2020

County of San Luis Obispo Retiree Benefits Brochure

2020 Open Enrollment
October 3 – October 21, 2019

SLO Retiree Enrollment Line: 1-855-230-0745 Ext. 4453
slocounty.ca.gov/2020OE

Who Do I Call If…?	You Call:
Enrollment Issues/Questions ▪ I want to make changes to my benefits this Open Enrollment, but I don't know how to use the online portal (www.BenXcel.net)	Call the SLO Retiree Enrollment Line between October 3 & October 21 to speak to one of BCC's dedicated enrollment specialists. 1-855-230-0745 Ext. 4453
Online 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 for my plan ▪ 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.
Pharmacy Issues/Questions ▪ I have questions on the cost of my medication ▪ I want to check if my medication is on the formulary ▪ I want to know what pharmacies I can get my medication from ▪ 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 Non-Medicare Retiree: 1-877-554-3091 Medicare Retiree: 1-844-468-0428
Dental Issues/Questions ▪ I want to check if there are any Aetna dentists in my area ▪ I have questions about my dental coverage ▪ I have a billing question	Call Aetna at 1-877-238-6200
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
Medicare Transition Issues/Questions ▪ I'm turning 65 and I do not know what I am supposed to do to enroll in Medicare ▪ I am not sure what kind of Medicare plan is right for me	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).

TABLE OF CONTENTS

2020 OPEN ENROLLMENT

IMPORTANT ELIGIBILITY INFORMATION 2
WHAT'S NEW IN 2020? 3
HOW TO ENROLL 4
WHO CAN YOU COVER? 5
FREQUENTLY ASKED QUESTIONS (FAQs) 6
MEDICAL PLANS & RATES 8
MEDICARE FAQs 10
PHARMACY 12
DENTAL AND VISION 14
CARRUM HEALTH 15
PLAN CONTACTS 16
IMPORTANT TERMS TO LEARN 17
DEPENDENT ELIBIGILITY DOCUMENTATION 18

Medicare Part D Notice

If you and/or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please refer to the Benefits webpage on the County's website, **www.slocounty.ca.gov/hr** or contact Human Resources at 805-781-5959, Pension Trust at 805-781-5465 or e-mail hr@co.slo.ca.us for more details.

Important Eligibility Information

- As retiree you have a one-time opportunity to opt in or out of medical upon retirement. If you opt in, you are able to change your election annually during Open Enrollment.
- If you opt out, you will not have another opportunity to enroll in medical until you turn 65 and enroll in Medicare. If you opt out at any time over Age 65, you are not eligible to enroll in a County medical insurance again in the future.

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.

Open Enrollment Period:

October 3 – October 21, 2019

Benefits Effective Dates:

January 1, 2020 - December 31, 2020

WHAT'S NEW IN 2020?

No action is required this year if you do not wish to make any benefit changes! There are no plan design changes to any of the retiree medical, dental or vision benefits for 2020 other than premium changes.

YOUR OPEN ENROLLMENT RESOURCES

	Visit slocounty.ca.gov/2020OE for the latest information available. This page will be updated regularly and is your best source of information.
	SLO Retiree Enrollment Line Retirees can speak to a licensed insurance representative to complete enrollment over the phone by calling the SLO Retiree Enrollment Line at 855-230-0745 Ext. 4453
	Personal Counseling Sessions (Limited Availability) A limited number of 20-minute appointments with a benefits counselor will be available on October 10. To schedule an appointment, please contact Pension Trust at (805) 781-5465.

HOW TO ENROLL

Remember

Open Enrollment will take place from October 3 – October 21, 2019. You do not need to take action if you do not want to change any of your current benefit elections. During this time, you can make changes to your current benefits such as:

- Change medical plans if enrolled
- Update your address, phone number or email address
- Add/drop dependents
- Add/drop dental & vision

Before You Enroll

- Collect the date of birth, Social Security Number (SSN), and address for each dependent you wish to add to your coverage.
- Consider your needs and the needs of your eligible dependents.
- Review any benefits offered through your spouse's/domestic partner's employer to avoid costly duplicate coverage.
- Carefully review the information in this benefits brochure and other enrollment materials.

