



County of San Luis Obispo 2020 Employee Benefits Brochure



2020 Open Enrollment is
October 3 – October 21, 2019
slocounty.ca.gov/2020OE

Important Benefit Information

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to the Summary of Benefits and Coverage (SBCs) and/or Evidence of Coverage (EOC) documents available at slocounty.ca.gov/benefits or by contacting Anthem. The EOC documents determine how all benefits are paid. A list of plan contacts is included at the back of this guide.

2020 Open Enrollment will be October 3 – 21, 2019. All benefits elected during 2020 Open Enrollment will be effective from January 1, 2020 – December 31, 2020.

ALWAYS REVIEW YOUR ELECTIONS DURING OPEN ENROLLMENT

While it is always recommended to take this opportunity to review your benefit elections, no action is required if you do not want to change benefits or dependents for 2020. Your current elections will roll over to the 2020 plan year unless you fall into one of the two below categories.

ACTION IS REQUIRED IF:

You waive County medical insurance. You are required to take action during Open Enrollment to provide proof of other group coverage to continue to waive.

If you participate in a Health or Dependent Care Flexible Spending Accounts (FSA) or Health Savings Account (HSA). Your 2019 FSA or HSA election amounts will not roll over into 2020.

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What's New in 2020?

	No changes were made to the 2019 medical plan offerings for 2020. All medical premiums will increase by 2.7%.
	Two New Pharmacy Programs Available! Rx 'n Go is a voluntary mail order pharmacy benefit for generic medications. All employees and covered dependents on County medical have the option to receive up to a 90-day supply of generic prescription maintenance medications by mail at no cost to you . Express Scripts Smart 90 Program is another new program this year. With this new program, you can now get up to a 90-day supply of your maintenance medications conveniently filled through CVS or Walgreens retail location in addition to home delivery.
	No changes were made to Aetna or Delta Dental plans for 2020.
	No changes were made to VSP's plan for 2020.
	New FSA & HSA Contribution Limits! 2020 FSA contribution limits were increased for both the Healthcare FSA, Limited Purpose Dental and Vision FSA, and Dependent Care FSA. 2020 HSA contributions limits were increased as well. See page 34 for more information.
	Improved Plan Design! Voya Voluntary Short-Term Disability: The weekly benefit percentage for this plan will increase as will the maximum weekly benefit payout. See page 38 for more information. No other changes were made to any of the other Voya products available to County employees.
	New Plan Available! Aflac Hospital Indemnity will be available for the first time in 2020. The plan will pay cash when you are confined to a hospital or experience certain qualifying events. See page 40 for more information.



Know Your Enrollment Resources



Visit the [2020 Open Enrollment](#) Webpage for the latest information available. This page will be updated regularly and is your best source of information including plan documents, enrollment resources, the 2020 Employee Benefits Brochure, and presentations given throughout Open Enrollment.



Attend the 2020 Employee Benefits Fair on September 24 from 10:00am-4:00pm at the Vets Hall in SLO. 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 insurance carrier booths & much more. We also encourage you to check out the workshops we have scheduled throughout the day on a variety of topics in the New Government Center and Vets Hall.



Carrier Contact Information for carriers like Anthem, Delta Dental, 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.



Attend an in person Open Enrollment Workshop to review the County Benefits and ask questions. Workshops will be held on September 24 at the Vets Hall, October 2 at 10 AM in the Atascadero Library, and October 2 at 3 PM in the Board Chambers. To register for a Benefits Fair or Open Enrollment workshop please visit [NeoGov Learn](#). Registration for each workshop will be closed when capacity is filled.



Join the Open Enrollment Webinar on October 8. To register for the webinar please visit [NeoGov Learn](#). A copy of the presentation will also be available on our [Open Enrollment webpage](#) after the event.



How to Enroll

The County of San Luis Obispo uses an online enrollment system, **BenXcel**. Here are some tips to help you get started.

Consider what actions you can take:



Before You Enroll

- **Enroll** in any of the County-sponsored plans and voluntary benefits
- **Add or drop** 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



Enroll Online

Go online to the County's eBenefits website, www.benxcel.net, to enroll, add a dependent, change your address, or make personal information updates. To access online enrollment, follow the steps below:

- **Login:** Visit the enrollment site at www.benxcel.net
- **User ID:** First letter of first name, full last name, entire DOB
EX: Judy Smith-Doe DOB:01/25/1973
USER ID: jsmithdoe01251973
- **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.
- **For Company Name Type:** SLO
- **Click** the Sign In button to enter the system
- **Begin Enrollment:** Follow the system prompts to review the benefit options and begin making election
- **Confirm:** A confirmation statement will appear when the enrollment is complete. Please save or print for your records.



Need Help?

If you need help with system navigation, **contact BCC at 1-800-685-6100** for assistance. If you enter the wrong username or password more than five 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. In addition, any employee meeting the definition of fulltime as defined by the Affordable Care Act (ACA) is benefits eligible. You can enroll the following family members in medical, dental and vision plans.

Your Eligible Dependents

- Your spouse who you are legally married to under state law, including a same- sex spouse.
- Your domestic partner. Domestic Partner Affidavit is required.
- Natural, adopted, stepchildren or domestic partner's children up to age 26. They do not have to live with you or be enrolled in school.
- Children under age 26 for which you have legal guardianship.
- Tax dependents over age 26 who are disabled and dependent on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law

Who is Not Eligible?

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

- Former spouses and stepchildren.
- Parents, grandparents and siblings.
- Employees who work fewer than 20 hours per week, temporary employees, contract employees, or employees residing outside the United States
- A County employee cannot be covered as both an employee and a dependent of another employee for medical insurance

Important Notification About Former Spouses & Former Stepchildren

Former spouses and former stepchildren are ineligible dependents and will be removed from County insurance plans effective the date of the divorce decree. Medical claims and premiums incurred by ineligible dependents due to late notification to the County are the responsibility of the employee.



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.

If you have a qualifying event outside of Open Enrollment and would like to make changes, it is your responsibility to login online at BenXcel.net within **31 days** to process the changes. [Click here](#) to watch an instructional video on how to initiate a Qualifying Event within BenXcel. Be sure to pay attention to the Qualifying Event date BenXcel instructs you to use in order to ensure your effective date is correct.

