2024

RETIREE BENEFIT BROCHURE

2024 Open Enrollment: October 6 - 20, 2023
SLO Retiree Enrollment Line: (833) 574-1838
slocounty.ca.gov/oe

Who do I Call if…?	Contact:
Enrollment Issues/Questions • I want to make changes to my benefits this Open Enrollment • I have a qualifying life event and I need to make changes to my benefits	**SLO Retiree Enrollment Line** (833) 574-1838
Medical Issues/Questions • Provider search • Questions about plan coverage or procedures • Medical ID card questions • Medical bills or claims questions	**Accolade Health Assistants** Available January 1, 2024 (866) 406-1275
Pharmacy Issues/Questions • Cost of my medication(s) • Check if my medication is on the formulary • What pharmacies can I utilize? • 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	**Express Scripts** Non-Medicare Retiree: (877) 554-3091 Medicare Retiree: (844) 468-0428
Dental Issues/Questions • Find an Aetna dentist in my area • Questions about plan coverage or procedures • I have a billing question	**Aetna** (877) 238-6200
Vision Issues/Questions • VSP provider search • Questions about plan coverage or procedures	**VSP** (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 which Medicare plan is right for me	**Alliant Medicare Solutions** (866) 273-6420 **Central Coast Commission for Senior Citizens** (805) 928-5663 Regarding Health Insurance Counseling & Advocacy Program (HICAP)

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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 review the Medicare Part D Notice on page 26.

OPEN ENROLLMENT & WHAT'S NEW

We are providing you with this brochure to help you understand the benefits available to you and how to best use them. Please review it carefully. A list of plan contacts and resources are provided on the last page of this booklet.

The information in this booklet is a general outline of the benefits offered under the County of San Luis Obispo benefits program. Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC) and/or insurance policies. If the information in this booklet differs from the plan documents, the plan documents will prevail. For more information, please visit **slocounty.ca.gov/Benefits** or contact the insurance carrier.

Open Enrollment will be October 6 – 20, 2023.
All benefit changes will be effective January 1, 2024 – December 31, 2024.

We are pleased to announce that we will offer the same benefit packages as last year with some improvements and additions! Please see the following summary below for all 2024 changes. For 2024 Open Enrollment, you must call the SLO Retiree Enrollment Line at (833) 574-1838 to make any changes to your medical, dental and vision elections.

New Healthcare and Benefits Service!

- Introducing Navigator PPO Plans powered by Accolade, your new benefit assistant and all-inclusive benefit service. Get connected to an Accolade Health Assistant or nurse to help answer your health and benefit questions, big or small. You will also have access to virtual primary mental health care.
- **A soft launch will be available in early December with full access to Accolade services starting January 1, 2024. See page 5 for more information on these new services that we are excited to share with you!**

Medical

- Effective January 1, 2024, the Anthem Blue Cross network will be changed to Blue Shield of California. **Your plan benefits (copays, coinsurances, deductibles, etc.) will not change.**
- New Medical ID cards will be mailed out in early December.
- Blue Shield's Tandem PPO Plan will replace the Anthem Select Plan as the new narrow network plan. All other medical plans will utilize Blue Shield's full PPO network.

Dental

- No changes to the Aetna plan or premiums for 2024.

Vision

- VSP has added Walmart and Sam's Club as in-network retail providers, and a LightCare benefit for non-prescription sunglasses or non-prescription blue light filtering glasses. Also, Polycarbonate lenses are now covered at no cost with in-network providers.

INTRODUCING Navigator PPO Plans Powered by Accolade

ACCOLADE HEALTH ASSISTANTS ARE AVAILABLE JANUARY 1!

County of San Luis Obispo retirees enrolled in a County medical plan will have access to Accolade, a new healthcare and benefits service beginning January 1, 2024.

A soft launch will be available in December to connect with your Accolade Health Assistant who will provide information about this service and how to get started.

Who are the Accolade Health Assistants?

Accolade Health Assistants are part of your Accolade Care team and are here to provide an exceptional healthcare experience through phone, their web portal, and mobile app.

AVAILABLE JANUARY 1, 2024!

PHONE: (866) 406-1274
WEBSITE: member.accolade.com

Health and Benefits Support

Accolade Health Assistants and nurses are your first place to turn whenever you have a healthcare need or benefits question. Available by phone or secure messaging through the web portal and web app.

