San Joaquin County Health Benefits Enrollment Form 2027
Cafeteria Allowance Employees of Units: A (Executive), B (Senior Management), C (Middle Management), D (Confidential), J (Sheriff's Management), L (Sheriff Sergeants) and O (Exempt)

Reason for Enrollment F: ☐ Open Enrollment ☐ New Hire ☐ Qualifying Life Event: _____ (Describe)

For HR staff use only
Effective Date_____

All required documents must be received before this form is processed.
For any questions or to submit this form, contact Human Resources Employee Benefits Office at (209) 468-9987
Email: employeebenefits@sjgov.org. Fax: (209) 468-9734. Mailing address: 44 North San Joaquin Street Suite 330, Stockton, CA 95202

Employee Personal Information			
First Name, Middle Initial, Last Name:		Employee ID#:	
Street Address:	City:	State:	Zip Code:
Date of Birth:	Social Security Number:		
Best Contact Phone Number:	☐Mobile ☐Home		☐Male ☐Female
Email Address:			

Medical Plan Options

Check the box next to the Plan you desire and check the box for the coverage level.

Medical Plan Options	**Coverage Level**	**Bi-Weekly Rates**	**Employee Only**	**Employee + One Dependent**	**Employee + Family**
☐ Select Exclusive Plan ☐ Select Plan ☐ Premier Plan ☐ Sutter Health Plus HMO ☐ Kaiser Permanente HMO ☐ Sutter Health Plus – High Deductible Health Plan (HDHP) ☐ Kaiser Permanente HMO – High Deductible Health Plan (HDHP) ☐ Opt-Out of Medical ☐ No Changes	☐ Employee Only ☐ Employee + One ☐ Employee + Family	Select Exclusive	$1,130.53	$2,261.08	$3,165.53
		Select Plan	$1,130.53	$2,261.08	$3,165.53
		Premier Plan	$1,225.47	$2,450.94	$3,431.29
		Sutter Health Plus HMO	$587.20	$1,174.43	$1,661.87
		Kaiser HMO	$519.46	$1,038.90	$1,470.05
		Sutter Health Plus HDHP	$441.44	$882.87	$1,249.25
		Kaiser HDHP	$397.38	$794.75	$1,124.56

-Employee's Primary Care Physician (PCP) code for Sutter Health Plus (required):
-Go to www.sutterhealthplus.org/provider-search to find a PCP or one will be auto-assigned to you)

Dental Plan Options

Check the box next to the Plan you desire and check the box for the coverage level.

Dental Plan Options	**Coverage Level**	**Bi-Weekly Rates**	**Employee Only**	**Employee + One Dependent**	**Employee + Family**
☐ Delta Dental (Standard) ☐ Delta Dental (Core) ☐ Delta Dental (Buy Up) ☐ United Healthcare (UHC) Dental ☐ Opt-Out of Dental ☐ No Changes	☐ Employee Only ☐ Employee + One ☐ Employee + Family	Delta Dental (Standard)	$19.60	$38.22	$64.15
		Delta Dental (Core)	$19.02	$37.09	$62.23
		Delta Dental (Buy Up)	$20.65	$40.27	$67.58
		UHC Dental	$15.64	$29.72	$42.18

Your dental office for UHC Dental (required):

Vision Plan Option

Vision Plan	**Coverage Level**	**Bi-Weekly Rates**	**Employee Only**	**Employee + One Dependent**	**Employee + Family**
☐ VSP (Standard) ☐ VSP (Buy Up) ☐ Opt-Out of Vision ☐ No Changes	☐ Employee Only ☐ Employee + One ☐ Employee + Family	VSP (Standard)	$2.34	$4.68	$8.39
		VSP (Buy Up)	$4.14	$8.28	$14.85

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SAN JOAQUIN COUNTY
Greatness grows here.

Only for High Deductible Health Plans: Health Savings Account (Optional)

The County will contribute $700 annually (divided by 26 pay periods) towards an employee's Health Savings Account (HSA) who elects a High Deductible Health Plan (HDHP) at the employee only coverage level. The County will contribute $1,400 annually (divided by 26 pay periods) towards an employee's HSA who elects a HDHP at the employee + one or employee + family coverage level. Employees have the option to contribute the difference between the annual maximum and what the County is contributing on a pre-tax basis. This plan is similar to the Flexible Spending Account as you are able to pay for qualifying health expenses. For more information on this plan, call (833) 232-4673 or email voyasupport@voya.benstrat.com

Enter the annual election for the plan you desire. These deductions cannot be used to pay for insurance premiums. Your annual amount will be divided between the remaining number of pay periods in the calendar year you are electing coverage for.