Enroll Over The Phone

Enroll Over the Phone by Calling the SLO Retiree Enrollment Line. Call 1-855-230-0745 Ext. 4453 to be connected with a dedicated enrollment specialist who will process the changes you would like to make over the phone.

Enroll Online

1. Go to: www.benxcel.net
2. Enter your user information:
   - **USER ID:** First letter of your first name, full last name, entire Date of Birth (DOB)
   - Ex: Judy Smith-Doe DOB: 01/25/1973, USER ID: jsmithdoe01251973
   - **PASSWORD:** If you cannot remember your password, you can utilize the "Forgot Password" button or call BCC at 1-800-685-6100.
   - **Company Name**: SLO
3. Click the Sign In button to enter the system.
4. Follow the system prompts to review the benefit options and begin making elections.
5. A Confirmation Statement will appear once you have made your elections. Click finish at the bottom of page and save or print the confirmation statement for your records.

Need Help?

If you have forgotten your username and/or password, are having system issues, or need hep navigating the portal, you can call **BCC at 1-800-685-6100** for assistance.

WHO CAN YOU COVER?

WHO IS ELIGIBLE?

All eligible Retirees – those officially retiring with the County within 120 days of separation– are able to participate in County medical insurance. Retirees that opt in or enroll in County medical insurance can continue to make changes annually at open enrollment and always have the ability to opt out at any time. All retirees can participate in Dental and Vision.

WHAT HAPPENS IF I OPT OUT OR WAIVE MEDICAL INSURANCE?

Retirees have a one-time opportunity to opt in or out of medical, upon retirement. If you opt out at any time, you will not have another opportunity to enroll in County medical until you turn Age 65 and enroll in Medicare. If you opt out at any time over Age 65, you are not eligible to enroll in medical plans again in the future.

ELIGIBLE DEPENDENTS

1. Your legal spouse under state law, including a same-sex spouse.
2. Your domestic partner. Domestic Partner Affidavit required.
3. Your children (including your domestic partner's children):
   a. Children under age 26 are eligible to enroll in medical, dental & vision coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
   b. Children you have legal guardianship of or those named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.
   c. Children over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support. Obtain the Disabled Dependent Certification Form by Anthem.
4. Legal documentation is required for all dependents, see page 19 for more information.

WHO IS NOT ELIGIBLE?

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

1. Parents, grandparents, and siblings.
2. Former spouses and stepchildren are ineligible dependents and will be removed from County insurance plans effective the date of the divorce decree. Medical claims and premiums incurred due to late notification to the County are the responsibility of the retiree.

ENROLLMENT PERIODS & QUALIFYING EVENTS

Open Enrollment is the only time each year that retirees can make changes to their benefit elections without a qualifying life event. Enrollment changes can be made by calling BCC at1-855-230-0745 Ext. 4453 or online at www.benxcel.net **within 31 days of your qualifying life event**.

Qualifying life events include, but are not limited to:

1. Marriage, divorce or death to add/remove dependents
2. Dependent involuntary loss of other healthcare coverage
3. Dependent new eligibility for other group coverage
4. Transition to Medicare

FREQUENTLY ASKED QUESTIONS: OPEN ENROLLMENT

If I take no action, will my coverage automatically carry over from last year?

Yes, if you take no action your plan enrollment and dependents covered will automatically rollover to next year.

How do I complete open enrollment if I want to make changes this year?

You have two options :

1. Call the SLO Retiree Enrollment Line at 1-855-230-0745 Ext. 4453
2. If you are currently enrolled in County benefits you can log on towww.BenXcel.net

What is the County Contribution to my County medical plan in 2020?

In 2020, the County will contribute $139 per month to the cost of your County medical plan. All of the County information will display the full medical premium costs without the County Contribution. The County contribution amount will be applied toward your medical premium before your pension deduction is taken each month.

