Exempt Fixed-Term

2020 Flexible Benefit Plan Election Form

Region 1- to see a full list of counties please visit https://www.calpers.ca.gov/docs/2020-health-rates-region-1.pdf. Please submit this form ONLY if you are making changes to your enrollment or if you are enrolling for the first time. **Flex dollar allowances and premium rates are for 2020, however since CalPERS requires prepayment of premiums, the scheduled rate increases go into effect in December of 2019 (for January 2020 coverage).**

Full Name: _____ Department: _____

I would like to make the following change to my health enrollment effective Jan 1, 2020 *(choose one)*:

Please complete Sections 1-3 below. You will need to complete a CalPERS Health Enrollment form (available on the HR intranet at https://employees.cityofsanrafael.org/benefits/) and supply the required documentation as noted in your selection below.)

- ☐ Enroll in Health *(requires birth/marriage cert or Declaration of Domestic Partnership if enrolling dependents)*
- ☐ Change Health Plan
- ☐ Add Dependent *(requires birth/marriage cert or Declaration of Domestic Partnership)*
- ☐ Delete Dependent *(if applicable, requires Divorce Decree or Termination of Domestic Partnership)*
- ☐ Decline/Cancel Coverage *(requires signed Waiver of Coverage form)*

Section 1 - Determine Flex Dollar Allowance (complete appropriate line only)	
I am electing "EE Only" Coverage:	☐ $ 634.57
I am electing "EE + 1" Coverage:	☐ $1,269.13
I am electing "EE + Family" Coverage:	☐ $1,649.88
I am waiving medical coverage	☐ $ 0.00

Section 2 - Select Medical Coverage			**EE only**		**EE + 1**		**EE + Family**
***Blue Shield Access+, Blue Shield EPO, Blue Shield Trio & United Healthcare are now available.**	Anthem EPO Del Norte	☐	$ 861.18	☐	$ 1,722.36	☐	$ 2, 239.07
	Anthem HMO Select	☐	$ 868.98	☐	$ 1,737.96	☐	$ 2,259.35
	Anthem HMO Traditional	☐	$ 1,184.84	☐	$ 2,369.68	☐	$ 3,080.58
	Blue Shield (BSC) Access+*	☐	$ 1,127.77	☐	$ 2,255.54	☐	$ 2,932.20
	Blue Shield EPO	☐	$ 1,127.77	☐	$ 2,255.54	☐	$ 2,932.20
	Blue Shield Trio	☐	$ 833.00	☐	$ 1,666.00	☐	$ 2,165.80
	HealthNet SmartCare	☐	$ 1,000.52	☐	$ 2,001.04	☐	$ 2,601.35
	Kaiser CA	☐	$ 768.49	☐	$ 1,536.98	☐	$ 1,998.07
	PERS Choice	☐	$ 861.18	☐	$ 1,722.36	☐	$ 2,239.07
	PERS Select	☐	$ 520.29	☐	$ 1,040.58	☐	$ 1,352.75
	PERS Care	☐	$ 1,133.14	☐	$ 2,266.28	☐	$ 2,946.16
	United Healthcare	☐	$ 899.94	☐	$ 1,799.88	☐	$ 2,339.84
	Western Health Advantage	☐	$ 731.96	☐	$ 1,463.92	☐	$ 1,903.10

Section 3	**Total Flex Dollar Amount**
Enter Total Flex Dollar Allowance from Section 1	$
Enter Medical Coverage Election Amount from Section 2	$
Subtract Line 2 from line 1. If total is less than zero, the amount shown will be a deducted from your paycheck (per month). If the total is greater than zero, this amount will be forfeited; there is no cash back option for Fixed-Term appointments.	$

I understand that by signing and submitting this Flexible Benefit Plan form I am making a binding election for a plan year for my benefits and am authorizing a pre-tax payroll deduction from my earnings. I understand that if I decline the above coverage, I cannot change my mind during the plan year and elect coverage, unless I experience a change in status.

Employee Signature: _____ **Date:** _____