Through Accolade you can:

- **Get Benefits Guidance** – health assistants can help you learn more about the benefits available to you and your family.
- **Access Virtual Care** – Accolade Care gives you 24/7 access to primary care and mental health support. Accolade Care doctors can also prescribe medications.
- **Find In-Person Care** – Accolade Health Assistants can help find and schedule appointments with high-quality, in-network doctors, specialists, or healthcare facilities. They can also help you understand your options for care (e.g., PCP, urgent care, emergency room).
- **Understand Coverage and Costs** – Accolade can help you understand your health plan coverage, costs, and make sense of confusing medical bills.
- **Receive Nurse Support** – get connected to a nurse who can help you understand symptoms, learn about conditions or explore treatment options. You can also connect with clinical programs that are specific to your health conditions and offer enhanced support.
- **Expert Medical Opinion** - *2nd. MD* is Accolade's expert medical opinion service. They can arrange for a second opinion from a world-renowned doctor about a diagnosis, treatment option, surgery or medication that you are feeling unsure about – at no cost to you.

KNOW YOUR ENROLLMENT RESOURCES

Open Enrollment will take place from October 6 – October 20, 2023. No action is needed on your part during Open Enrollment unless you wish to:

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

All County medical plans will transition from Anthem Blue Cross to Blue Shield of California. If you do not make changes to your medical plan enrollment, you will be automatically enrolled in the corresponding Blue Shield medical plan.

Visit **slocounty.ca.gov/oe** 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 (833) 574-1838.

Personal Counseling Sessions (Limited Availability)

A limited number of 15-minute in-person counseling appointments with a benefits counselor are available on September 18, September 20 and October 4. To schedule an appointment, please contact Human Resources at (805) 781-4199.

Medicare Assistance/Questions

Retirees can call **Alliant Medicare Solutions (AMS)** at (866) 273-6420 to speak to a Licensed Insurance Agent for Medicare help and questions. You can also find more information about Medicare and services from AMS at **https://alliantbenefits.cld.bz/coslo-medicare-guide**.

Retirees can also contact **Central Coast Commission for Senior Citizens** at (805) 928-5663 to speak to a Medicare Counselor from their Health Insurance Counseling & Advocacy Program (HICAP).

Contact your Accolade Health Assistant!

Accolade Health Assistants and nurses are your first place to turn whenever you have a healthcare need or benefits question. Available beginning January 1, 2024, by phone at (866) 406-1275 or through the web portal and web app at **member.accolade.com**.

WHO'S ELIGIBLE FOR BENEFITS?

All eligible Retirees – those officially retiring with the County within 120 days of separation – are eligible to participate in County medical insurance.

Retirees who enroll in County medical insurance can only make changes during the annual open enrollment period or when you have a qualifying life event.

All retirees can participate in dental and vision insurance.

IMPORTANT NOTE: If you terminate your enrollment in the retiree medical program, you and your dependents will not have another opportunity to participate again in the future until age 65. You will have a final opportunity to opt in when you turn age 65 and enroll in Medicare.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

You can enroll the following family members in our medical, dental and vision plans:

- Spouse (the person who you are legally married to under state law, including a same-sex spouse).
- Registered Domestic Partner (must be recognized by state law and confirmed by registration with the state).
- Children up to age 26 (including your domestic partner's children). Married children are eligible for benefits.
- Children over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support. You must request a Disabled Dependent Certification form from Blue Shield.
- Dependents named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

DEPENDENT VERIFICATION

Adding dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You will be required to provide legal documentation within 31 days of their eligibility. See page 9 for more information.

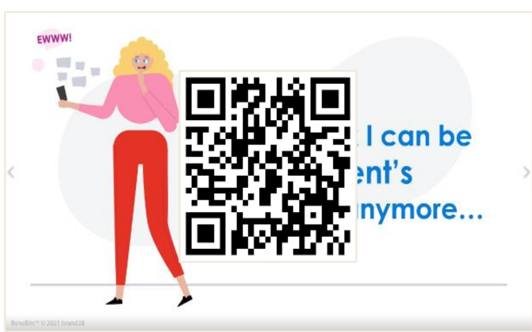
If you do not supply the proper documentation to add dependents within the 31-day period, you will not be able to add the dependent(s) until the next open enrollment period.