Once you process the Qualifying Event, you must upload corresponding documentation as well. Refer to page 9 for the types of documentation you will need to submit when adding dependents to your coverage for the first time.

COMMON QUALIFYING EVENTS

Birth, adoption or new legal guardianship of a child

Marriage, Divorce or Death

Former spouses and stepchildren are ineligible dependents and will be removed from County insurance plans effective the date of the divorce decree.

Change in your health coverage or your spouse's coverage due to your spouse's employment

New eligibility for other group healthcare coverage – If your spouse is hired at a new job & is offered group medical coverage that they would like to enroll in, etc.

Change in employment status that affects eligibility for you, your spouse, or dependent child(ren) including retirement, going temp to perm, part-time to full time and returning to work from non-pay status/leave

Change in an individual's or dependents eligibility for Medicare or Medicaid

Dependent Documentation

Dependent Type	Required Documentation	Resources to Obtain Documentation
Dependent Spouse (same or opposite gender)	Add: Marriage Certificate Remove: Divorce Decree	<ul style="list-style-type: none"> County office that issued original marriage Certificate Vitalchek.com
Registered Domestic Partner	Add: State of California, County or City issued Declaration/ Certificate of Domestic partnership Remove: Termination of Domestic Partnership	<ul style="list-style-type: none"> County/City office that issued original certificate 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.	<ul style="list-style-type: none"> 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 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 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	<ul style="list-style-type: none"> 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 Vitalchek.com

Frequently Asked Questions

I'm happy with my current benefit elections, do I need to take action?

While it is always recommended to take this opportunity to review your benefit elections, no action is required if you do not want to change benefits or dependents for 2020. Your current elections will roll over to the 2020 plan year unless you fall into one of the two below categories and then mandatory action is required:

- 1) You waive County medical insurance. You are required to take action during Open Enrollment to provide proof of other group coverage to continue to waive.
- 2) If you participate in a Health or Dependent Care Flexible Spending Accounts (FSA) or Health Savings Account (HSA). Your 2019 FSA or HSA election amounts will not roll over into 2020.

Will I receive a new pharmacy and medical ID card?

You will only receive a new medical and/or pharmacy card if you are changing plans or adding a dependent. You can request one from the carriers at any time.

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 46 of this brochure.

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.

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 has 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 an EOB?

When your provider bills Anthem an Explanation of Benefits (EOB) will be generated outlining 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 at 1-800-967-3015.

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.

Explanation of Benefits (EOB)

Customer service: 1-800-123-4567

Statement date: XXXXXX
Document number: XXXXXXXXXXXXXXXXXXXX

Member name: _____
Address: _____
City, State, Zip: _____



THIS IS NOT A BILL

Subscriber number: XXXXXXXXXX ID: XXXXXXXXXX Group: ABCDE Group number: XXXXXX

Patient name: _____ **5** Provider: _____ Claim number: XXXXXXXXXXXX
Date received: _____ Payee: _____ Date paid: XXXXXXXXXX

Claim Detail				What your provider can charge you		Your responsibility			Total Claim Cost		
Line No.	Date of Service	1	Claim Status	2	3	Co-Pay	Deductible	Co-Insurance	4	6	7
		Service Description									
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.



Compare Our Medical Plans

The County of San Luis Obispo offers 5 different types of medical plans for different needs and budgets. Every plan includes free preventive care from network providers to check that you're staying healthy. Each plan provides its own network of doctors, hospitals and labs. The differences are in cost, flexibility and access to care.

HDHP: High Deductible Health Plan

- Anthem HDHP HSA

You're in the driver's seat when it comes to managing your medical care and finances. An HDHP is the only plan with a Health Savings Account (HSA) funded by your own tax-free dollars. The HSA helps you pay your deductible and other healthcare expenses. You can visit any provider, but if you stay in-network, you'll be able to save more of your HSA dollars for future healthcare needs.

PPO: Preferred Provider Option

- Anthem Select PPO
- Anthem Choice PPO
- Anthem Care PPO

A PPO gives you flexibility and choice, but you might pay more. You can go to any doctor without a referral, but you will pay more of the cost if they are not in the plan's network. You'll need to meet an annual deductible before the plan starts to pay.

EPO: Exclusive Provider Organization

- Anthem EPO

An EPO gives you more predictable costs but less flexibility. Out-of-network care is not covered except in an emergency. You pay a fixed copay for most services.

Choosing A Medical Plan

Here are some important considerations when deciding on which is the right medical plan for you:

- **Your Doctors**– Do you prefer to see specific doctors? Visit the Anthem’s website to check that the doctors you see regularly are in-network before enrolling in a plan. If your doctor is not in network, a visit will cost you more. A few minutes of research can avoid an expensive surprise.
- **Your Healthcare Needs**– Do your family members need to see a doctor often or visit urgent care? Do you have regular lab work or X-rays? Do you take medications on an ongoing basis? Do you have surgery planned? Review the benefit tables in this guide to compare your costs.
- **Your Total Cost**– How much will be deducted from your pay for coverage? Does the plan have a deductible? What is the plan's annual out-of-pocket maximum? Can you offset your costs with a tax-free health account such as an HSA or an FSA? Each of these factors can affect your bottom-line cost for healthcare.
- **Important Terms**- Learn these insurance terms and compare them for each plan available to you.

