(HR USE ONLY)
Effective Date:_____ Copy to Payroll:_____

CITY OF SAN CLEMENTE
2024 FULL FLEX CAFETERIA PLAN & VISION ELECTIONS
Benefited Part-Time City Employees

If you are making any changes to your current enrollment, additional documents are required (see pg. 3 for details). All additional enrollment and change forms are available on the Employee Dashboard and the shared i-drive. For comprehensive plan information and comparison, please review the CalPERS 2024 Health Benefit Summary on the CalPERS website at https://www.calpers.ca.gov/docs/forms-publications/2024-health-benefit-summary.pdf.
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EMPLOYEE NAME: _____

(Please PRINT using Black or Blue Ink)

1. SELECT APPLICABLE OPTION BELOW:

☐ The elections on this form reflect no change to my current elections for coverage.

☐ I have made an election on this form that is a change to my current enrollment.
☐ Tier Change ☐ Medical Plan Change ☐ Dental Plan Change

☐ I am a new employee making a Cafeteria Plan Election ☐ Qualifying Event

THE AMOUNTS SHOWN ON THIS FORM ARE **BIWEEKLY/PER PAY PERIOD** (there are 26 pay periods per year). YOUR "FLEX DOLLAR ALLOWANCE" IS A BIWEEKLY ALLOWANCE THE CITY PROVIDES FOR YOUR BENEFITS UNDER THE CITY'S CAFETERIA PLAN.

FULL FLEX CAFETERIA PLAN ELECTIONS

2. BIWEEKLY FLEX DOLLAR ALLOWANCE: Circle the dollar amount that corresponds to your coverage tier, write that number in the box "Biweekly Flex Allowance". This is your biweekly flex dollar allowance under the Cafeteria Plan.

	COVERAGE TIER AND BIWEEKLY FLEX DOLLAR ALLOWANCE	Biweekly Flex Allowance
	If you are electing Employee Only coverage.	$332.88
	If you are electing Employee + 1 Dependent coverage.	$332.88
	If you are electing Employee + Family coverage.	$332.88
	If you are waiving medical coverage - You will need to provide proof of medical coverage to HR. The City pays 100% of the cost of dental HMO coverage for employees waiving medical coverage.	$46.15
	If you are waiving medical & dental coverage you will need to provide proof of medical coverage to HR.	$53.13
	If you and your spouse are both City employees, and you opt out of medical, dental & vision because you are covered under your spouse.	$40.38

BIWEEKLY Flex Allowance $ _____

3. <u>MEDICAL PLAN ELECTION:</u> Circle the dollar amount in the correct column that corresponds to your enrollment for medical coverage, write that number in the box.

MEDICAL PLAN ENROLLMENT (BASED ON THE COUNTY YOU LIVE IN)					
Region 3: COUNTIES OF: LOS ANGELES, SAN BERNARDINO, & RIVERSIDE					
	Plan Code	**Change (✓)**	**Employee only**	**Employee + 1**	**Employee + Family**
Anthem Blue Cross Select HMO	508		$388.21	$776.43	$1009.36
Anthem Blue Cross Traditional HMO	511		$467.39	$934.77	$1215.20
Blue Shield Access + HMO	527		$349.22	$698.45	$907.98
Blue Shield Trio HMO	452		$325.24	$650.48	$845.63
Health Net Salud y Mas HMO	532		$290.83	$581.66	$756.16
Kaiser Permanente CA HMO	535		$399.42	$798.84	$1038.49
PERS GOLD PPO	615		$362.44	$724.87	$942.34
PERS PLATINUM PPO	603		$522.22	$1044.43	$1357.76
United Healthcare Signature Alliance HMO	578		$381.43	$762.87	$991.73
United Healthcare Signature Harmony HMO	475		$339.12	$678.24	$881.71