WHO IS NOT ELIGIBLE?

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

- Parents, grandparents, and siblings.
- 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.

CHANGING YOUR BENEFITS



Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

SURVIVOR BENEFITS

A spouse or domestic partner survivor of a deceased retiree may be eligible for health coverage if they are both:

1. Enrolled OR eligible to enroll as a dependent at the time of death

AND

2. Qualify for a monthly survivor retirement benefit.

The survivor may request health enrollment from the County within 60 days from the date of death. Subsequent spouses and children will be ineligible for County retiree benefits.

Open Enrollment is the only time each year that retirees can make changes to their benefit elections without a qualifying life event. Any changes that you make must be consistent with the change in status.

To make enrollment changes, call BCC at (833) 574-1838 **within 31 days** of your qualifying life event. Call (855) 230-0745 ext. 4453 to update your address.

If you have a qualifying life event for a mid-year benefit change, you will be required to submit proof of the change. Refer to the next page for the types of documentation you will need to submit when adding dependents to your coverage for the first time.

Common Qualifying Life Events
Birth, Adoption, or New Legal Guardianship of a Child
Change in legal marital status including 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 and is offered group medical coverage that they would like to enroll in.
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 - Medicare or Medicaid eligibility is a qualifying event only for the individual with which this applies to and does not allow other covered individuals, either retiree or dependent, to make changes to their coverage.

DEPENDENT DOCUMENTATION

The following verification documents are required to enroll a dependent in health benefit plans. Social Security Numbers for all dependents are required to be covered on the plans. County of San Luis Obispo reserves the right to request additional documentation to substantiate eligibility. A retiree may be held responsible for substantial charges if services are provided for a person who is found to be ineligible.

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 • **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 • **sos.ca.gov/registries/domestic-partners-registry**
Dependent Child by Birth	Birth Certificate (must include parents' names), 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 • **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' names), 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 • **Vitalchek.com**
Dependent Child by Legal Guardianship	Birth Certificate (must include parents' names), and copies of any court orders or other legal documents relating to custody or health coverage	• County 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**

FREE RETIREE BENEFITS

Take advantage of these free value-added services available to retiree members and their dependents aged 18+ on a County Blue Shield plan to help you get and stay healthy.

BENEFIT HIGHLIGHTS	AVAILABILITY & HOW TO GET STARTED
Physical Therapy for Back or Joint Pain **Hinge Health** Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy. Newly added Women's Pelvic Health program for pelvic floor issues and pain. Available for preventative, acute, and chronic needs at no cost.	**Medicare as well as Non-Medicare PPO & EPO members** **Call:** (855) 902-2777 **Visit** hingehealth.com/prism/
Surgical and Breast Cancer Treatment Benefit **Carrum Health** Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel for patient and companion, and medical bills. Oncology benefit is also available; guidance for all cancers types; and treatment for Breast Cancers at City of Hope. Please Note: total joint replacement, spinal fusion and bariatric (weight loss) surgeries will require a second opinion evaluation through the Carrum Health Program.	**Non-Medicare PPO & EPO members** **Call:** (888) 855-7806 *Mon-Fri 9am to 5pm PST* **Visit** carrum.me/prism
Diabetes Management Program **Livongo** No cost program to help members with diabetes reduce risk and improve condition management. Free meter and unlimited test strips using 24/7 cellular real-time technology. Active monitoring and coaching also available. No copays or out-of-pocket fees.	**Non-Medicare & Medicare PPO & EPO members** **Call:** (800) 945-4355 **Visit** welcome.livongo.com/prism **Registration code:** PRISM

CHOOSING A MEDICAL PLAN

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

Your Doctors – Do you prefer to see specific doctors? Visit the Blue Shield 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 to help with comparing your plan options.

Deductible: The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.

Out-Of-Pocket Max: Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.

Coinsurance: After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.

Copay: 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.

Balance Billing: 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.

WHICH PLAN IS RIGHT FOR YOU?

Need Help Understanding your Medicare Options? Use Alliant Medicare Solutions!

Call Alliant Medicare Solutions (AMS) at (866) 273-6420 to speak to a licensed Insurance Agent. AMS can help you with questions on your current insurance coverage, types of coverage that are offered by the County, original Medicare, Medigap, Medicare Advantage, and prescription drug plans. AMS is here to help you find which plans might be the best for you!

