BENEFIT SELECTION FORM

BLUE SHIELD MEDICAL ENROLLEE

RATES VALID JULY 1, 2023 TO JUNE 30, 2024

Employee Name_____

Please complete this form in order to confirm your enrollment selections in the following plans.

NOTE: This is not a carrier enrollment or change form. To enroll or make changes, you must complete the appropriate carrier enrollment form(s). For Flex 125 Benefits Enrollment, you can obtain an Open Enrollment packet from Human Resources. If you are not enrolling for health insurance for yourself and/or your dependents, check the appropriate "WAIVE COVERAGE" box and complete the waiver form on the back. You must also provide proof of other coverage.

IMPORTANT: For Employees enrolling in a Blue Shield Medical plan, the City of Imperial will contribute 100% of the Employee Only cost and 50% of the Dependent cost. The employee will be responsible for the remaining monthly medical premium. If you are enrolling with Blue Shield or Waiving Coverage, the City of Imperial will contribute 100% of the Employee Only cost and 50% of the Dependent cost for the dental and vision plans.
For those who waive medical coverage, the City of Imperial will contribute $400 towards an Opt-Out Credit. Proof of medical coverage is required. If you receive Medi-Cal coverage, you will not qualify for the $400 Opt-Out Credit.

***The rates below reflect your total monthly cost assuming you elect Blue Shield Medical.**

Medical		**Monthly Premium Cost**	**Employee Total Monthly Cost**	
☐ Blue Shield Gold Access+ HMO 0/30 OffEx	☐ Employee Only ☐ Employee + Spouse/Registered DP* ☐ Employee + Child(ren) ☐ Employee + Family	$822.57 $1,727.40 $1,480.63 $2,632.22	$0.00 $452.42 $329.03 $904.83	Waive Medical Coverage ☐
☐ Blue Shield Gold Full PPO 500/30 OffEx	☐ Employee Only ☐ Employee + Spouse/Registered DP* ☐ Employee + Child(ren) ☐ Employee + Family	$832.83 $1,748.94 $1,499.09 $2,665.06	$0.00 $458.06 $333.13 $916.12	
Dental				
☐ Principal POS	☐ Employee Only ☐ Employee + Spouse/Registered DP* ☐ Employee + Child(ren) ☐ Employee + Family	$35.98 $69.15 $86.14 $134.86	$0.00 $16.59 $25.08 $49.44	Waive Dental Coverage ☐
☐ SIMNSA HMO	☐ Employee Only ☐ Employee + Spouse/Registered DP* ☐ Employee + Child(ren) ☐ Employee + Family	$20.05 $33.42 $44.56 $53.47	$0.00 $6.69 $12.26 $16.71	
Vision				
☐ Principal PPO	☐ Employee Only ☐ Employee + Spouse/Registered DP* ☐ Employee + Child(ren) ☐ Employee + Family	$7.32 $16.12 $15.08 $23.87	$0.00 $4.40 $3.88 $8.28	Waive Vision Coverage ☐
Group Life/AD&D: Principal				
	☒ Employee Only Life/AD&D ($50,000) ☐ Dependent Life (no AD&D)	$8.85 $0.54	$0.00 $0.00	Waive Dependent Life Coverage ☐

**State Registered Domestic Partner*

I have chosen to participate in City of Imperial's Section 125 plan, and I understand that my health insurance premiums will be deducted on a pre-tax basis as established under this plan (unless otherwise noted). I understand that as a participant in this plan, I will not be able to change or terminate my selected coverage(s) until next year's open enrollment unless an IRS Qualifying Event occurs.

EMPLOYEE SIGNATURE: _____ **DATE**: _____

These benefits and rates are only a brief summary and they are subject to meeting and conferring. This document is not intended to fully describe the benefits or plan limitations. Rates are shown for selection of coverage and authorization of payroll deductions. The actual plan documents will govern final benefits and rates.

HEALTH INSURANCE COVERAGE WAIVER STATEMENT

Employee Name_____

If you wish to decline coverage for yourself and/or your dependent(s) who are eligible to enroll in our group health plans, you must complete this form AND provide proof of coverage elsewhere. Before declining coverage, read the Late Enrollment Warning on the bottom of this form listing the circumstances under which you may enroll later in our plan without being considered a late enrollee.

If you are declining coverage under this plan because you and/or your eligible dependent(s) have coverage under another employer's benefit plan, please indicate that in the spaces provided below. Please note that if you are:

1. Declining enrollment for yourself or your dependents (including your spouse) because of other insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you notify HR and request enrollment within 30 days after your other coverage ends.
2. If you have a new dependent as a result of a qualifying event (i.e. marriage, birth, adoption, or placement for adoption), you need to notify HR enroll them within 30 days and will be required to submit appropriate documentation.

EMPLOYEE'S STATEMENT – MUST BE COMPLETED

I acknowledge that I have been given the opportunity to enroll my eligible dependents and myself in my employer's benefit plans and have read the **Late Enrollment Warning**. I am declining to enroll the following eligible persons under the employee benefits program:

1. Employee – Check Reason:

- ❑ Covered under another Medical, Dental and/or Vision plan (provide name of plan):
  _____
- ❑ I have provided my employer with proof of coverage elsewhere

2. Spouse or State Registered Domestic Partner (provide name) – Check Reason:

- ❑ Covered under another Medical, Dental and/or Vision plan (provide name of plan):
  _____
- ❑ I have provided my employer with proof of coverage elsewhere

3. Child or Children (provide name(s))– Check Reason:

- ❑ Covered under another Medical, Dental and/or Vision plan (provide name of plan):
  _____
- ❑ I have provided my employer with proof of coverage elsewhere

Late Enrollment Warning

An employee or an employee's eligible dependent must be enrolled in the employer's benefit plan during the initial enrollment period (normally 30 days from the date the employee or dependent is first eligible to be covered). Any request for enrollment after the initial enrollment period will be considered a Late Enrollee. There are some exceptions. **Late Enrollee Exceptions:**

1. Persons who decline coverage during their initial enrollment period because they have coverage under another employer's benefit plan (and indicate this reason for declining coverage), will not be considered Late Enrollees if:
   a. Their coverage under the other employer's health benefit plan ends because of:
      1) Termination of employment or change of employment status
      2) Termination of the other employer's benefit plan
      3) The employer stops paying a required contribution for the person's coverage
      4) Death of, or divorce from, the person through whom they were covered

      And:
   b. They notify HR and request enrollment within 30 days after termination of coverage under the other employer's benefit plan.
2. If the employer offers multiple benefit plans, a person will not be considered a Late Enrollee if they elect a different plan during an open enrollment period.
3. A spouse or minor child who is enrolled within 30 days after issuance of a court order directing that coverage be provided for the person under a covered employee's benefit plan will not be considered a Late Enrollee.
4. If the plan waives Late Enrollee status during open enrollment (see plan document for requirements).