 Eligible Expense	<p>A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.</p>
 Deductible	<p>The amount of healthcare costs you have to pay for with your own money before your plan will start to pay.</p>
 Coinsurance	<p>After the deductible, you and the plan share the cost on a PPO or HDHP. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.</p>
 Copay	<p>A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.</p>
 Out-Of-Pocket Maximum	<p>Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.</p>
 Balance Billing	<p>In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is \$100 but the plan's allowable charge is only \$70, an out-of-network provider may bill you for the \$30 difference.</p>

Anthem PPOs



Plan Benefits	Anthem Select PPO		Anthem Choice PPO		Anthem Care PPO	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Annual deductible	\$500 per individual \$1,000 per family		\$500 per individual \$1,000 per family		\$500 per individual \$1,000 per family	
Annual out-of-pocket maximum	\$3,000 per individual \$6,000 per family		\$3,000 per individual \$6,000 per family		\$2,000 per individual \$4,000 per family	
Primary provider office visit	\$20 per visit (deductible waived)	Plan pays 60% after deductible	\$20 per visit (deductible waived)	Plan pays 60% after deductible	\$20 per visit (deductible waived)	Plan pays 60% after deductible
Specialist office visit	\$20 per visit (deductible waived)	Plan pays 60% after deductible	\$20 per visit (deductible waived)	Plan pays 60% after deductible	\$20 per visit (deductible waived)	Plan pays 60% after deductible
Chiropractic care In-Network 20 visit limit per benefit period	\$15 per visit	Plan pays 60% after deductible	\$15 per visit	Plan pays 60% after deductible	\$15 per visit	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
Diagnostic lab and X-ray	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%	Plan pays 90%	Plan pays 60%
Urgent care	\$20 per visit	Plan pays 60%	\$20 per visit	Plan pays 60%	\$20 per visit	Plan pays 60%
Emergency room Copay waived if admitted	\$50+ plan pays 80%	Covered as in- network	\$50+ plan pays 80%	Covered as in- network	\$50+ plan pays 90%	Plan pays 60%
Hospitalization	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%	\$250+plan pays 90%	Plan pays 60%
Outpatient surgery	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%	Plan pays 90%	Plan pays 60%
Provider Network	Select PPO (Narrow Network)		Blue Cross PPO (Prudent Buyer) -Large Group		Blue Cross PPO (Prudent Buyer) -Large Group	
	Premiums Monthly Cost					
Single	\$554.00		\$623.00		\$649.00	
Two Party	\$1,093.00		\$1,233.00		\$1,286.00	
Family	\$1,425.00		\$1,606.00		\$1,677.00	

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.

Anthem EPO



Plan Benefits	In-Network Only
Annual deductible	No Deductible
Annual out-of-pocket maximum Embedded	\$1,500 per individual \$3,000 per family
Primary provider office visit	\$15 per visit
Specialist office visit	\$15 per visit
Chiropractic care	\$15 per visit (Coverage for In-Network Provider is limited to 20 visit limit per benefit period combined with Acupuncture visits)
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)
Diagnostic lab and X-ray	No Charge
Urgent care	\$15 per visit
Emergency room	\$50 per visit
Hospitalization	No Charge
Outpatient surgery	No Charge
Provider Network:	Blue Cross PPO (Prudent Buyer) – Large Group
Plan/Coverage Type	Premiums Monthly Cost
Single	\$768.00
Two Party	\$1,528.00
Family	\$1,995.00

Anthem High Deductible Health Plan

Plan Benefits	In-Network	Out-Of-Network
Annual deductible (Aggregate)	\$2,000 per individual (offset by HSA account balance) \$6,000 per family (offset by HSA account balance)	\$3,000 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
Chiropractic care	Plan pays 80% after deductible (Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visit limit per benefit period)	Plan pays 60% after deductible (Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visit limit per benefit period)
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)
Diagnostic lab and X-ray	Plan pays 80% after deductible	Plan pays 60% after deductible
Urgent care	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency room	Plan pays 80% after deductible	Plan pays 80% after deductible
Hospitalization	Plan pays 80% after deductible	Plan pays 60% after deductible (up to \$600 per day)
Outpatient surgery	Plan pays 80% after deductible	Plan pays 60% after deductible (up to \$350 per surgery)
Provider Network:	Blue Cross PPO (Prudent Buyer) - Large Group	
Plan/Coverage Type	Monthly Premium Cost	
Single	\$523.25	
Two Party	\$1,032.25	
Family	\$1,344.25	

Understanding High Deductible Health Plans (HDHP)

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.



The HDHP deductible operates differently on the HDHP and it's important to be aware of how this impacts you. With the 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%. Please [click here](#) for information on this key distinction.

Another key difference is that you are required to meet your annual deductible for both medical and prescription drug expenses before the plan's coinsurance cost sharing begins. In addition, you have a separate deductible for both in and out of network benefits.

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 every fill until you reach your deductible. You do not have a set co-pay. Once you meet your deductible, the plan will share the cost of care with you through co-insurance, 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% for the remainder of the year.

Understanding a Health Savings Account (HSA)

A Health Savings Account (HSA) 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.

The Triple Tax Savings of an HSA		2019 HSA Contribution Limits
1.	Pre-Tax Contributions Through Payroll Deductions	Individual: \$3,500.00
2.	Tax-Free Interest & Investment Earnings	Family \$7,000.00
3.	Tax-Free Deductions for Qualified Medical Expenses	Note: 2020 Limits have not been released by the IRS.

- 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.
- You will receive a notification in the mail from Avidia Bank, the third party provider for your HSA asking you to take action to open your HSA. Your payroll deductions will not begin until the pay period after your HSA bank account has successfully been opened.
- Any unspent HSA contributions roll at the end of the year. The funds 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.
- Because your unspent contributions roll over at the end of the 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 more medical expenses.
- Use your MySmartCare HSA debit card to pay for qualified medical expenses.
- 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 or in your own or a spouse's general-purpose Healthcare FSA.

HSA Eligibility Requirements:

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; other than a spouse, you cannot be claimed on another person's tax return; 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.

HDHP & HSA FAQs

Are there any risks to enrolling in a HDHP?

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 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. One key difference from a traditional PPO health plan is that you are required to meet your medical annual deductible before prescription drugs are covered under coinsurance cost sharing. You are likely to pay more for your prescription drugs with a HDHP than a traditional PPO health plan.

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.

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, and 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.

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 Healthcare FSA. However, you do have the option to pair your HSA with a Limited Purpose Dental & Vision FSA. Please see page 29 for more information on the Limited Purpose FSA.

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 regular 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.



Is It Preventive Or Diagnostic?

You benefit both financially and health-wise when you get annual medical checkups. Preventive care helps you avoid more serious and costly health problems down the road. Plus, it's free.

But did you know that, depending on the situation, the same test or service can be considered preventive (100% covered) or diagnostic (you share the cost)?

