2024 TAP and Per Diem Benefit Election Form

The County of Riverside collects premiums one month ahead of the coverage effective date. Missed premiums (arrears) and the current required premium will be deducted in full from your first available pay warrant(s). This could result in a significant deduction from your paycheck. Please be sure to prepare for this added expense.

2024 HMO COPAY STRUCTURE

	CalPERS HMO Plans
Office visit	$15
Specialist	$15
Urgent care	$15
Emergency room	$50
Generic prescription (retail – up to a 30-day supply)	$5

2024 IN-NETWORK PPO COPAY STRUCTURE

	PERS Gold Only in California	PERS Platinum Worldwide
Network	Smaller network of doctors and hospitals	Larger network of doctors and hospitals
Office visit copay	$35*	$20
Annual deductible*		
Individual	$1,000*	$500
Family	$2,000*	$1,000
Coinsurance (Percentage you pay after deductible is met)	You pay 20%, plan pays 80%	You pay 10%, plan pays 90%
Max coinsurance		
Individual	$3,000	$2,000
Family	$6,000	$4,000
Generic prescription – up to a 30-day supply	$5	$5

**PERS Gold offers incentives that can reduce the annual deductible and PCP office visit copay.*

HOW TO ENROLL

During the onboarding process, you will complete a TAP Benefit election form. The elections you make during your onboarding process will **go into effect on the first of the month following a 60-day waiting period.** If you are including a dependent in your enrollment, be sure to provide the proper documentation when submitting your enrollment form (birth certificate, marriage certificate, domestic partner registration).

In the event your election request changes before it is processed and a premium has been collected, please contact the Benefits Division of HR at (951) 955-4981, option 1 or email benefits@rivco.org so that a new form can be completed.

SEMIMONTHLY PLAN COSTS FOR 2024*

	Region 2 (Orange, San Diego and Imperial Counties)	Region 3 (Riverside, Los Angeles, San Bernardino and Ventura Counties)	Out-of-State Region (Residents Outside of California)
Anthem Select HMO			
Single	$275.86	$292.57	Not Available
Two-Party	$679.71	$713.13	
Family	$922.03	$965.47	
Anthem Traditional HMO			
Single	$389.19	$378.34	Not Available
Two-Party	$906.38	$884.67	
Family	$1,216.70	$1,188.47	
Blue Shield Access+ HMO			
Single	$306.57	$250.33	Not Available
Two-Party	$741.14	$628.65	
Family	$1,001.88	$855.65	
Blue Shield Trio HMO			
Single	$277.12	$224.35	Not Available
Two-Party	$682.24	$576.69	
Family	$925.31	$788.10	
Health Net Salud y Mas HMO			
Single	$214.39	$187.07	Not Available
Two-Party	$556.77	$502.13	
Family	$762.20	$691.17	
Kaiser Permanente HMO			
Single	$324.48	$304.71	$528.23
Two-Party	$776.95	$737.41	$1,184.45
Family	$1,048.44	$997.04	$1,578.19
PERS Gold PPO			
Single	$271.72	$264.64	Not Available
Two-Party	$671.44	$657.28	
Family	$911.27	$892.87	
PERS Platinum PPO			
Single	$447.75	$437.74	$445.43
Two-Party	$1,023.50	$1,003.47	$1,018.86
Family	$1,368.95	$1,342.91	$1,362.92
PORAC PPO			
Single	$335.00	$335.00	$400.00
Two-Party	$803.50	$803.50	$944.00
Family	$1,057.50	$1,057.50	$1,142.00
Sharp HMO			
Single	$288.62	Not Available	Not Available
Two-Party	$705.24		
Family	$955.21		
UnitedHealthcare Alliance HMO			
Single	$290.94	$285.22	Not Available
Two-Party	$709.88	$698.44	
Family	$961.25	$946.37	
UnitedHealthcare Harmony HMO			
Single	$268.33	$239.38	Not Available
Two-Party	$664.65	$606.76	
Family	$902.45	$827.19	

**Some rates were rounded to the next even number for even semimonthly premium deductions.*

HBD-12 FORM COMPLETION INSTRUCTIONS

To enroll or decline enrollment in the County of Riverside's medical plans or to change your health plan, you must submit a completed *HBD-12 form*, which is attached to the end of this guide. If you have more than five dependents, please complete a secondary *HBD-12 form*. Every section of the form must be completed in order for your election to be processed. Incomplete forms will cause a delay in your request being processed.

SECTION A: APPLICANT INFORMATION

Enter your basic information as requested. If you are using your work zip code for health eligibility, please include your work zip code in part 8.