Indicate the election change by checking the appropriate box below.

☐ Cancel Future Contributions to the HSA

☐ Begin Contributions (First HSA Contribution this year)	$ _____Optional Annual Employee Contributions to the HSA
☐ Change Contributions	$ _____Optional Annual Employee Contributions to the HSA

The IRS has established annual limits that can be contributed to a Health Savings Account in 2027, which are $4,500 for single coverage and $9,000 for 2-Party or Family coverage (including the County's Contribution of $700 for employee only or $1,400 for employee + one/employee + family).

IMPORTANT:

In order to open a Health Savings Account (HSA) and have tax-free contributions made to that account, you must be "HSA Eligible." **IRS guidelines define an HSA Eligible individual as a person who:**

- **is covered under a HSA-qualified high deductible health plan (HDHP), and**
- **has "no other health coverage" (except what is permitted by the IRS), and**
- **is not enrolled in Medicare, and**
- **cannot be claimed as a dependent on someone else's tax return.**

By law, you are not eligible for HSA contributions if you:

- are enrolled in Medicare* (Part A, Part B, Medicare Advantage Plans, Part D, and Medigap/Medicare Supplemental Insurance),
- are covered by another health care plan that is not a qualified high deductible health plan (HDHP),
- can be claimed as a dependent on someone else's tax return,
- are covered by a non-HDHP such as Medicaid, TRICARE or TRICARE for Life, or
- are enrolled in a general purpose Health Care Flexible Spending Account or Healthcare Reimbursement Account (or covered by a spouse's FSA or HRA).

*With respect to being enrolled in Medicare, if you are enrolling in Medicare after attaining age 65, **HSA contributions generally should be discontinued at least six (6) months prior to filing for Medicare benefits**, because Medicare enrollment (called Medicare entitlement) can occur retroactively if you apply after you attain age 65. In such case, if you do not stop HSA contributions in a timely fashion, i.e., the six (6) months (or the months between turning age 65 and the date of application, if shorter) before you apply for Social Security (applying for Social Security is a first step toward Medicare coverage), you may have made an excess contribution and incur a tax penalty.

Information about Health Savings Account Contributions and Prorating the Maximum Yearly Contribution: If you aren't certain you'll be enrolled in a HDHP during the entire next tax year, you can contribute a prorated amount for the months you're actually eligible in the current tax year. To do this, divide the yearly allowable maximum contribution by 12, then multiply the result by the number of months you're enrolled in a HDHP during that tax year.

Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your HDHP. If you are enrolled in the HDHP as of December 1, you are not required to prorate your contributions to your health savings account and can make the full year's contribution to your HSA account. However, if you base an entire tax year's contribution on your status on December 1 (and you were not HSA eligible for that entire year) and you cease to be an eligible individual before the end of the following year, any funding of the HSA over the prorated amount for the months of actual eligibility in the prior year is considered an excess health savings account contribution and the excess amount is subject to a penalty and income tax.

A few states including California may not conform their state tax laws with federal tax laws and contributions to the HSA may be taxed under these state laws. It is advisable to discuss with your tax advisor about joining a HDHP with HSA. Remember, **it is your responsibility to assure that you are an "HSA eligible" individual while contributions are made to your HSA.**

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I understand that in order for the County of San Joaquin to contribute to a health savings account (HSA) on my behalf, I must meet all of the following conditions for HSA eligibility:

- **I am covered under the County's Kaiser or Sutter Health Plus HSA-Qualified High Deductible Health Plan (HDHP), and**
- **I have "no other health coverage" (except what is permitted by the IRS), and**
- **I am not entitled to Medicare, and**
- **I cannot be claimed as a dependent on someone else's tax return.**

By signing below, I certify that all of the above statements are true. I agree to promptly notify the County of San Joaquin Human Resources Employee Benefits Office in writing if I cease to meet these conditions. I understand that the County will make contributions to my HSA only on the basis of my certifications, and that HSA contributions are subject to certain limits under federal tax law. **I further acknowledge that employee contributions are taken out of my pay check on a pre-tax basis, and that a monthly administrative fee (currently $1.15 per month) will be deducted from my HSA account. Additional fees also apply if I utilize VOYA's optional investment account options within my HSA account.**

Signature:_____ Date_____

Section 125 – Flexible Spending Accounts

If you have elected to enroll in either of the High Deductible Health Plan options, you are ineligible to enroll in the Medical Flexible Spending Account. You may elect the Health Savings Account in lieu of the Medical Flexible Spending Account listed above.