Preventive Care Services

- Help you stay healthy by checking for disease before you have symptoms or feel sick
- Can include flu shots and other vaccinations, physical exams, lab tests and prescriptions
- 100% covered when delivered by an in-network provider

Diagnostic Services

- Check for disease after you have symptoms or because of a known health issue
- Can also include physical exams, lab tests and prescriptions
- You pay your share of the cost



PREVENTIVE: At Don's annual checkup, his doctor orders a blood sugar test to screen for diabetes, even though Don does not have symptoms.



DIAGNOSTIC: Grace's doctor orders a blood sugar test because she complains of increased thirst, frequent urination, weight loss, and fatigue—all symptoms of diabetes.



PREVENTIVE: As part of her well woman exam, Vanessa receives a mammogram to make sure there have been no changes since last time.



DIAGNOSTIC: Darla visits her doctor because she found a lump. Her doctor schedules a mammogram and a biopsy to check for cancer.



PREVENTIVE: Aki's doctor orders lab work during his annual physical, including a cholesterol check.



DIAGNOSTIC: Hector was diagnosed with high cholesterol two years ago. He has blood tests twice a year to check his cholesterol levels and make sure his medication is the right dose.

If you're unsure why a test was ordered, ask your doctor. And don't forget to schedule your preventive care visits. Many people use a key date like their birthday or anniversary as a reminder to make their appointments each year.



Know Where To Go

ER or Urgent Care?

The emergency room shouldn't be your first choice unless there's a true emergency.

CONSIDER URGENT CARE FOR...	GO TO THE EMERGENCY ROOM FOR...
<p>Symptoms, pain or conditions that require quick medical attention but do not require hospital care, such as:</p> <ul style="list-style-type: none"> - Earache - Sore throat - Rashes - Sprains - Broken fingers or toes - Flu - Fever up to 104 degrees 	<p>Serious or life-threatening conditions that require immediate treatment that you can get only at a hospital, such as:</p> <ul style="list-style-type: none"> - Chest pain or severe abdominal pain - Trouble breathing - Loss of consciousness - Severe bleeding that can't be stopped - Large broken bones - Major injuries from a car crash, fall or other accident - Fever above 104 degrees

Can't get to the doctor's office? Have your visit online!

Have you ever needed to see a doctor but couldn't because of scheduling, holidays, weekends, travel or even bad weather? Anthem saves you both time and money by connecting you to a doctor via video chat from any location, 24/7, no appointment needed. You'll be connected to a board-certified physician who can diagnose and treat many common medical problems such as colds and flu, headache, minor rashes, allergies, digestive issues, and more. Prescriptions can even be sent to your local pharmacy. To get started, download Anthem's Live Health Online app from the AppStore or Google Play.

Other non-emergency care options

Our medical plans offer plenty of options when you need care or advice, but it's not an emergency:

Plan	Call a nurse 24/7	Find doctor/urgent care
Anthem	1-800-967-3015	anthem.com/ca/EIAHealth



Alternative Facilities

If you have a life-threatening medical emergency, your first concern is getting help as soon as possible. But if you have more time to evaluate your options, you may be able to save big bucks by shopping around. Alternative facilities can provide the same results as a hospital at a fraction of the cost.



SURGERY: Consider an Ambulatory Surgery Center (ASC)

An ASC is a healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more. ASCs are held to the same types of patient safety standards as hospitals. ASC prices can be as much as 50% lower than hospital outpatient charges for the same procedure.



PHYSICAL THERAPY: Consider a free-standing physical therapy office

Physical therapy (PT) can be an important part of recovery after an injury or surgery. On average, PT in a free-standing center can cost 40 to 60% less than PT delivered in a hospital setting.



SLEEP STUDY: There's no place like home

If you have a condition like sleep apnea, your doctor may recommend an overnight sleep study. The cost is often covered by insurance if the test is considered medically necessary. Overnight tests in a sleep center may cost up to \$5,000 per night; however, a home test often costs less than \$500.



HOME INFUSION THERAPY: Avoid a costly hospital stay

Infusion therapy may be prescribed when a patient must receive intravenous drugs, injections, or epidurals instead of oral medications. Treatment by a licensed infusion therapy provider at home or at an outpatient center can be safe and effective. Avoiding a hospital stay can provide savings of up to 90%, and also helps maintain a normal lifestyle in the comfort of home.

How to find an alternative treatment facility

If your treatment involves a visit to a hospital operating room or clinic, ask your doctor if you can get the same medical care somewhere else. If you are doing your own research, start with your plan's "find a provider" link to search for surgical centers, physical therapy, and more. Or call your plan's member services for assistance. Finding an in-network facility ensures you get the plan's negotiated rates.

Beware of extra fees

Be aware that many hospitals, treatment centers, and even primary care doctor's offices have begun to charge a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

Solera Health Diabetes Prevention

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.

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?

This Diabetes Prevention Program (DDP) 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, & 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

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.

How much does it cost?

This program is at no cost to members if they are enrolled in a County Anthem medical plan. Once a member enrolls in the program, their health plan provider will receive a claim from Solera to cover the program services for this preventive benefit. DPP is a covered preventive benefit.

Carrum Health



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.

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.

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

More Providers, More Coverage

Hoag
Orthopedic
Institute



Orange County



PROVIDENCE
Saint John's
Health Center

Santa Monica



Stanford
HEALTH CARE
ValleyCare

San Francisco Bay Area

Scripps

San Diego

Here Is Our Promise to You:



See the Highest-Quality Surgeons



No Bills, No Surprise Costs*



Peace of Mind Knowing a Care Concierge is There

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.
*For 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.

Carrum Health FAQs

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.

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).

