Health Benefits Program Implementation Guidelines
AB 205, Domestic Partnership Coverage

Implementation of Domestic Partnership Coverage

Effective January 1, 2005, domestic partners of employees of state and public agencies contracting for health coverage will be eligible for addition in the CalPERS' Health Program.

The domestic partnership must either be registered with the Secretary of State prior to application for enrollment, or, be a same sex legal union, validly formed in another jurisdiction, deemed to be substantially equivalent to a registered domestic partnership in California. More information regarding domestic partners, the rights and responsibilities and the registration process is available through the Secretary of State's Web site, **http://www.ss.ca.gov/dpregistry .**

Process

1. A member seeking to enroll a domestic partner must:

    - Register the partnership with the California Secretary of State. The Declaration of Domestic Partnership form is available through the Secretary's Web site, **http://www.ss.ca.gov/dpregistry; or**,

    - Present to CalPERS' evidence of a same sex legal union, validly formed in another jurisdiction, deemed to be substantially equivalent to a registered domestic partnership in California.

2. The following are eligible to register with the Secretary of State:

    - Specified same-sex domestic partnerships between persons who are both at least 18 years of age; or,

    - Specified opposite sex domestic partnerships where one person is over the age of 62.

The CalPERS' enrollee must provide a copy of the registered Declaration of Domestic Partnership provided by the Secretary of State to the active member's Personnel Office or, if retired, to the CalPERS' Office of Employer and Member Health Services.

Enrollment Instructions

Refer to page 4 of this section for HBD-12 instructions for enrollment of domestic partners.

Eligibility and Enrollment Rules

The addition of a domestic partner is not a permitting event for a change of Health Plan unless there is a concurrent event, such as a move, that would normally allow a plan change. CalPERS' will use the same enrollment statutes and regulations for domestic partnerships as are currently used for spouses.

Effective Date of Domestic Partner Enrollment

For Domestic Partnerships registered with the Secretary of State prior to January 1, 2005, the permitting event date shall be January 1, 2005. The effective date of enrollment in health can be no earlier than January 1, 2005 and shall be the first day of the month following the date of receipt of the enrollment request by the employer or CalPERS.

Enrollments for domestic partnerships registered prior to January 1, 2005, which are submitted more than 60 days after January 1, 2005, shall be considered late enrollments and shall be effective on the first day of the month following a 90-day waiting period after receipt of the application by the employer or CalPERS'. If the late enrollment is made during the Open Enrollment period, the effective date of coverage is the first of the month following the 90-day waiting period, or the Open Enrollment effective date, whichever is earlier.

For domestic partnerships established after January 1, 2005, applications for enrollment will be processed in the same manner as other family additions. Enrollment documents submitted within 60 days of the permitting event will provide Health Benefit coverage effective on the first day of the month following the month in which the employer received the enrollment document.

Enrollments submitted later than 60 days after the permitting event are considered late enrollments, and the effective date of the coverage for new dependents will be the first of the month following a 90 day wait from the date the enrollment request was received by the employer or CalPERS'. If the late enrollment is made during the Open Enrollment period, the effective date of coverage is the first of the month following the 90-day waiting period, or the Open Enrollment effective date, whichever is earlier.

Health Insurance Portability and Accountability Act (HIPAA)

CalPERS' will apply rules equivalent to HIPAA requirements for spouse and children, when making determinations on domestic partners obtaining benefits and for potential future loss of coverage. Employers must retain a copy of the supporting documents.

Children of Domestic Partners

Children of a domestic partner may be covered if they meet other criteria for coverage (i.e., under age 23 years old, never married, not in the military, not covered in this Health Program in their own right through qualifying employment).

The member must submit a copy of the birth certificates of children of the domestic partner.

Termination of Coverage

Coverage of Children of Domestic Partners will be terminated in the same manner and for the same reasons as other dependent children.

1. The child attains the age of 23 (extensions may be requested for children with disabilities under existing rules for these cases);

2. The child marries;

3. The domestic partnership is terminated and the member elects to end coverage of the former partner's children; or

4. Child attains CalPERS' coverage in their own right.

Termination of Benefits

Enrolled members must notify their employer of changes in family status of dependents. The enrolled individual or employer must cancel the Health Benefits coverage of the domestic partner when the domestic partnership terminates. The effective date of termination of benefits will be the first of the month following the termination of the family relationship in accordance with state law.