Enter the annual election for the plans you desire. These deductions cannot be used to pay for insurance premiums. Your annual amount will be divided between the remaining number of pay periods in the fiscal year you are electing coverage for. (The months with 3 paychecks, only 2 paychecks have deductions.) ***New Hires can enroll, but on a prorated amount.**

Plan Options

Medical Spending Account
(Elect up to $3,300* for 2025 – 2026 annually) $_____annually **or** $_____bi-weekly amount deduction

Dependent Day Care Account
(Elect up to $5,000 for 2025 – 2026 annually) $_____annually

☐ I acknowledge that I have received a copy of the **Rules of Participation** and understand and agree to the terms and conditions of participation in the Flexible Spending Account(s), including those of the Flexible Spending Account Card.

Eligible Dependent Coverage

Check the box for the health services you wish to enroll your eligible dependents. You, as the employee, must be enrolled in the plan if you want your dependent(s) enrolled. If your dependents are enrolled, the plan selection(s) must be the same as the employee.

Required Documentation:
Social Security Number for all, Marriage Certificate (spouse), Birth Certificate (child),Certificate of Partnership (registered domestic partner), court paperwork (adopted child/legal guardianship)

Dependent(s) Name (spouse and/or children)	Relation-ship	Date of Birth	Social Security Number (required)	Medical	Dental	Vision	Primary Care Physician (PCP)

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Other Medical Coverage:
Is your spouse or any of your eligible dependents covered by another group medical plan, including San Joaquin County coverage, MediCal, or Medicare?
☐ Yes. Name and Address of Other Medical Coverage_____
☐ No. I certify that my spouse and/or dependents are not covered by any other medical coverage.

Kaiser Foundation Health Plan Arbitration Agreement
Please read and sign if you are electing the Kaiser plan (required).

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with Employee Retirement Income Security Act regarding certain benefit related disputes) any dispute between myself, my heirs, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not be lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full Arbitration provision is contained in the Evidence of Coverage.

Employee Signature **Date**

Sutter Health Plus Plan Arbitration Agreement
Please read and sign if you are electing the Sutter Health Plus plan (required).

Member accepts the terms, conditions and provisions of the Group Subscriber Contract and *EOC*, upon completion and execution of this enrollment form.

Binding Arbitration
Sutter Health Plus (SHP) handles/resolves member disputes through grievance, appeal and independent medical review processes. In the event that a dispute is not resolved in those processes, SHP uses binding arbitration as the final method for resolving all such disputes. As a condition of your membership in SHP, you agree that any and all disputes between yourself (including any heirs or assigns) and SHP, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for small claims court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and SHP, including any heirs or assigns to this Agreement, 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 binding arbitration. I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and *EOC*.

Employee Signature **Date**

Qualifying Life Events
If you have a qualifying life event, you must provide proof within 60 days of the event. If you obtain a new dependent (through marriage, birth, adoption, registered domestic partnership, legal guardianship) or if you or your dependents lose medical, dental, and/or vision coverage, you must request enrollment in the County's plans within 60 days of the date of the event. If you do not request enrollment within 60 days, you or your dependent must wait until the next County Open Enrollment period before you can enroll and/or make changes. It is also the employee's responsibility to delete a spouse or dependent from coverage within 60 days of an event that makes the dependent ineligible for benefits (such as divorce or over-age child).

By signing below, I acknowledge that deductions are taken out of my pay check on a pre-tax basis. I must provide all dependent verification documentation within 60 days from my date of hire or qualifying life event. Rates are negotiated through my bargaining unit and approved by the Board of Supervisors. All dependents enrolled must be eligible. I understand that falsification of information by me will allow my employer to recover payments made, cancel my coverage, refuse payment of claims, and may include discipline.

Signature: _____ **Date:** _____

Please do not forget to sign here!