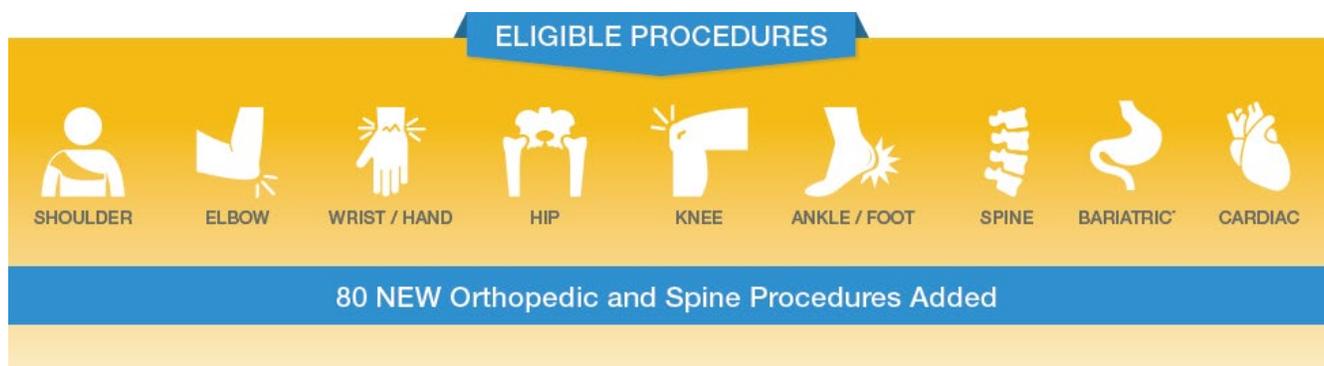
Which travel expenses are covered? The following expenses are covered for you and one companion:

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.



ELIGIBLE PROCEDURES

SHOULDER ELBOW WRIST / HAND HIP KNEE ANKLE / FOOT SPINE BARIATRIC CARDIAC

80 NEW Orthopedic and Spine Procedures Added

Pharmacy Benefits

Express Scripts program coordinates with following medical plans:

- Anthem Select PPO
- Anthem Choice PPO
- Anthem Care PPO
- Anthem EPO



Only in-network costs are shown. Use network pharmacies to ensure coverage and best price.

Annual deductible	None
Annual out-of-pocket maximum	Individual: \$2,000 separate from medical out-of-pocket max Family: \$4,000 separate from medical out-of-pocket max
Generic	Pharmacy: \$5 copay after Rx deductible Mail Order: \$10 copay after Rx deductible
Preferred brand	Pharmacy: \$20 copay after Rx deductible Mail Order: \$40 copay after Rx deductible
Non-preferred brand	Pharmacy: \$50 copay after Rx deductible Mail Order: \$100 copay after Rx deductible
Supply	Pharmacy: 30 days Mail Order: 90 days

IngenioRx program coordinates with the Anthem HDHP medical plan.



Annual deductible	Medical Deductible Applies
Annual out-of-pocket maximum	Medical out-of-pocket maximum Applies
Generic	Pharmacy: 20% after Rx deductible Mail Order: 20% after Rx deductible
Preferred brand	Pharmacy: 20% after Rx deductible Mail Order: 20% after Rx deductible
Non-preferred brand	Pharmacy: 20% after Rx deductible Mail Order: 20% after Rx deductible
Supply	Pharmacy: 30 days Mail Order: 90 days

New! Pharmacy Benefits

Express Scripts Smart 90 Program

You now have two ways to get up to a 90-day supply of your maintenance medications, which are drugs you take regularly for ongoing conditions. You can conveniently fill those prescriptions either through home delivery or at a retail pharmacy in the Smart90 network, either CVS or Walgreens!

In addition, there's a savings for getting one 90-day supply vs. three 30-day supplies at retail pharmacies. After the third time you purchase up to a 30-day supply of a maintenance medication at a pharmacy, you'll pay a higher cost under your plan. By choosing a 90-day option—either through home delivery or at a Smart90 pharmacy—you can avoid this higher cost. You will pay the same copayment for your 90-day supply with either option.



Rx'n Go

Rx 'n Go is a voluntary mail order pharmacy benefit that provides you access to over 1,200 generic medications at no cost to you. All employees and covered dependents, on an Anthem medical plan*, have the option to receive up to a 90-day supply of generic prescription maintenance medications by mail at no cost to you. In addition, you may also receive up to a 90-day supply of Prodigy® diabetic test strips and lancets delivered to your home at **no cost**. The initial test strip order includes a new Prodigy® diabetic monitor.

What do I have to do?

1. Go to rxngo.com and confirm your medication(s) is on the Rx 'n Go drug list.
2. Complete the Pharmacy Profile form online or by calling Rx 'n Go.
3. Mail the Pharmacy Profile form and original prescription(s) to Rx 'n Go. Your physician may also fax, phone or E-Scribe your prescription.
4. Receive your medication(s) by mail at your home.

Questions? Contact Rx'n Go at 888.697.9646 or visit rxngo.com for a full list of available medications.

**Note: Due to IRS guidelines on the HDHP, only preventive maintenance medications are available to you for free. Rx'n GO has over 750 preventative medications on their drug list.*



Prescription Drug Savings

Are prescription drug costs breaking your budget?

A little research before you go to the pharmacy could result in huge savings. This is especially important in a high deductible health plan because you pay the full cost of prescription drugs until you meet your deductible.

	INSIDER TIP	RX ROCK STAR!
	Your medical plan includes prescription drug coverage. You pay a different amount depending on the “tier” or class of drug.	GENERIC drugs are always the least expensive. Get in the habit of asking your doctor or pharmacist if there’s a generic alternative.
	A FORMULARY is a list of drugs that are preferred by the plan. Plans use formularies to encourage the most cost-effective drugs.	If a generic drug is not available, ask your doctor whether there is an effective brand name medication that is on the plan’s preferred drug list.
	A PARTICIPATING PHARMACY (one that contracts with your medical plan) will usually offer the best price. You can find a participating (in-network) pharmacy on your plan’s website or by calling member services.	SHOP AROUND! Even within the same drugstore chain, you may find a better price at a different location. Your medical plan may have an online tool or app to compare prices. Or try websites like goodrx.com or rxsaver.com
	SPECIAL HANDLING REQUIRED? Your plan may require preauthorization (plan approval) or step therapy (trying certain drugs before others). Specialty drugs such as injectables may need to be purchased from a certain provider.	Talk with your doctor about your course of treatment and confirm whether your plan requires any special procedures. Before filling your prescription, verify that the pharmacy is in-network.
	You can get medicines that you take routinely by MAIL ORDER . Your doctor will need to authorize a 90-day supply. You can submit refills through a website or app, or by phone.	Compare your plan’s mail-order copay and shipping against your local pharmacy price and/or other discount programs. If it’s less expensive locally, ask if your doctor can write a 90-day prescription rather than a 30-day one.