Region 2: COUNTIES OF: ORANGE, SAN DIEGO, & IMPERIAL

	Plan Code	**Change (✓)**	**Employee only**	**Employee + 1**	**Employee + Family**
Anthem Blue Cross Select HMO	507		$372.79	$745.58	$969.25
Anthem Blue Cross Traditional HMO	510		$477.41	$954.81	$1241.26
Blue Shield Access+ HMO	526		$401.14	$802.28	$1042.97
Blue Shield Trio HMO (**Orange County Only**)	088		$373.96	$747.91	$972.29
Health Net Salud y Mas HMO	531		$316.05	$632.09	$821.72
Kaiser Permanente CA HMO	534		$417.67	$835.34	$1085.94
PERS GOLD PPO	614		$368.97	$737.94	$959.33
PERS PLATINUM PPO	602		$531.46	$1062.92	$1381.80
Sharp Performance Plus HMO (**San Diego County Only)**	575		$384.57	$769.14	$999.89
United Healthcare Signature Alliance HMO	577		$386.71	$773.43	$1005.46
United Healthcare Signature Harmony HMO	399		$365.84	$731.68	$951.18
			Medical Plan Election $		

4. <u>DENTAL PLAN ELECTION:</u> Circle the dollar amount in the correct column that corresponds to your enrollment for dental coverage, write that number in the box.

DENTAL ENROLLMENT	**Plan #**	**Change (✓)**	**Employee only**	**Employee + 1**	**Employee + Family**
Delta Dental Premier	8793-0001		$34.20	$58.90	$88.92
A. Delta Care HMO Plan	72012-00104		$6.98	$12.54	$18.55
		Dental Plan Election $			

5. NET AMOUNT OF BIWEEKLY ELECTIONS

<u>If the NET AMOUNT OF BIWEEKLY ELECTIONS is:</u>

- ZERO – No deductions will be made from your compensation.
- A POSITIVE NUMBER – This amount will be withheld from each paycheck (PRE-TAX).
- A NEGATIVE NUMBER – You will receive this amount as cash every paycheck (TAXABLE).

Medical Plan Election $ (section 3)	+
Dental Plan Election $ (section 4)	+
Sub-total of Medical & Dental	=
Biweekly Flex Allowance $ (section 2)	-
NET AMOUNT of Biweekly Elections $	

VISION INSURANCE ELECTION

6. <u>VISION PLAN ELECTION:</u> Circle the dollar amount in the correct column that corresponds to your enrollment for vision coverage, write that number in the box.

This must be the same coverage tier you have for all other plans. This is a city-paid benefit and not part of the Cafeteria Plan. Enrollment is mandatory. (Employees who waive medical and dental coverage with the City will only participate in the "Employee Only" Coverage Tier with VSP).

VISION ENROLLMENT		Plan #	Change (✓)	Employee only	Employee + 1	Employee + Family
	VSP Vision Plan	30005394-0001		$6.20	$9.48	$16.72

Vision Plan Election $

(THIS IS CITY-PAID)

STATEMENT AND SIGNATURE

7. READ THE STATEMENT BELOW, AND COMPLETE THE BOTTOM PORTION.

I understand that by signing and submitting this form to elect coverage I am making a binding election for my benefits and am authorizing a payroll deduction from my earnings on a pre-tax basis (if applicable). I understand that if I waive participation in any of the above coverage, I cannot later change my mind during the plan year and elect coverage, unless I experience a qualifying life change. This election will remain in place unless I make a change during the annual open enrollment period.

_____ _____

Employee Name (Print) **Date**

_____

Employee Signature

****** NOTE: INCORRECT OR INCOMPLETE FORMS WILL BE RETURNED FOR CORRECTION******

PLAN CHANGES AND REQUIRED FORMS:

MEDICAL AND TIER CHANGES:
- ☐ Hbd-12 (CalPERS) Enrollment Form
- ☐ SC Enrollment Form
- ☐ Supporting documents (birth/marriage cert. etc.)

DENTAL AND VISION (NO TIER CHANGE):
- ☐ SC Enrollment Form

ADD OR DELETE DEPENDENTS (NO TIER CHANGE):
- ☐ SC Enrollment Form
- ☐ Supporting documents (birth/marriage cert. etc.)

OPT OUT OF MEDICAL COVERAGE
- ☐ OPT OUT FORM
- ☐ Proof of alternate coverage