The County of San Luis Obispo offers four non-Medicare plans and two Medicare plans for different needs and budgets. Every plan includes free preventive care from in-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.

Consider an EPO (Exclusive Provider Organization) if:

- You want lower, predictable out-of-pocket costs
- You like having one doctor to manage your care
- You are happy with the selection of in-network providers
- You don't see any doctors that are out-of-network
- You want to pay a fixed copay for most services

Plans To Consider

- Blue Shield EPO
- Blue Shield Medicare EPO

Consider a PPO (Preferred Provider Organization) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers

Plans To Consider

- Blue Shield Tandem PPO Plan (Formerly Anthem Select PPO Plan)
- Blue Shield Choice PPO
- Blue Shield Care PPO
- Blue Shield Medicare PPO

	PPO	EPO
Deductible	✓	Maybe
Out-of-Network Care Covered	✓	No
Referral Needed to See Specialist	Not Required	Not Required
Must Select Primary Care Physician	Not Required	Not Required
Pros	• Go anywhere, whether in-network or out-of-network	• Fewer restrictions than an HMO
Cons	• Pay more for out-of-network providers	• No out-of-network coverage

NON-MEDICARE MEDICAL PLANS

Plan Benefits	Blue Shield Tandem PPO (Narrow Network)		Blue Shield Choice PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible Individual Family	$1,250 per individual $2,500 per family		$1,000 per individual $2,000 per family	
Annual Out-of-Pocket Maximum Individual Family	$3,000 per individual $6,000 per family	No Limit per individual or family	$3,000 per individual $6,000 per family	No Limit per individual or family
Office Visit Primary Care and/or Specialist	$35/visit (deductible waived)	Plan pays 60%	$35/visit (deductible waived)	Plan pays 60%
Preventive Care	No Charge	Plan pays 60%	No Charge	Plan pays 60%
Chiropractic (limits apply)	$15/visit (deductible waived)	Plan pays 60%	$15/visit (deductible waived)	Plan pays 60%
Acupuncture (limits apply)	$15/visit (deductible waived)	Plan pays 60%	$15/visit (deductible waived)	Plan pays 60%
Lab and X-ray	Plan pays 75%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Advanced Imaging (MRI/PET/CAT scans)	Plan pays 75%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Urgent Care	$35/visit (deductible waived)	Plan pays 60%	$35/visit (deductible waived)	Plan pays 60%
Emergency Room (copay waived if admitted)	$100 + plan pays 75%	Covered as in-network	$100 + plan pays 80%	Covered as in-network
Hospitalization	Plan pays 75%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Outpatient Surgery ***Carrum Health**	Plan pays 75% No charge	Plan pays 60% No charge	Plan pays 80% No charge	Plan pays 60% No charge
Provider Network	**Blue Shield Tandem PPO (Narrow Network)**		**Blue Shield of California PPO Network**	

To find a provider visit https://blueshieldca.com/fad/home. 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 Blue Shield's allowable amount. Charges in excess of the allowable amount do not count toward the calendar year deductible or out-of-pocket maximum. *Please Note: total joint replacement, spinal fusion and bariatric (weight loss) surgeries will require a second opinion evaluation through the Carrum Health Program.

NON-MEDICARE MEDICAL PLANS

Plan Benefits	Blue Shield Care PPO		Blue Shield EPO
	In-Network	Out-of-Network	In-Network Only
Annual Deductible Individual Family	$500 per individual $1,000 per family		$250 per individual $750 per family
Annual Out-of-Pocket Maximum Individual Family	$2,000 per individual $4,000 per family	No Limit No Limit	$1,500 per individual $3,000 per family
Office Visit Primary Care and/or Specialist	$20/visit (deductible waived)	Plan pays 60%	$25/visit
Preventive Care	No Charge	Plan pays 60%	No Charge
Chiropractic (limits apply)	$15/visit (deductible waived)	Plan pays 60%	$15/visit
Acupuncture (limits apply)	$15/visit (deductible waived)	Plan pays 60%	$15/visit
Lab and X-ray	Plan pays 90%	Plan pays 60%	$25/visit
Advanced Imaging (MRI/PET/CAT scans)	Plan pays 90%	Plan pays 60%	$25/visit
Urgent Care	$20/visit	Plan pays 60%	$25/visit
Emergency Room	$50 + plan pays 90%	$50 + plan pays 90%	$150/visit
Hospitalization	$250 + plan pays 90%	$250 + plan pays 60%	$250/admit
Outpatient Surgery ***Carrum Health**	Plan pays 90% No charge	Plan pays 60% No charge	No Charge No Charge
Provider Network	**Blue Shield of California PPO Network**		**Blue Shield of California PPO Network**