Are the medical or pharmacy provider networks changing?

No, the Anthem provider networks available will not be changing. Whether or not a provider chooses to accept an insurance network is the provider's choice and is always subject to change. Always verify with your provider that they accept your insurance by providing them your Medicare and medical insurance ID cards.

Will I receive ID cards?

Medical & Pharmacy: No, if you are currently enrolled in a medical plan, you will not receive a new medical or pharmacy ID card. If you are enrolling for the first time or making plan changes then you will receive a new ID card prior to January 1, 2020. For pharmacy, 2 ID cards are issued to the subscriber with subscriber name only. No ID cards are issued with dependent names.

Dental & Vision: No, neither Aetna nor VSP issues ID cards. To confirm yours and your dependent's coverage, the provider will need the subscriber's Social Security Number and the plan group number. Group numbers for each plan are listed on page 16 of this document.

FREQUENTLY ASKED QUESTIONS: BILLING

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 should contact Anthem directly to resolve any billing issues. 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.

I'm enrolled in Medicare & my provider billed me for my deductible, do I have one?

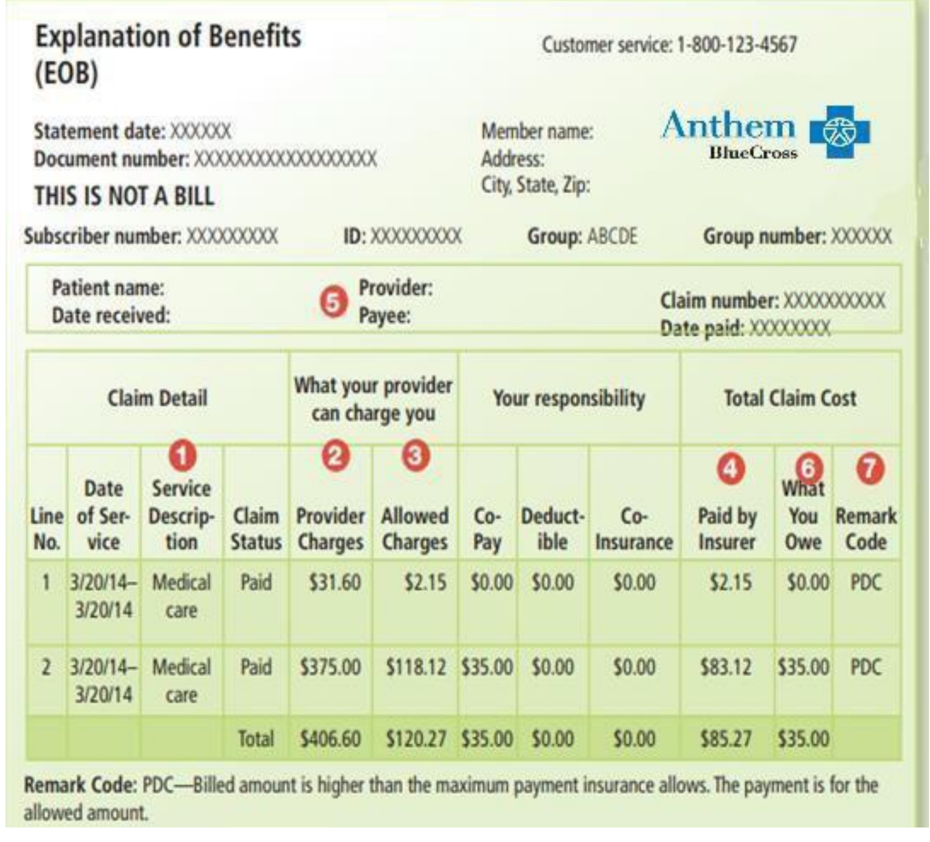
No, retirees on Medicare do not have a deductible for medical. Contact your provider and confirm they have billed Medicare primary and Anthem secondary. If they have, contact Anthem.