Dental



	AETNA DMO		DELTA DENTAL DPPO	
	In-Network Only	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 DMO Premium		Delta Dental PPO Premium	
Dependents	Semi-Monthly	Monthly	Semi-Monthly	Monthly
Employee	\$15.94	\$31.88	\$23.73	\$47.46
Employee + 1	\$26.36	\$52.72	\$40.34	\$80.67
Family	\$38.94	\$77.88	\$61.69	\$123.37

Dental



Did you know that regular dental checkups keep your smile bright and help keep your whole body healthy? Our dental coverage provides cleanings, exams and x-rays. The County offers two dental plans for you to choose from. All employees are required to enroll in a dental plan.

If you select the Aetna plan you will be required to utilize one of their in-network dentists. The Aetna Dental plan has a limited network of providers and it is recommended that you complete a provider search before enrolling in this plan. With nearly 80% of practicing dentists in Delta's networks, there is a good chance you already see 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.

You will not receive ID cards from the dental carriers. Below is the information you will need to confirm your eligibility with your provider for yourself and your dependents.



Aetna Dental HMO
www.aetna.com
1-877-238-6200

Member ID: Employee's Social Security Number

Note: The Member ID for dependents is the Subscriber's Social Security Number

Group Name: County of San Luis Obispo

Group Number: 883524-001

In-Network Benefits Only

You must call Aetna at the above number with your Primary Care Dentist (PCD) selection before you can schedule an appointment.



Delta Dental PPO
www.deltadentalins.com
1-800-765-6003

Member ID: Employee's Social Security Number

Note: The Member ID for dependents is the Subscriber's Social Security Number

Group Name: County of San Luis Obispo

Group Number: 2999-0011

Accepted Providers: Delta PPO Provider, Premier Provider, & Non-Delta Dental Providers. For the maximum plan benefit, visit a Delta PPO Provider.

Vision



Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

VSP VISION		
	In-network	Out-of-network
Frequency		
Examination	12 months	12 months
Frames	24 months	24 months
Eyeglass lenses	12 months	12 months
Contacts (elective)	12 months	12 months
Benefit		
Examination	\$10 copay then Plan pays 100%	Up to \$50, in-network limitations apply
Materials	\$10 copay then Plan pays 100%	Up to \$105, in-network limitations apply
Frames	Up to \$175	Up to \$70
Single vision lenses	\$25 copay then plan pays 100%	Up to \$50
Bifocal lenses	\$25 copay then plan pays 100%	Up to \$75
Trifocal lenses	\$25 copay then plan pays 100%	Up to \$100
Contacts (elective)	Up to \$150	Up to \$105

PREMIUMS		
	Semi-Monthly	Monthly
Employee Only	\$4.77	\$9.54
Employee + 1	\$7.27	\$14.54
Family	\$11.76	\$23.52



VSP Vision
www.vsp.com
 1-800-877-7195

Member ID: Employee's Social Security Number
Note: The Member ID for dependents is the Subscriber's Social Security Number

Group Name: County of San Luis Obispo
Group Number: 00105558-01
 In & Out of Network Benefits



Tax Saving Accounts

ACCOUNT	PURPOSE	LIMIT
<p>Health Savings Account (HSA) (For HDHP enrollees only)</p>	<p>An HSA is what makes high deductible health plans (HDHP) so popular. It helps with your current healthcare expenses and helps you build a safety net the future. Unused money rolls at the end of the year, earns interest, and can even be invested like a 401(k). After 65, you can even use the money for non-healthcare expenses (subject to your regular tax rate). You own the account, even if you change jobs. You may change the deduction amounts at any time. The contributions are subject to CA state taxes.</p>	<p>\$3,550 for individual \$7,100 for a family (Additional \$1,000 is added to limit if you are over age 55)</p>
<p>Healthcare Flexible Spending Account (FSA) (For all benefits eligible employees)</p>	<p>You can set aside money from your pay, pre-tax, and use it for medical, dental, and vision expenses any time during the plan year. 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 You don't have to enroll in one of our medical plans to participate in the healthcare FSA. See the table on the next page for more information on how to access your FSA account.</p> <p>Beginning 1/1/2020 you can rollover up to \$550 of your previous year's FSA unused balance.</p>	<p>\$2,700/calendar year</p>
<p>Limited Purpose FSA (For HDHP enrollees only)</p>	<p>If you or your spouse participate in an HDHP HSA plan, you are eligible for the Limited Purpose FSA which you can use for qualified dental and vision expenses only (not medical).</p>	<p>\$2750/calendar year</p>
<p>Dependent Care Flexible Spending Account (FSA) (For all benefits eligible employees)</p>	<p>Pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include daycare centers, in-home childcare, and before or after school care for your dependent children under age 13. 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 Flexible Spending Account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses.</p>	<p>\$5,000/calendar year</p>

Flexible Savings Accounts

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. If you already have a debit card from last year's Flexible Savings Account (FSA) election, you may use the same card for accessing your 2020 FSA.

Important Information regarding Flexible Spending Accounts

- All eligible medical expense must occur before 12/31/2020
- You have until March 15, 2021 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 [Tax Savings Accounts page](#).
- Stops on the last day of active employment. You have 60 days from termination to submit eligible expense receipts.
- If you have questions regarding your account(s) or a specific claim, please contact BCC's Customer Service Center at 1-800-685-6100

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 and a 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.

Forgot Your Debit Card? No Problem!

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

Basic Life And AD&D + Long Term Disability



These are employer paid benefits provided to employees in select bargaining units. No action is needed during Open Enrollment to maintain these benefits.

Bargaining Unit	Amount of Life Insurance	Amount of AD&D Insurance
08, 09, 10, 15, 16, 29	\$50,000	\$50,000
04, 06, 07, 11, 12	\$30,000	\$30,000

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 County. Coverage is provided by Voya. Remember to review your beneficiary information during Open Enrollment and update any necessary changes.

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.