Note for Out-of-Network benefits for all PPO Plans - 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 Blue Shield's allowable amount. Charges in excess of the allowable amount do not count toward the calendar year deductible or out-of-pocket maximum. *Please Note: total joint replacement, spinal fusion and bariatric (weight loss) surgeries will require a second opinion evaluation through the Carrum Health Program.

NON-MEDICARE MEDICAL PLANS PREMIUMS

Monthly medical premiums displayed are before the County's contribution of $157.00 per month. You must be enrolled in a County Medical plan to receive the County contribution.

BLUE SHIELD NON-MEDICARE MEDICAL PLANS

BLUE SHIELD TANDEM PPO	
Retiree Only	$766.00
Retiree + One Dependent	$1,510.00
Retiree + Family	$1,967.00
BLUE SHIELD CHOICE PPO	
Retiree Only	$870.00
Retiree + One Dependent	$1,721.00
Retiree + Family	$2,242.00
BLUE SHIELD CARE PPO	
Retiree Only	$939.00
Retiree + One Dependent	$1,864.00
Retiree + Family	$2,430.00
BLUE SHIELD EPO (In-Network Only)	
Retiree Only	$1,065.00
Retiree + One Dependent	$2,119.00
Retiree + Family	$2,769.00

MEDICARE MEDICAL PLANS

Plan Benefits	Blue Shield Medicare PPO		Blue Shield Medicare EPO
	In-Network	Out-of-Network[1]	In-Network Only
Annual Deductible Individual Family	None		None
Annual Out-of-Pocket Maximum Individual Family	None		$1,500 per individual $3,000 per family
Office Visit Primary Care and/or Specialist	No Charge		$15 copay/visit
Preventive Care	No Charge		No Charge
Chiropractic (limits apply)	No Charge		$15 copay/visit
Acupuncture (limits apply)	$15 copay		$15 copay/visit
Lab and X-ray	No Charge		No Charge
Advanced Imaging (MRI/PET/CAT scans)	No Charge		No Charge
Urgent Care	No Charge		$15 copay/visit
Emergency Room	No Charge		$50 copay/visit (copay waived if admitted)
Emergency Medical Transportation	No Charge		No Charge
Hospitalization	No Charge		No Charge
Outpatient Surgery	No Charge		No Charge
Durable Medical Equipment	No Charge		No Charge
Vision Services & Allowance	See Benefit Summary for Details		See Benefit Summary for Details
Hearings Aids	20% (limited to $2,000 max once every 24 months)		20% (limited to $1,000 max once every 36)
Provider Network	**Blue Shield of California PPO Network**		**Blue Shield of California PPO Network**

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

MEDICARE MEDICAL PLAN PREMIUMS

Monthly medical premiums displayed are before the County's contribution of $157.00 per month. You must be enrolled in a County Medical plan to receive the County contribution.

BLUE SHIELD MEDICAL PPO PLANS

PPO MEDICARE – ALL MEMBERS MUST HAVE MEDICARE	
Retiree Only	$621.45
Retiree + One Dependent	$1,238.45
Retiree + Family	$1,858.45
PPO MEDICARE – COMBO PLANS with Blue Shield Choice PPO When at least one person enrolled is not on Medicare.	
Retiree (1 Medicare, 1 Without)	$1,472.45
Retiree (1 Medicare, 2 Without)	$1,993.45
Retiree (2 Medicare, 1 Without)	$1,759.45

BLUE SHIELD EPO MEDICARE PLAN

EPO MEDICARE (In-Network Only) – ALL MEMBERS MUST HAVE MEDICARE	
Retiree Only	$568.45
Retiree + One Dependent	$1,136.45
Retiree + Family	$1,702.45
EPO MEDICARE (In-Network Only) – COMBO PLANS with Blue Shield EPO When at least one person enrolled is not on Medicare.	
Retiree (1 Medicare, 1 Without)	$1,622.45
Retiree (1 Medicare, 2 Without)	$2,272.45
Retiree (2 Medicare, 1 Without)	$1,786.45

PRESCRIPTION DRUG SAVINGS

Are prescription drug costs breaking your budget? A little research before you go to the pharmacy could result in huge savings.