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, 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

Anthem BlueCross

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

Member name:
Address:
City, State, Zip:

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		
Line No.	Date of Service	(1) Service Description	Claim Status	(2) Provider Charges	(3) Allowed Charges	Co-Pay	Deductible	Co-Insurance	(4) Paid by Insurer	(6) What You Owe	(7) 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: What services you received, whether it was an office visit, lab work, or other diagnostic screenings.
2. Provider Charges: This is what your provider billed your insurance company for your care.
3. Allowed Charges: What your provider receives as payment from the insurance company, usually different from the preceding provider charges.
4. Paid by Insurer: The amount your health plan pays your provider.
5. Payee: You!
6. What You Owe: The difference between what the provider charged and what your health plan paid.

EARLY RETIREE NON- MEDICARE MEDICAL PLANS

Medical Plans	Anthem Select PPO		Anthem Choice PPO		Anthem Care PPO		Anthem EPO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Benefits Only
Annual Deductible Individual/ Family	$500/$1,000		$500/$1,000		$500/$1,000		None
Annual Out-of-Pocket Maximum Individual/ Family	$3,000/ $6,000	No Limit	$3,000/ $6,000	No Limit	$2,000/ $4,000	No Limit	$1,500/ $3,000
Physician Office Visit (Deductible Waived)	$20	40%	$20	40%	$20	40%	$15 / visit
Specialist Copay (Deductible Waived)	$20	40%	$20	40%	$20	40%	$15 / visit
Preventative Care	No Charge	40%	No Charge	40%	No Charge	40%	No Charge
Lab and X-Ray							
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 (Copay per visit waived if admitted)	$50+ 20%	$50 + 20%	$50 + 20%	$50 + 20%	$50 + 10%		$50 / Visit
Urgent Care Services	$20	40%	$20	40%	$20	40%	$15 / visit
Durable Medical Equipment	20%	40%	20%	40%	10%	40%	No Charge
Chiropractic/ Acupuncture (20 visits combined with acupuncture / calendar year)	$15	40%	$15	40%	$15	40%	$15 / visit
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
Monthly Premium Costs	Monthly		Monthly		Monthly		Monthly
Retiree Only	$554.00		$623.00		$649.00		$768.00
Retiree + 1 Dependent	$1,093.00		$1,233.00		$1,286.00		$1,528.00
Family	$1,425.00		$1,606.00		$1,677.00		$1,995.00

Note: Coverage for out-of-network provider or services is limited to a maximum per day. Please reference benefits summaries for additional details.

RETIREE MEDICARE MEDICAL PLANS

2020 Medical Plans	Anthem Medicare PPO		Anthem Medicare EPO In Network Benefits ONLY	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible	None	None	None	
Annual Out-of-Pocket Maximum	None	No Limit	$1,500 individual/ $3,000 family	No Limit
Physician Office Visit	No Charge	No Charge	$15 / Visit	Not Covered
Specialist Copay	No Charge	No Charge	$15 / Visit	Not Covered
Preventative Care	No Charge	No Charge	No Charge	Not Covered
Lab and X-Ray				
CT, MRI, PET scans	No Charge	No Charge	No Charge	Not Covered
Other lab and x-ray tests	No Charge	No Charge	No Charge	Not Covered
Hospitalization				
Inpatient & Outpatient	No Charge	No Charge	No Charge	Not Covered
Emergency Room (waived if admitted)	No Charge	No Charge	$50 / Visit	Not Covered
Urgent Care Services	No Charge	No Charge	$15 / Visit	Not Covered
Durable Medical Equipment	No Charge	No Charge	No Charge	Not Covered
Chiropractic/ Acupuncture (20 visits per year combined with acupuncture)	$15 / Visit	$15 / Visit	$15 / Visit	Not Covered
Provider Network	Blue Cross PPO (Prudent Buyer) - Large Group		Blue Cross PPO (Prudent Buyer) – Large Group	