Continuation of Benefits (COBRA)

The former partner may be eligible for a period of limited coverage equivalent to COBRA provisions. The active member's Personnel Office will provide information and enrollment forms for this continuation coverage. Retired members will receive this information from CalPERS**.**

Financial Liability

The employee or annuitant is responsible for maintaining accurate enrollment status in the CalPERS' Health Program for all dependents. Failure to notify the employer or CalPERS' of the termination of the domestic partnership shall make the employee or annuitant liable for any and all additional expenses incurred by the domestic partner and/or his or her dependents.

Tax Implications

Providing Health Benefits to a domestic partner and children of a domestic partner is a taxable benefit for the enrolled individual(s). Employees, annuitants and their partners should consult their tax counselors regarding withholding requirements for these additional benefits.

HBD-12 Modifications for Domestic Partner Enrollment

The HBD-12 will be used to establish enrollment for domestic partners in the CalPERS' Health Benefit Program.

Health Benefit Officers (HBO's) shall obtain Domestic Partner Social Security Numbers and report them on the HBD-12, Item #3. HBO's shall make pen and ink modifications to the form in the following manner:

Item #3. Strike through "Spouse" and enter "DP"

Item #7 Check "No" and enter "DP" to the right of the "No" box

Item #14 Add domestic partner, use Reason Code 215

Item #15 Use date of Declaration of Domestic Partner registration date, except if prior to January 1, 2004, use December 2004 date. Effective date will be first of month following "Date received in employing office" – Box 33.

Items #17 and #18. In the "Family Relationship" box, enter "DP" for Domestic Partner and "DPC" for children of domestic partners.

Please use the following relationship codes for domestic partner enrollment transactions:

A = Domestic Partner Male C = Domestic Partner Child Male
B = Domestic Partner Female D = Domestic Partner Child Female

PERS
Public Employees' Retirement System
Post Office Box 942714
Sacramento, CA 94229-2714

HEALTH BENEFIT PLAN ENROLLMENT FORM
PERS—HBD-12 (Rev. 10/93)

DO NOT SEND MEDICAL CLAIMS TO THIS ADDRESS

PERS USE ONLY—DOCUMENT REFERENCE NUMBER

▶ PLEASE TYPE ◀

1. TYPE OF ACTION (Check One)
- [ ] a. NEW enrollment
- [x] b. CHANGE of coverage
- [ ] c. CANCEL all coverage

2. SOCIAL SECURITY NUMBER: 111 – 22 – 3333

3. ~~SPOUSE'S~~ DP SOCIAL SECURITY NUMBER: 444 – 55 – 7777

4A. Name: Pat A Doe (FIRST) (MI) (LAST)
Mailing Address: 400 P Street
City, State, ZIP: Sacramento, CA 95816

4B. RESIDENCE ZIP CODE (If different from 4A)

5. [ ] Please check if Permanent Intermittent Employee (applies to active State employees only)

6. SEX: [x] Male [ ] Female

7. MARRIED: [ ] Yes [x] No DP

8. PLAN CODE: 2222

9. NAME OF HEALTH PLAN: PERS CHOICE

10. GROSS PREMIUM: $ 458.00

11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP

12. PRIOR PLAN CODE: 2221

13. PRIOR HEALTH PLAN: PERS CHOICE

14. Permitting Event Code: 2 1 5

15. Permitting Event Date: Mo. 01 Day 01 Year 05

16. EFFECTIVE DATE: Mo. 01 Day 01 Year 05

LIST ALL PERSONS (including self) TO BE ENROLLED IN:

17. BASIC PLAN

ACTION CODE	(FIRST)	(MI)	(LAST)	Mo.	Day	Yr.	Family Relationship	CODE
	Pat	A	Doe	10	10	48	SELF	
	Chris	B	Doe	11	11	55	DPM	A

18. SUPPLEMENTAL PLAN

ACTION CODE	(FIRST)	(MI)	(LAST)	Mo.	Day	Yr.	Relationship	CODE

19. CHECK ONE
- [ ] I **DO NOT** wish to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- [ ] I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above in Items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.
- [ ] I elect to CANCEL the Health Benefits Plan as shown in Items 12 and 13 above.

20. EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse)
▶ (Current Signature Required) (Phone No.)

21. DATE SIGNED Mo. Day Year

▶ PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22–27 ◀

22. DEDUCTION PLAN CODE

23. Type of action (Check One): 1. [ ] New 2. [ ] Cancel 3. [ ] Change

24. PAY PERIOD Month Year

25. PARTY CODE

26. EMPLOYEE DESIGNATION: STRS

27. BARGAINING UNIT: 000

28. AGENCY NAME (or Retirement System): Monterey Unified School District

29. PAYROLL OFFICE CODE: 9

30. AGENCY CODE: 0203

31. UNIT CODE: 039

32. I hereby certify under penalty of perjury as follows: That I am a duly appointed, qualifed and acting officer of the above named agency, and that payment by the agency as provided by Sections 22825–22832 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.

SIGNATURE OF HEALTH BENEFITS OFFICER: ▶ HBO Signature

33. Date received in employing office: Mo. 12 Day 31 Yr. 04

34. PHONE NUMBER: (831) 521-5555

35. REMARKS: Domestic Partnership Registration
________ of ________ Forms

CalPERS

Public Employees' Retirement System
Post Office Box 942714
Sacramento, CA 94229-2714

HEALTH BENEFIT PLAN ENROLLMENT FORM
PERS—HBD-12 (Rev. 10/93)

DO NOT SEND MEDICAL CLAIMS TO THIS ADDRESS

PERS USE ONLY—DOCUMENT REFERENCE NUMBER

▶ PLEASE TYPE ◀

1. TYPE OF ACTION (Check One)
- ☐ a. NEW enrollment
- ☑ b. CHANGE of coverage
- ☐ c. CANCEL all coverage

2. SOCIAL SECURITY NUMBER: 111 — 22 — 3333

3. SPOUSE'S SOCIAL SECURITY NUMBER: — —

4A. Name: Pat (FIRST) A (MI) Doe (LAST)
Mailing Address: 400 P Street
City, State, ZIP: Sacramento, CA 95816

4B. RESIDENCE ZIP CODE (If different from 4A):

5. ☐ Please check if Permanent Intermittent Employee (applies to active State employees only)

6. SEX: ☑ Male ☐ Female

7. MARRIED: ☐ Yes ☑ No

8. PLAN CODE: 2222

9. NAME OF HEALTH PLAN: PERS CHOICE

10. GROSS PREMIUM: $ 458.00

11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP:

12. PRIOR PLAN CODE: 2221

13. PRIOR HEALTH PLAN: PERS CHOICE

14. Permitting Event Code: 2 1 6

15. Permitting Event Date: Mo. 01 Day 01 Year 05

16. EFFECTIVE DATE: Mo. 01 Day 01 Year 05

ACTION CODE	LIST ALL PERSONS (including self) TO BE ENROLLED IN: 17. BASIC PLAN (FIRST) (MI) (LAST)	DATE OF BIRTH Mo.	Day	Yr.	Family Relationship	CODE
	Pat A Doe	10	10	48	SELF	
A	John E Doe	08	11	99	DPCM	C

ACTION CODE	18. SUPPLEMENTAL PLAN (FIRST) (MI) (LAST)	DATE OF BIRTH Mo.	Day	Yr.	Relationship	CODE

19. CHECK ONE

- ☐ I **DO NOT** wish to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above in Items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.
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21. DATE SIGNED Mo. Day Year

▶ PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22–27 ◀

22. DEDUCTION PLAN CODE	23. Type of action (Check One) 1. ☐ New 2. ☐ Cancel 3. ☐ Change	24. PAY PERIOD Month Year	25. PARTY CODE	26. EMPLOYEE DESIGNATION	27. BARGAINING UNIT
				STRS	000

28. AGENCY NAME (or Retirement System)	29. PAYROLL OFFICE CODE	30. AGENCY CODE	31. UNIT CODE
Monterey Unified School District	9	0203	039

32. I hereby certify under penalty of perjury as follows: That I am a duly appointed, qualified and acting officer of the above named agency, and that payment by the agency as provided by Sections 22825–22832 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.

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_____ of _____ Forms