	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 plans will not be separate.
	Medicare members & Non-Medicare members have different customer service lines.	Non-Medicare Line: (877) 554-3091 Medicare Line: (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 with subscriber name only. No ID cards are issued with dependent names
	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.

PHARMACY BENEFITS

Prescription drug coverage is through Express Scripts and is the same for all non-Medicare plans. To access information regarding prescription drugs visit: www.express-scripts.com. You should ensure you are using an in-network pharmacy and your Express Scripts ID card to obtain prescriptions.

Click to play video

NON-MEDICARE PHARMACY BENEFITS

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

MEDICARE PHARMACY BENEFITS

	Retail (in-network) (30 Day Supply)	Retail/Home Delivery (90 Day Supply)
Generics	$5 copay	$10 copay
Preferred Brands	$20 copay	$40 copay
Non-Preferred Brands	$50 copay	$100 copay
Deductible	None	
Out-of-Pocket Maximum	N/A	
Mail Order Out-of-Pocket Maximum	N/A	

IMPORTANT Non-Medicare & Medicare: If you choose to have a brand-name medication when a generic is available, you will pay the difference in cost between the brand and generic, plus the generic copay. The Preferred Generic Program does not apply when the physician has specified "dispense as written" (DAW) and when it has been determined that the brand name drug (formulary or non-formulary) is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.

PHARMACY BENEFITS

Pharmacy programs on this page are only available to non-Medicare plan participants.

BENEFIT HIGHLIGHTS	AVAILABILITY & HOW TO GET STARTED
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! 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 copay for your 90-day supply with either option.	**Website:** www.express-scripts.com
RX 'N GO FREE GENERIC MEDICATIONS – 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 non-Medicare employees and covered dependents, on a Blue Shield 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. **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's pharmacy, Transition Pharmacy. Your physician my also fax, phone or E-Scribe your prescription. 4. Receive your medication(s) by mail at your home.	**Website:** https://rxngo.com/ **Call:** (888) 697-9646 **Escribe:** Transition Pharmacy
SAVEONSP SPECIALTY MEDICATION PROGRAM – Specialty medications are high-cost drugs. You pay a copay but the true cost is much higher. SaveOnSP is a program that helps reduce the plan's cost. If you enroll, your copay will be $0. Some conditions covered by SaveOnSP include: Hepatitis C, Multiple Sclerosis, Psoriasis, Inflammatory Bowel Disease, Rheumatoid Arthritis, or Cancer.	**Call:** (800) 683-1074

TURNING 65? UNDERSTAND YOUR MEDICARE OPTIONS

Alliant Medicare Solutions is a no cost service available to you, your family members, and friends nearing age 65.

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

***Note 2024 rates have not been released yet by CMS.**

Whether you retire or continue to work, choosing the right healthcare option is an important decision when you reach age 65

Most people become eligible for Medicare at age 65. When that happens, you'll probably have some time-sensitive decisions to make, based on your individual situation.

Introducing Alliant Medicare Solutions

Medicare can be complicated. Figuring out the rules—not to mention how Medicare works with or compares to your employer-provided medical coverage—can be a headache. That's why we are offering Alliant Medicare Solutions. The licensed insurance agents at AMS can help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation.

How does it work?

1. Call Alliant Medicare Solutions at **(866) 273-6420** to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
2. Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
3. Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll at a later date.

Find Out More

Medicare 101 Video

Social Security Planning Video

Your Guide to Medicare

Direct Link: https://alliantbenefits.cld.bz/coslo-medicare-guide

TRANSITIONING TO MEDICARE FAQ

I need Medicare advice or information, is there someone I can talk to?

Yes! We encourage our retirees to reach out to the Alliant Medicare Solutions (AMS) at (866) 273-6420. This is a free service to help you understand your Medicare options and prescription plans.

