, after you've met your annual deductible. You will pay a percentage of a covered service while your health insurance plan pays the remainder.

- **Out of Pocket Maximum (OOPM):** The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

The above example illustrates Anthem Select & Anthem Choice Employee Only coverage.

EXPLANATION OF BENEFITS (EOB)



Explanation of Benefits (EOB)

Customer service: 1-800-123-4567

Statement date: XXXXXX
Document number: XXXXXXXXXXXXXXXXX
THIS IS NOT A BILL

Member name:
Address:
City, State, Zip:

Anthem BlueCross

Subscriber number: XXXXXXXXX ID: XXXXXXXXX Group: ABCDE Group number: XXXXXX

Patient name:
Date received:

5 Provider:
Payee:

Claim number: XXXXXXXXXX
Date paid: XXXXXXXX

Claim Detail				What your provider can charge you		Your responsibility			Total Claim Cost		
		1		2	3				4	6	7
Line No.	Date of Service	Service Description	Claim Status	Provider Charges	Allowed Charges	Co-Pay	Deductible	Co-Insurance	Paid by Insurer	What You Owe	Remark Code
1	3/20/14–3/20/14	Medical care	Paid	$31.60	$2.15	$0.00	$0.00	$0.00	$2.15	$0.00	PDC
2	3/20/14–3/20/14	Medical care	Paid	$375.00	$118.12	$35.00	$0.00	$0.00	$83.12	$35.00	PDC
			Total	$406.60	$120.27	$35.00	$0.00	$0.00	$85.27	$35.00	

Remark Code: PDC—Billed amount is higher than the maximum payment insurance allows. The payment is for the allowed amount.

1 **Service Description** is a description of the health care services you received, like a medical visit, lab tests, or screenings.

2 **Provider Charges** is the amount your provider bills for your visit.

3 **Allowed Charges** is the amount your provider will be reimbursed; this may not be the same as the Provider Charges.

4 **Paid by Insurer** is the amount your insurance plan will pay to your provider.

5 **Payee** is the person who will receive any reimbursement for over-paying the claim.

6 **What You Owe** is the amount the patient or insurance plan member owes after your insurer has paid everything else. You may have already paid a portion of this amount, and payments made directly to your provider may not be subtracted from this amount.

7 **Remark Code** is a note from the insurance plan that explains more about the costs, charges, and paid amounts for your visit.

What is an EOB?

When your provider bills Anthem an Explanation of Benefits (EOB) will be generated outlying the amount that you owe. The EOB will also tell you how much your plan has covered. An EOB is not a bill. If your provider bills you a different amount than what is on your EOB, contact your provider to resolve. If you believe there is an error on your EOB, contact Anthem.

How Do I Get My EOB?

An EOB is automatically mailed to you from Anthem. You will not receive an EOB if you have elected for paperless EOBs, at which point you can view them on your Anthem portal. You will also not receive an EOB if the claim was processed and completely covered by your insurance because you will not owe anything out of pocket.

Notes

Rev. 9/6/2018