The County also provides employees in those select Bargaining Units with Long Term Disability insurance. This insurance is provided at no cost to you. When you become disabled, you must complete a waiting period meaning that you are absent from work due to the same disability for 90 consecutive days before benefits are payable. Any days that you are able to work after the start of your disability will not count towards your elimination period. You may be eligible for Short Term Disability payments during this time if you enroll in Voya’s Voluntary Short Term Disability plan, which is employee paid.

EMPLOYER PAID LONG TERM DISABILITY (LTD)	
Monthly Benefit Amount	Plan pays 66 2/3% of monthly earnings
Maximum Monthly Income Benefit	\$10,000
Minimum Monthly Income Benefit	\$50
Waiting Period	90 days of disability

Voluntary Life and AD&D



Voluntary Supplemental Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself. New Hires are eligible for a one-time Guaranteed Issue if they enroll within their first 31 days of employment. Note: the benefit amount reduces to 65% at age 65, to 50% at age 70 and to 30% at age 75.

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

LIFE & AD&D		
	Election Amounts	New Hire Guaranteed Issue
Employee amount	\$20,000 up to a maximum of \$500,000 in \$10,000 increments	Up to \$150,000
Spouse amount	\$20,000 OR 50% of employee amount	Up to \$50,000
Child(ren) amount	\$10,000, not to exceed 100% of employee amount	Up to \$10,000

Evidence of Insurability (EOI) Requirement

If you are enrolling in this plan for the first time or increasing your coverage amount you must submit an **EOI form** directly to Voya unless you are within the first 31 days after your hire date. Enrolling in the plan in BenXcel does not mean you have been approved. Coverage and payroll deductions do not begin until you have been approved by Voya.

[Click here for instructions on how to complete an EOI.](#)

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	Child (Flat Rate Not Based On Age)
<25	\$0.07	50 - 54	\$0.38	\$1.90 for \$10,000 Coverage
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	



Voluntary Short Term Disability

Group Short Term Disability Income Insurance provides you with benefits to replace part of your paycheck when you can't work because of a sickness or injury. Your Short Term Disability benefits are paid for up to 12 weeks. Employees can enroll without providing an Evidence of Insurability (EOI) form if they apply within 31 days of first becoming eligible. An [EOI form](#) will be required for all other enrollees. [Click here](#) for instructions on how to complete an EOI.

Please note: Employees eligible for this plan do not pay into California State Disability Insurance (CA SDI) and this plan differs from CA SDI in that it does not have a paid family leave benefit.

SHORT TERM DISABILITY (STD)	
Weekly Benefit Amount	2020 Enhancement! Plan pays 60% covered weekly earnings
Maximum Weekly Benefit	2020 Enhancement! \$1,325
Minimum Weekly Benefit	\$50
Waiting Period	7 days
Maximum Payment Period	12 weeks
Coverage Type	Non-occupational coverage (off the job)

Cost of Coverage: Rates will change with salary and age throughout the life of your plan. See [plan brochure](#) or [BenXcel.net](#) for your personalized premium.

Eligibility Note: Employees in select bargaining units that do not participate in CA SDI or PORAC are eligible to enroll in this plan. This benefit will only be displayed for enrollment if you are eligible. See the [plan document](#) for more details.

Voluntary Long Term Disability

Long Term Disability coverage pays you a 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, like workers' compensation and Social Security. Remember, long term disability benefits begin after short term disability benefits end. Employees can enroll without providing an evidence of insurability (EOI) form if they apply within 31 days of first becoming eligible. An [EOI form](#) will be required for all other enrollees.

LONG TERM DISABILITY (LTD)	
Monthly Benefit Amount	Plan pays 60% covered monthly earnings
Maximum Monthly Benefit	\$10,000
Minimum Monthly Benefit	\$100 / 10%
Waiting Period: Accident or Sickness	360 days of disability
Maximum Payment Period	Social Security Normal Retirement Age
Survivor Benefit	3 months gross monthly benefit

Additional Benefits:

Vocational rehabilitation services are available to assist you in returning to work when possible. While you are receiving benefits from Voya, they will waive your insurance premiums. Lastly, if you leave your job, you may be eligible to convert your long-term disability coverage and take the policy with you.

Cost of Coverage: Rates will change with salary and age throughout the life of your plan. See [plan document](#) or [BenXcel.net](#) for your personalized premium.

Eligibility Note: All County employees are eligible to participate except for employees that are covered by another long term disability policy. This benefit will only be displayed for enrollment if you are eligible. See the [plan document](#) for more details.

New! Hospital Indemnity



This plan pays you a lump sum cash benefit when you are confined to a hospital, whether for planned or unplanned reasons that can assist you with related out of pocket medical expenses or anything else you may need the cash for, like your mortgage. For more information about exclusions and other plan details, [click here](#).

VOLUNTARY HOSPITAL INDEMNITY	
Benefit Amount	\$2,000
Issue Ages	Employee: 18+ Spouse: 18+ Children: Under the age 25
Guaranteed Issue	Guaranteed issue coverage is offered to all eligible applications during the initial enrollment and for new hires thereafter. At the group's first anniversary, late enrollees are eligible to enroll on a guaranteed issue basis.
Waiting Period	No waiting period
Pre-Existing Condition Clause	None
Benefit Reduction	No reduction at any age
Waiver of Premium	After 90 days of total disability due to covered sickness or accidental injury for up to 12 months
Hospital Admission	\$2,000
Hospital Confinement	\$200 up to 31 days per accident
Hospital Intensive Care (This benefit is payable in addition to the Hospital Confinement Benefit.)	\$200 up to 10 days per accident
Intermediate Intensive Care Step-Down Unit (This benefit is payable in addition to the Hospital Confinement Benefit.)	\$100 up to 10 days per accident
Rehab Benefit	Not covered
Wellness/Health Screening	\$50, once per calendar year
Mammography Screening	\$100, once per calendar year
Pregnancy Coverage	Covered
Mental and Emotional Disorder Coverage	Covered

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. This plan pays you a lump sum cash benefit when you experience a qualifying event. Coverage is provided with no health questions and is paid in addition to your medical coverage. For more information about exclusions and other plan details [click here](#).

Wellness Benefit - this policy includes a Wellness Benefit which gives covered employees and dependents an annual benefit of \$50 for completing a qualified health screening test 1x every 12 months.