Plan & Coverage Tier	Premium
Anthem Medicare PPO When all family members enrolled are on Medicare	
Retiree Only	$429.20
Retiree + 1	$856.20
Family	$1,283.20
Anthem Medicare PPO Combo Plans The retiree is on Medicare	
1 Medicare, 1 non-Medicare	$1,039.20
1 Medicare, 2 non-Medicare	$1,412.20
2 Medicare, 1 non-Medicare	$1,229.20
Anthem Medicare PPO Combo Plans The Retiree is **Not** on Medicare	
1 Medicare, 1 Anthem Select	$968.20
1 Medicare, 2 Anthem Select	$1,300.20
2 Medicare, 1 Anthem Select	$1,188.20
1 Medicare, 1 Anthem Care	$1,066.20
1 Medicare, 2 Anthem Care	$1,457.20
2 Medicare, 1 Anthem Care	$1,247.20

Plan & Coverage Tier	Premium
Anthem Medicare EPO When all family members enrolled are on Medicare	
Retiree Only	$393.20
Retiree + 1	$785.20
Family (All Medicare)	$1,176.20
Anthem Medicare EPO Combo Plans When at least one person enrolled is not on Medicare	
1 Medicare, 1 non-Medicare	$1,153.20
1 Medicare, 2 non-Medicare	$1,620.20
2 Medicare, 1 non-Medicare	$1,252.20

Medical premiums displayed are before the County's contribution of $139.00. You must be enrolled in a County Medical plan to receive the County Contribution.

FREQUENTLY ASKED QUESTIONS: MEDICARE

What is the Medicare transition process?

60 - 90 days before the members 65th birthday, you will receive a Medicare enrollment packet from our third-party administrator, BCC. The enrollment packet will ask you to select a new Medicare plan and provide your Medicare Part A & B effective dates and Health Insurance Claim Number (HICN) OR Medicare Beneficiary Number (BMI) located on your Medicare card. Non-Medicare dependent plan enrollment will not change.

Myself or my dependent are turning 65 this year, how does this impact our County medical benefits?

Turning 65 is a Qualifying Event to transition to a County sponsored Medicare plan at a lower monthly premium for both the retiree and any enrolled dependents. To be eligible for a County Medicare plan, the member turning 65 must enroll in Medicare Part A & Part B through the Social Security Administration (SSA). This is only a qualifying event for a member to transition to a Medicare plan, no other changes are permitted.

You must complete and postmark the enrollment form to BCC by your 65th birthday to either transition to a Medicare plan or to opt out of County medical coverage. **Failure to complete and return this form will be considered opting out of County Medical and will result in termination of your non-Medicare medical plan.**

Will I get a new Anthem & Express Scripts ID card when I transition to Medicare?

Yes, you will receive news ID cards for both Anthem and Express Scripts once you transition to Medicare. Be sure to discard your old ID cards and use the news ones or you may be billed for services incorrectly.

How do I know if my provider accepts Medicare?

Always be sure to ask your provider if they accept Medicare in addition to being in Anthem's network. When utilizing your County benefits Medicare is the primary payer and Anthem is the secondary payer. Present both your Medicare card and Anthem ID card to your provider. Under the County Medicare plans, providers that do not accept Medicare are not covered even if they are in Anthem's network.

I need Medicare advising, is there someone I can talk to?

Yes! We always encourage our retirees to reach out to the Health Insurance Counseling Advocacy Program (HICAP) sponsored by the Central Coast Commission for Senior Citizens. HICAP does not sell anything but provides free and unbiased information and counseling about Medicare so you can make informed decisions. You can visit their website http://centralcoastseniors.org/hicap/ or call them at 1-800-510-2020.

FREQUENTLY ASKED QUESTIONS: MEDICARE

How do the County Medicare plans work?

The County offers Coordination of Benefit (COB) plans that are designed to cover the costs that Medicare does not. Medicare is the primary payer and your Anthem plan is the secondary payer. Present both your Medicare card and Anthem ID card to your provider and always confirm that your provider accepts Medicare. Providers that do not accept Medicare are not covered even if they are in Anthem's network.

