



Exempt Fixed-Term 2021 Flexible Benefit Plan Election Form

Region 1- to see a full list of counties please visit <https://www.calpers.ca.gov/docs/health-rates-region-1-2021.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 2021, however since CalPERS requires prepayment of premiums, the scheduled rate increases go into effect in December of 2020 (for January 2021 coverage).**

Full Name: _____ Department: _____

I would like to make the following change to my health enrollment effective Jan 1, 2021 (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:	<input type="checkbox"/> \$ 634.57
I am electing "EE + 1" Coverage:	<input type="checkbox"/> \$ 1,269.13
I am electing "EE + Family" Coverage:	<input type="checkbox"/> \$ 1,649.88
I am waiving medical coverage	<input type="checkbox"/> \$ 0.00

Section 2 - Select Medical Coverage		EE only	EE + 1	EE + Family
*Blue Shield Trio is only available in El Dorado, Nevada, Placer, Sacramento, and Yolo.	Anthem EPO Del Norte	<input type="checkbox"/> \$ 935.84	<input type="checkbox"/> \$ 1,871.68	<input type="checkbox"/> \$ 2,433.18
	Anthem HMO Select	<input type="checkbox"/> \$ 925.60	<input type="checkbox"/> \$ 1,851.20	<input type="checkbox"/> \$ 2,406.56
	Anthem HMO Traditional	<input type="checkbox"/> \$ 1,307.86	<input type="checkbox"/> \$ 2,615.72	<input type="checkbox"/> \$ 3,400.44
	Blue Shield (BSC) Access+	<input type="checkbox"/> \$ 1,170.08	<input type="checkbox"/> \$ 2,340.16	<input type="checkbox"/> \$ 3,042.21
	Blue Shield EPO	<input type="checkbox"/> \$ 1,170.08	<input type="checkbox"/> \$ 2,340.16	<input type="checkbox"/> \$ 3,042.21
	Blue Shield Trio*	<input type="checkbox"/> \$ 880.50	<input type="checkbox"/> \$ 1,761.00	<input type="checkbox"/> \$ 2,289.30
	HealthNet SmartCare	<input type="checkbox"/> \$ 1,120.21	<input type="checkbox"/> \$ 2,240.42	<input type="checkbox"/> \$ 2,912.55
	Kaiser CA	<input type="checkbox"/> \$ 813.64	<input type="checkbox"/> \$ 1,627.28	<input type="checkbox"/> \$ 2,115.46
	PERS Choice	<input type="checkbox"/> \$ 935.84	<input type="checkbox"/> \$ 1,871.68	<input type="checkbox"/> \$ 2,433.18
	PERS Select	<input type="checkbox"/> \$ 566.67	<input type="checkbox"/> \$ 1,133.34	<input type="checkbox"/> \$ 1,473.34
	PERS Care	<input type="checkbox"/> \$ 1,294.69	<input type="checkbox"/> \$ 2,589.38	<input type="checkbox"/> \$ 3,366.19
	United Healthcare	<input type="checkbox"/> \$ 941.17	<input type="checkbox"/> \$ 1,882.34	<input type="checkbox"/> \$ 2,447.04
	Western Health Advantage	<input type="checkbox"/> \$ 757.02	<input type="checkbox"/> \$ 1,514.04	<input type="checkbox"/> \$ 1,968.25

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 <u>less</u> than zero, the amount shown will be deducted from your paycheck (per month). If the total is <u>greater</u> 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:** _____