Please note when using your work zip code for health eligibility, any changes in your work location during the plan year may affect your health plan enrollment. Should your work location change result in a change in region eligibility, you will automatically be enrolled in the same health plan for your region eligibility. If you are no longer eligible for the enrolled health plan, you will be required to select a new health plan.

SECTIONS B & C: TYPE OF ACTION AND TYPE OF PERMITTING EVENT

Elect the option that's consistent with your request: "Enroll in a Health Plan," "Cancel All Coverage" or "Decline Coverage."

Your Permitting Event Date should be the month you are requesting to enroll, change or decline coverage. For example, if you are a new employee hired on April 15, 2024, your Permitting Event Date would be July 1, 2024.

If you are requesting to cancel your coverage, your Permitting Event Date should be the first of the month following the signature date. Please contact the Benefits Division of Human Resources at **(951) 955-4981, option 1** if you need clarification on how these dates will impact your benefits and paychecks.

EXAMPLES

- A new employee hired on April 15, 2024 who meets and maintains the criteria listed on page 1 would make the following selections: "Enroll in a Health Plan" and "New Employee," with a Permitting Event Date of July 1, 2024.
- A new Per Diem employee who transitioned from Regular to Per Diem status on August 8, 2024 and would like to cancel coverage would make the following selections: "Cancel All Coverage," "Other" (then write in "Decline coverage"), with a Permitting Event Date of September 1, 2024. In the "Name of Health Plan" section, write in "Cancel all coverage."

SECTION D: SUBSCRIBER AND DEPENDENT INFORMATION

List yourself and other dependents and the actions you are requesting (add or delete).

SECTION E: ENROLLMENT

To enroll in a CalPERS health plan, you must review the information and check the box in part 16. To decline enrollment in a CalPERS health plan, you must review the information and check the box in part 17. Sign and date the form in parts 18 and 19.

CONTACT INFORMATION		
Plan	**Telephone**	**Website**
CalPERS Medical Plans		
Blue Shield	**(800) 334-5847**	**www.blueshieldca.com/calpers**
Kaiser Permanente (HMO)	**(800) 464-4000**	**www.kp.org/calpers**
PERS Platinum and PERS Gold (PPO)	**(877) 737-7776**	**www.anthem.com/ca/calpers**
PORAC	**(800) 655-6397**	**http://ibtofporac.org/**
Anthem Select HMO and Anthem Traditional HMO	**(855) 839-4524**	**www.anthem.com/ca/calpers**
Health Net Salud y Mas	**(888) 926-4921**	**www.healthnet.com/calpers**
Sharp	**(855) 995-5004**	**www.sharphealthplan.com/calpers**
UnitedHealthcare	**(877) 359-3714**	**www.uhc.com/calpers**
OptumRx	**(855) 505-8110**	**www.optumrx.com**

Health Benefits Plan Enrollment for Active Employees (HBD-12)

Return to:
County of Riverside - Employee Benefits Division
Mail: P.O. BOX 1569 Riverside, CA 92502
Email: benefits@rivco.org
Fax: 1-951-955-3490

SECTION A: Applicant Information

TAP Employee ID #

1. **Employee Name:** *(First)* *(M.I.)* *(Last)*
2. **Hire Date:** (mm/dd/yyyy)
3. **CalPERS ID or Social Security Number:**
4. **Date of Birth:** *(mm/dd/yyyy)*
5. **Gender:** ☐ Male ☐ Female ☐ Nonbinary
6. **Physical Address:** *(Street)* *(City)* *(State)* *(ZIP)* *(County)*
7. **Mailing Address** (If different): *(Street)* *(City)* *(State)* *(ZIP)* *(County)*
8. **Use Work ZIP Code for Health Eligibility**: ☐ Yes ☐ No *If yes, enter zip code here: (ZIP)*
9. **E-mail Address:**
10. **Primary Phone:** **Alternate:**

SECTION B: Type of Action

11. ☐ Enroll in a Health Plan ☐ Add/Delete Dependents ☐ Change Health Plan ☐ Cancel All Coverage ☐ Decline Coverage

SECTION C: Type of Permitting Event

12. ☐ New Employee ☐ New Contracting Agency ☐ Marriage or Domestic Partnership Date *(mm/dd/yyyy)*: ☐ Open Enrollment ☐ Move
☐ Delete Dependent Due to Death ☐ Divorce or Domestic Partnership Termination ☐ Birth/ Adoption ☐ Other:
13. **Permitting Event Date**: (mm/dd/yyyy)
14. **Name of Health Plan**: (If changing health plans, list new plan name)

SECTION D: Subscriber and Dependent Information (List yourself and all of your dependents)

15.