You can also contact Health Insurance Counseling Advocacy Program (HICAP) sponsored by the Central Coast Commission for Senior Citizens. HICAP provides free and unbiased information and counseling about Medicare so you can make informed decisions. Visit their website **http://centralcoastseniors.org/hicap/** or call them at (805) 928-5663.

I am and/or my dependent are turning 65 this year, how does this affect our County medical benefits?

Turning 65 is a Qualifying Event to transition to a County sponsored Medicare plan 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 dental and/or vision changes are permitted.

What is the Medicare transition process?

Roughly 60 - 90 days before your 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, provide your Medicare Part A & B effective dates and provide your Medicare Beneficiary Number (BMI) located on your Medicare card. Non-Medicare dependent plan enrollment will not change.

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 Blue Shield/Accolade & Express Scripts ID card when I transition to Medicare?

Yes, you will receive new ID cards for both Blue Shield/Accolade and Express Scripts once you transition to Medicare. Be sure to use the new ID cards 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 Blue Shield's network. When utilizing your County benefits, Medicare is the primary payer and Blue Shield is the secondary payer. Present both your Medicare card and Blue Shield ID card to your provider. Under the County Medicare plans, providers that do not accept Medicare are not covered even if they are in Blue Shield’s network.

How does the County Medicare plan 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 Blue Shield plan is the secondary payer. Present both your Medicare card and Blue Shield 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 Blue Shield'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 (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 selected when some members of your family are over age 65 and on Medicare, and other members are under age 65 and not on Medicare yet. In those instances, the members that are on Medicare should refer to page 16 to see their Medical plan details. The non-Medicare members of that Combo Plan should refer to page 13-14 for their plan details, they will not be the same as the Medicare member's. All medical premiums are available on pages 15 & 17.

The retiree Medicare status and medical plan election drive which plan options are available for your spouse and dependents enrolled on your medical insurance. 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 Blue Shield Medicare PPO and Blue Shield Medicare EPO. What Medicare plan is selected will impact the choice available for the non-Medicare member.

Retirees should select a plan from either the right or left column depending on your Medicare status. The retiree plan selection determines what plan any dependents could enroll in.			
Non-Medicare (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 (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**
Blue Shield Tandem PPO Blue Shield Choice PPO Blue Shield Care PPO	Blue Shield PPO Medicare	Blue Shield PPO Medicare	Blue Shield Choice PPO
Blue Shield EPO	Blue Shield EPO Medicare	Blue Shield EPO Medicare	Blue Shield EPO

DENTAL

The Aetna Dental plan has a limited network of providers and does not have a network in all states. Complete a provider search for your area before enrolling in this plan. When you have an appointment, tell them you have Aetna DHMO. There's no ID card necessary. Your member ID is your Social Security Number. The member ID for your dependents, is the subscriber's (retiree) social security number.

	AETNA DHMO
	In-Network Only
Annual Deductible	$0
Annual Plan Maximum	Not applicable
Diagnostic & Preventive	Plan pays 100% for preventative; other diagnostic various copay apply
Basic Services Fillings Root Canals Periodontics	Plan pays 100% Various copays apply Various copays apply
Major Services	Various copays apply
Orthodontia Adults & Children (up to age 26)	Patient pays: • Screening $30 • Diagnostic Records $150.00 • Retention $275

DENTAL PREMIUMS	
Retiree Only	$31.88
Retiree + One Dependent	$52.72
Retiree + Family	$77.88

What you need to know about this plan

Group Name: County of San Luis Obispo
Group Number: 883524-001
NEW ENROLLEES: You must select a Primary Care Dentist (PCD) or one will be assigned before you can schedule an appointment. To find a Primary Care Dentist visit www.aetna.com or call (877) 238-6200.

VISION

When you have an appointment, tell them you have VSP. There's no ID card necessary. Your member ID is your Social Security Number. The member ID for your dependents is the subscriber's (retiree) Social Security number. To find a Provider visit **www.vsp.com** or call **(800) 877-7195**.