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 1 st year/\$400 after 1 st year
Torn Knee Cartilage (treatment within 60 days)	\$100 during 1 st year/\$400 after 1 st 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	LUMP SUM BENEFIT AMOUNT
Hip/Thigh	\$4,000
Leg	\$2,400
Foot/Ankle/Knee Cap/Forearm/Hand/Wrist	\$2,000
ADDITIONAL BENEFITS	LUMP SUM BENEFIT AMOUNT
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 (2 nd 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 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. For more information on exclusions and other plan details [click here](#).

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.

Aflac: Cost of Coverage



VOLUNTARY HOSPITAL INDEMNITY (PER MONTH)	
Employee Only	\$33.12
Employee and Spouse	\$66.74
Employee and Child(ren)	\$52.26
Family	\$85.88

VOLUNTARY ACCIDENT INSURANCE (PER MONTH)	
Employee	\$18.86
Employee and Spouse	\$28.26
Employee and Dependent Child(ren)	\$32.48
Family	\$41.88

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.

VOLUNTARY CRITICAL ILLNESS INSURANCE (PER MONTH)					
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

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

When you call Employee Assistance Program their 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 & negotiate with creditors
- Restore your credit to pre-theft level & offer you materials on credit and ID theft

EAP COURSE	DATE & TIME
Getting Organized	November 12 9:30-10:30am
Estate Planning: Legal Issues for Adults & Dependents	November 20 9:30-11:00am
Making the Most of Your Paychecks	December 4 3:30-4:30pm
Workday Workouts	February 11 9:30-10:30am
Reinventing Retirement	February 20 2:30-4:00pm
Maximizing Your Brain's Potential	March 10 9:30-10:30am
Taming Tech	April 7 9:30-10:30am
Investment Basics	April 16 2:30-4:00pm
Social Security Retirement Planning	May 20 9:00-10:30am
Getting Your Affairs in Order: 5 Essential Documents	May 28 9:30-10:30am
Clean Living	June 16 9:30-10:30am

To register for any of these trainings, please visit [NeoGov Learn](#).

Other 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.

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.

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.

WHAT DO I DO IF...?	YOU CAN:
<p>Enrollment Issues/Questions</p> <ul style="list-style-type: none"> 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 	<p>Call BCC at 1-800-685-6100.</p>
<p>Medical Issues/Questions</p> <ul style="list-style-type: none"> 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 	<p>Call Anthem at 1-800-967-3015 or Create an online Anthem account to print a copy of your ID card, view claims, plan documents, estimate a cost for a procedure and more.</p>
<p>Pharmacy Issues/Questions</p> <ul style="list-style-type: none"> 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 	<p>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 and find a pharmacy.</p>
<p>Dental Issues/Questions</p> <ul style="list-style-type: none"> I want to check if there are any dentists in my area I have questions about my dental coverage I have a billing question 	<p>Call Aetna at 1-877-238-6200 Or Call Delta Dental at 1-888-335-8227</p>
<p>Vision Issues/Questions</p> <ul style="list-style-type: none"> I want to know which providers near me accept VSP I have questions about my vision coverage 	<p>Call VSP at 1-800-877-7195</p>
<p>Carrum Health Surgical Benefit Questions</p> <ul style="list-style-type: none"> I want to learn more about the Carrum Health surgical benefit program. I want to know if a certain procedure is covered 	<p>Call Carrum at 1-888-855-7806 or Create an account at carrum.me/EIAHEALTH</p>

Important Dates

CHECK WHEN COMPLETED	ACTION ITEM	DUE DATE
<input type="checkbox"/>	Research your options: <ul style="list-style-type: none"> • Attend the 2020 Benefits Fair • Attend an Open Enrollment Workshop • Review this brochure • Review the 2020 Open Enrollment Website • Talk to your spouse about their benefits • Review your current utilization 	Now
<input type="checkbox"/>	Login to BenXcel.net to make your 2020 election changes <ul style="list-style-type: none"> • Verify your contact and dependent information • Review current elections and make updates • Upload any documentation required • Save or print a copy of your confirmation statement for your records 	October 3 - 21

EVENT NAME	DATE & TIME	LOCATION
Benefits Fair	September 24 from 10:00 AM – 4:00 PM	Vets Hall
Open Enrollment Workshops	September 24 at 10:15 AM, 11:00 AM and 11:45 AM October 2 at 10 AM October 2 at 3 PM	Vets Hall Atascadero Library BOS Chambers
Open Enrollment Webinar	October 8 at 2pm	Visit NeoGov Learn to Register

Plan Contacts

Plan Type	Provider	Phone Number	Website	Group Number
Enrollment Resources				
BenXcel	BCC	1-800-685-6100	BenXcel.net	
Medical, Dental & Vision				
Medical	Anthem	1-800-967-3015	anthem.com/ca/EIAHealth	
Dental	Aetna DMO	1-877-238-6200	aetna.com	883524-001
	Delta Dental	1-800-765-6003	deltadentalins.com	2999-0011
Vision	VSP	1-800-877-7195	vsp.com	00105558
Pharmacy				
PPO & EPO Pharmacy	Express Scripts	1-877-554-3091	express-scripts.com	Issuer: 9151014609 RxBIN: 610014 RxGrp: RX4EIAH
HDHP Pharmacy	IngenioRx	1-833-255-0645	anthem.com/ca	
Specialty Pharmacy	Accredo	1-800-803-2523		
RxNGo	RxNGo	1-888-697-9646	rxngo.com	
Voluntary Benefits				
Life & Disability Insurance	Voya	1-800-955-7736	voya.com	CSAC EIA 31640-7 Acct 37
Accident, Critical Illness, Hospital Indemnity	Aflac	1-800-433-3036	aflacgroupinsurance.com	CA17800 C21000
FSA & COBRA	BCC	1-800-685-6100	BenXcel.net	
Miscellaneous Benefits				
Surgical Benefit	Carrum Health	1-888-855-7806	carrumhealth.com	
Post-Employment Health Plan	Nationwide	1-877-677-3678	nationwide.com/business/employee-benefits	
EAP	Anthem EAP	1-800-999-7222	anthemEAP.com	Company Code: San Luis Obispo
Resources				
Human Resources		1-805-781-5959	slocounty.ca.gov/benefits	