Name (First, M.I., Last)	Relationship Code *1	Gender	Date of Birth (mm/dd/yyyy)	CalPERS ID or Social Security Number	Action	Primary Care Physician
	SELF	☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	

*1 **Relationship Codes:** **S** - Spouse **DP** - Domestic Partner **NC** - Natural Child **SC** - Step Child **AC** - Adopted Child **DPC** - Domestic Partner Child **PCR** - Parent Child Relationship

SECTION E: Enrollment

16. **To enroll, carefully review the information in this section and check the box:**

☐ **I ELECT TO ENROLL** in (or **MAKE CHANGES TO**) a health benefits plan as indicated above and agree to authorize deductions from (1) my salary to cover my share of the cost of enrollment as it is now or as it may be in the future (2) my retirement allowance to continue health benefits coverage into retirement. **I CERTIFY** that the information provided herein is accurate and listed dependents are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.

I VOLUNTARILY enroll into the selected Health Plan. **I AGREE** to read the associated Evidence of Coverage (EOC) and any subsequent EOCs in the following years to understand the benefits of the plan. The Subscriber and all eligible dependents agree to all the terms and conditions of the EOC and the Health Plan.

I UNDERSTAND that enrolling in certain health plans requires binding arbitration and that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California Law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The parties to this agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.

17. **To decline, carefully review the information in this section and check the box:**

☐ **I DECLINE ENROLLMENT** into the CalPERS Health Program for myself and my dependents.

I UNDERSTAND that if I choose to enroll at a later date, I must wait at least 90 days after I request enrollment or until the next Open Enrollment (OE) period before enrolling in the CalPERS Health Program. Furthermore, if I or my dependents involuntarily lose other health insurance coverage, I may request enrollment into the Program within 60 days from the date of lost coverage. If I do not request enrollment within 60 days, I must wait at least 90 days or until the next OE period before I can enroll. The effective date of coverage will be the first of the month following the 90 day waiting period or the OE effective date.

18. **Employee Signature:**
19. **Date:** *(mm/dd/yyyy)*

SECTION F: CalPERS Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose
The information requested is collected pursuant to the Government Code Sections (20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in the system being unable to perform its functions regarding your status.

Please do not include information that is not requested.

SSN
Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS first request for disclosure of your SSN, then disclosure is mandatory. If your SSN has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction / state contributions
3. Billing of contracting agencies for employee / employer contributions
4. Reports to the CalPERS system and other state agencies
5. Coordination of benefits among carriers
6. Resolve member appeals, complaints, or grievances with health plan carriers

Information Disclosure
Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights
You have the right to review your membership files maintained by the system. For questions about this notice, our Privacy Policy, or your rights, please write the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call our Customer Contact Center at 888-CalPERS (888-225-7377).

SECTION G: Privacy Information

Submission of the requested information is mandatory. The information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and is used for administration of the CalPERS Board's duties under the Public Employees' Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians and insurance carriers but only in strict compliance with current statutes regarding confidentiality. Failure to supply the information may result in CalPERS being unable to perform its functions regarding your status.

You have the right to review your CalPERS membership files. For questions concerning your rights under the Information Practices Act of 1977, please contact the CalPERS Customer Contact Center at **1-888-CalPERS** (or 1-888-225-7377).

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, State, or local governmental agency requesting an individual to disclose a Social Security account number to inform the individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and State benefits. Furthermore, the CalPERS health program requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits.

The CalPERS health program uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and State contribution for State employees.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to CalPERS and other state agencies.
5. Coordination of benefits among health plans.
6. Resolution of member complaints, grievances and appeals with health plans.

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include domestic partnership termination, establishment of a parent-child relationship, acquisition of a dependent child, change of address, marriage, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

SECTION H: For Employer Use

Please retain original signed form and all supporting documentation or affidavits in employee file. DO NOT send to CalPERS.

20. **Agency Name:**	21. **Date of Hire**: *(mm/dd/yyyy)*	22. **Retirement System**: ☐ CalPERS ☐ CalSTRS ☐ Other
23. **CalPERS Employer ID:**	24. **Division ID:**	25. **Employee Bargaining Unit/Employee Group:**
26. **Payroll Office:** ☐ State Controller's Office ☐ Non Central ☐ Public Agency Billing	27. **Date Received by Employer:**	28 **Effective Date:** *(mm/dd/yyyy)*

I hereby certify under the penalty of perjury that I am a duly appointed, qualified and acting Health Benefits Officer (HBO) of the above named agency, and the payment by the agency as provided by Section 22870-22905 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.

29. **Health Benefits Officer:** (Print name)	30. **Signature:**	31. **Date:** *(mm/dd/yyyy)*	32. **Phone Number:**

33. **Remarks:**

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Please do not include information that is not requested.

Social Security Numbers

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