Do the County's Medical plans include Medicare Part D Pharmacy benefit?

Yes, the County's Medicare plans do include a Part D prescription benefit. Do not enroll in a separate Part D plan or your county medical plan will be terminated by the Center for Medicare and Medicaid Services. For more information on your Medicare prescription coverage, contact Express Scripts at 1-844-468-0428.

What happens when only 1 person in my family is Medicare age?

Combo plans are special medical insurance plans available for retirees with dependents of a different Medicare status and only apply to medical insurance. Combo Plans are for when some members of your family are over age 65 & on Medicare, and some of the other members are not on Medicare yet. In those instances, the members that are on Medicare should refer to page 9 to see their Medical plan details. The non-Medicare members of that Combo Plan should refer to page 8 for their plan details, they will not be the same as the Medicare member's. Premiums for all medical plans are available on page 9.

The retiree Medicare status and medical plan election drive which plan options are available for their spouse and dependents enrolled on their medical insurance to select. See below chart for the available options. When a member of your family is over Age 65, they will have the choice between two Medicare plans, the Anthem Medicare PPO and Anthem Medicare EPO. What Medicare plan is selected will impact the choice available for the non-Medicare member.

Retirees should select your plan from either the right or left column depending on your current age. The retire plan selection determines what plan any dependents would be enrolled in.			
Early Retiree (Retirees Under Age 65) Select one of the below plans. If you have dependents 65 or older, they will be enrolled in the corresponding Medicare plan.		**Medicare Retiree (Retirees Age 65 or over)** Select one of the below plans. If you have dependents under age 65, they will be enrolled in the corresponding non-Medicare Plan.	
Retiree Non-Medicare Plan	**Dependent Medicare Plan**	**Retiree Medicare Plan**	**Dependent Non-Medicare Plan**
Anthem Select PPO Anthem Choice PPO Anthem Care PPO	Anthem PPO Medicare	Anthem PPO Medicare	Anthem Choice PPO
Anthem EPO	Anthem EPO Medicare	Anthem EPO Medicare	Anthem EPO

PHARMACY BENEFITS

Early Retiree Non-Medicare Pharmacy Benefits

Early Retiree Non-Medicare Pharmacy Benefits	Retail Pharmacy (1 Month Supply)	Mail-Order (3 Month Supply)
Annual Out-of-Pocket- Limit	$2,000 Individual/ $4,000 Family	$1,000
Generic	$5 Copay	$10 Copay
Preferred Brand	$20 Copay	$40 Copay
Non-Preferred Brand	$50 Copay	$100 Copay

MEDICARE RETIREE (65+) PHARMACY PLAN

Tier	Retail Pharmacy (1 Month Supply)	Retail Pharmacy (2 Month Supply)	Retail Pharmacy (3 Month Supply)	Mail Order (3 Month Supply)
Generic (Tier 1)	$5 Copay	$10 Copay	$15 Copay	$10 Copay
Preferred Brand (Tier 2)	$20 Copay	$40 Copay	$60 Copay	$40 Copay
Non-Preferred (Tier 3)	$50 Copay	$100 Copay	$150 Copay	$100 Copay

Create an Online Express Scripts Account or Download the App

With an online account or through the mobile 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. You can set up home delivery & track your delivery, order refills, print a copy of your ID card, view your RX claims & balances, and so much more!

INSIDER TIPS

	Medicare members & Non-Medicare members have separate Express Scripts accounts, even if you are covered by the same plan.	If your covered family members are all on Medicare, or all are not, then your accounts will not be separate.
	Medicare members & Non-Medicare members have different customer service lines.	Non-Medicare Line: 1-877-554-3091 Medicare Line: 1-844-468-0428
	You will only receive a new ID card if you are enrolling for the first time or making plan changes.	Two ID cards are issued to the subscriber with subscriber name only. No ID cards are issued with dependent names

NEW! PHARMACY BENEFITS

Express Scripts Smart 90 Program – (Available to Non-Medicare Retirees Only)

With this new program, you have two ways to get up to a 90-day supply of your maintenance medications (those 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. 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'nGO – (Available to Non-Medicare Retirees Only)

Rx 'n Go is a voluntary mail order pharmacy benefit. All employees and covered dependents, on a non-HDHP 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.