	VSP Provider Network: VSP Signature	
	In-Network	**Out-of-Network[1]**
Exams Benefit Frequency	 $10 copay Once every 12 months	 Plan reimburses up to $50 In-Network limitations apply
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	 $25 copay $25 copay $25 copay Once every 12 months	 Plan reimburses up to $50 Plan reimburses up to $75 Plan reimburses up to $100 In-Network limitations apply
Lens Enhancements Standard Progressive Lenses Premium Progressive Lenses Custom Progressive Lenses	 $0 $80 - $90 $120 - $160	 Plan reimburses up to $75 Plan reimburses up to $75 Plan reimburses up to $75
Frames Benefit (Included in prescription glasses) Frequency	Plan pays up to $175 allowance Plan pays up to $195 for featured frames Plan pays up to $95 allowance for Costco frames + 20% savings on the amount over your allowance Once every 24 months	Plan reimburses up to $70 In-Network limitations apply
Contacts (in-lieu of frames) Benefit (fitting & evaluation) Frequency	 Plan pays up to $250 allowance Once every 12 months	 Plan pays up to $105 In-Network limitations apply

VISION PREMIUMS	
Retiree Only	$9.54
Retiree + One Dependent	$14.54
Retiree + Family	$23.52

What you need to know about this plan

Group Name: County of San Luis Obispo
Group Number: 00105558-01

New LightCare Benefit Enhancement! Even if you don't wear prescription glasses, an annual eye exam is an easy and cost-effective way to take care of your eyes and overall health. VSP members can now use their frame allowance and benefits for non-prescription sunglasses or blue light filtering glasses. Visit vsp.com for more information on your benefits.

Walmart & Sam's Club: Members can now access their $175 frame allowance at Walmart & Sam's Club retailers.

[1]If you choose to, you may receive covered benefits outside of the VSP network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement of your out-of-network allowance. In-network benefits and discounts will not apply. Out-of-Network Claim Forms located online: www.vsp.com. Login to your account and access the *Benefits & Claims* section. You will be asked to upload your receipts, or you may mail in receipts. **Reminder:** A Costco membership is not required to receive an eye exam from a Costco optometrist, but it is required to purchase eyewear (glasses and/or contacts) from Costco Optical.

Medicare Part D Notice

Important Notice from County of San Luis Obispo About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with County of San Luis Obispo and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. County of San Luis Obispo has determined that the prescription drug coverage offered by Blue Shield and Express Scripts is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your County of San Luis Obispo coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Blue Shield is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your County of San Luis Obispo prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with County of San Luis Obispo and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through County of San Luis Obispo changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	01/01/2024
Name of Entity/Sender:	Esmeralda Barragan
Contact-Position/Office:	Benefits Manager
Address:	1055 Monterey St., San Luis Obispo CA 93408
Phone Number:	(805) 781-5015

FOR BENEFITS ASSISTANCE

Enrollment Resources

SLO Retiree Enrollment Line: (833) 574-1838
Human Resources: (805) 781-5959 or **slocounty.ca.gov/Benefits**

Medicare Assistance

If you have general Medicare questions, contact Alliant Medicare Solutions at (866) 273-6420 or HICAP at (805) 928-5663. **cahealthadvocates.org/hicap**

Plan Type	Provider	Phone Number	Website	Group Number
MEDICAL				
Medical EPO & PPO Plans	Navigator PPO Powered By Accolade	(866) 406-1275	member.accolade.com	Coming Soon
PHARMACY				
Non-Medicare Pharmacy	Express Scripts	(877) 554-3091	www.express-scripts.com	**Issuer:** 9151014609 **RxBin:** 610014 **RxGrp:** RX4EIAH
Medicare Pharmacy	Express Scripts	(844) 468-0428	www.express-scripts.com	
Specialty Pharmacy	Accredo	(800) 803-2523	www.accredo.com	
Rx Mail Order	Rx 'n Go	(888) 697-9646	rxngo.com	
DENTAL & VISION				
Dental HMO	Aetna	(877) 238-6200	www.aetna.com	883524-001
Vision	VSP	(800) 877-7195	vsp.com	00105558
OTHER				
Voluntary Surgical Benefit	Carrum Health	(888) 855-7806	carrum.me/prism	
MSK Benefit	Hinge Health	(855) 902-2777	hingehealth.com/prism	
Diabetes Management	Livongo	(800) 945-4355	Welcome.livongo.com/prism	Company Code: PRISM
Post-Employment Health Plan	Nationwide	(877) 677-3678	www.nationwide.com	

Employee Benefits Booklet designed and developed by

in conjunction with the County of San Luis Obispo.
rev.8.25.23