Over 1,200 generic medications for free through Rx 'n Go!

What do I have to do?

1. Go to www.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'nGo at 888.697.9646

View the available generic and preventive maintenance medications at **www.rxngo.com**

DENTAL AND VISION

Aetna Dental DHMO (In-Network Benefits Only)		
Calendar Year Deductible, Annual Plan Maximum, & Waiting Period	None	
Preventive Care	Diagnostic pays 100% Preventive various copays apply	
Basic Services, Fillings, Root Canals, Periodontics, & Major Services	Plan pays 100% Various copays apply	
Orthodontic Services (Patient Pays)	Screening: $30 Diagnostic Records: $150	Treatment: $1,545 Retention: $275
Orthodontia Lifetime Maximum	None (limited to one full course of treatment)	

VSP Vision	
Examination Benefit	$10 copay then plan pays 100% *Frequency: 1 x every 12 months*
Material	$10 copay then plan pays 100%
Eye Glasses, Single Vision Lens, Bifocal Lens, *or* Trifocal Lens	$25 copay then plan pays 100% *Frequency: 1 x every 12 months*
Frames	Up to $175 *Frequency: 1 x every 24 months*
Contacts (in lieu of Glasses)	Up to $150 *Frequency: 1 x every 24 months*

Aetna Dental	
Coverage Tier	**Premium**
Retiree Only	$31.88
Retiree +1	$52.72
Family	$77.88

VSP Vision	
Coverage Tier	**Premium**
Retiree Only	$9.54
Retiree +1	$14.54
Family	$23.52

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
New Enrollees: You must call with your Primary Care Dentist (PCD) section before you can schedule an appointment.

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

Please refer to the Benefit Summaries for detailed information on how these plans will pay for services. The VSP Vision benefits details only apply for in-network services. To view the Benefits Summaries, visit www.slocounty.ca.gov/2020OE

CARRUM HEALTH

(AVAILABLE TO NON-MEDICARE RETIREES ONLY)

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.

*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.

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

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).

PLAN CONTACTS

Plan Type	Provider	Phone Number	Website	Group Number
Enrollment Resources				
Retiree Enrollment Line	BCC	1-855-230-0745 Ext. 4453		
BenXcel Assistance	BCC	1-800-685-6100	benxcel.net	
Medical, Dental, & Vision				
Medical	Anthem	1-800-967-3015	anthem.com/ca/EIAHealth	175075
Dental	Aetna DMO	1-877-238-6200	aetna.com	883524-001
Vision	VSP	1-800-877-7195	vsp.com	00105558
Pharmacy				
Non-Medicare Pharmacy	Express Scripts	1-877-554-3091	express-scripts.com	Issuer: 9151014609 RxBIN: 610014 RxGrp: RX4EIAH
Medicare Pharmacy	Express Scripts	1-844-468-0428	express-scripts.com	
Specialty Pharmacy	Accredo	1-800-803-2523		
RxNGo	RxNGo	1-888-697-9646	rxngo.com	
Miscellaneous Benefits				
Voluntary Surgical Benefit	Carrum Health	1-888-855-7806	carrumhealth.com	
Post-Employment Health Plan	Nationwide	1-877-677-3678	nationwide.com/employee-benefit-services.jsp	
Resources				
Human Resources		1-805-781-5959	slocounty.ca.gov/benefits	
Pension Trust		805-781-5465	slocounty.ca.gov/Departments/Pension-Trust.aspx	
Medicare Questions	HICAP	1-805-928-5663	cahealthadvocates.org/hicap	

IMPORTANT TERMS TO LEARN

Health insurance seems to have its own language. You will get more out of your plans if you 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 expensesyou 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.

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

Notes

Rev. 11/13/2019