






OPEN ENROLLMENT INSTRUCTIONS

These instructions will help you navigate through BenefitBridge in making your elections for Open Enrollment

 COUNTY OF SACRAMENTO
Active Employees

ALL PLANS



USER LOGIN

User Name

Password

[LOGIN](#) [Forgot User Name / Password?](#)

NEW USER

[REGISTER](#) Create a User Name and Password to access your account.

NEED HELP?

- Contact BenefitBridge Support
- Monday thru Friday 8:00am - 5:00pm (PST)
- (800) 814-1862
- benefitbridge@keenan.com

For benefits effective in

2021

Start by navigating to the website at www.benefitbridge.com/saccounty

If this is your first time using BenefitBridge you will need to register; refer to the New User registration instructions. After you register, you are ready to log in and begin making your elections.

Click **Make Changes to My Benefits** to make changes.




COUNTY OF SACRAMENTO
Active Employees

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Open Enrollment
is currently *open*.

Open enrollment will end in:
32 days on Oct 30, 2020



Make Changes
to My Benefits

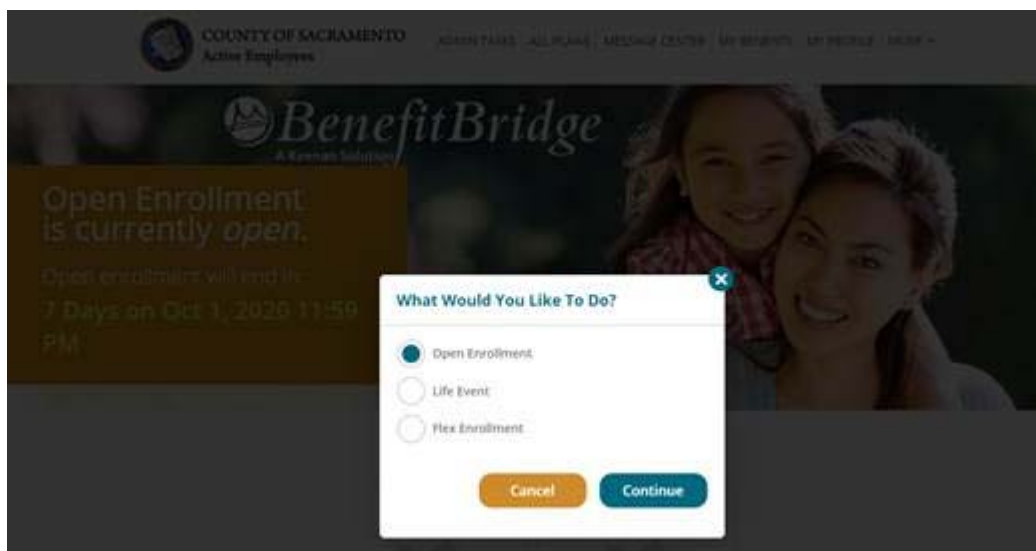


Flex Enrollment
Only

Please select **Open Enrollment** if you're making an Open Enrollment election. Open Enrollment changes are effective 1/1/2021.

If you experienced a “qualifying event” within the last 30 days such as marriage, divorce, registration of domestic partnership, birth or adoption of a child, loss or gain of group coverage, etc., please select **Life Event**. For midyear enrollment changes associated with a birth or adoption, only medical coverage becomes effective on the date of birth or adoption in accordance with HIPAA regulations, as long as you enroll and provide any required documentation in a timely manner. For all other midyear qualifying events, the coverage is effective the first day of the month following eligibility and enrollment, provided you timely submit required documentation.

Select **Flex Enrollment** if your only change is to enroll for Flexible Spending Account (FSA) for 2021.



Important Reminder: no matter where you stop in your Open Enrollment steps, your enrollment request is not complete until you get to the Summary tab at the end of your enrollment, check the “Your Approval: I agree” box and click the “SUBMIT” button to complete your Open Enrollment request.

Note: If you do not wish to accept the arbitration agreement above, select Cancel and return to the **"Medical"** enrollment page to make a new Health Plan selection.

***NAME:**

☐ *** Your Approval: I AGREE** (Check to confirm your final approval.)

EMPLOYEE INFORMATION

Let's start with EMPLOYEE INFORMATION-A summary of your personal information will be displayed.

The screenshot shows a web application interface for the County of Sacramento. At the top, there is a navigation bar with 'WELCOME EMPLOYEE TEST' and links for 'Home | Logout | Need Help?'. Below this, the 'COUNTY OF SACRAMENTO' logo and 'Active Employees' text are visible, along with links for 'ALL PLANS | MESSAGE CENTER | MY BENEFITS | MY PROFILE | MORE'. A sidebar on the left titled 'Open Enrollment' contains a progress bar and a list of sections: 'EMPLOYEE' (highlighted), 'TIER NAME', 'DEPENDENTS', 'BENEFITS', and 'SUMMARY'. The main content area is titled 'EMPLOYEE INFORMATION' and includes a blue instruction icon and text: 'Change the desired information and select **Continue** to update. Please contact the appropriate department within your organization for any information you are unable to change.' A red asterisk indicates required fields. The form fields are: 'FIRST NAME:' (EMPLOYEE), 'MIDDLE NAME:' (M), 'LAST NAME:' (TEST), 'DATE OF BIRTH:' (03/03/1963), 'GENDER:' (Male), 'ADDRESS 1:' (4711 POWDER COURT), and 'ADDRESS 2:' (empty). A separate panel on the right contains 'CITY:' (ELK GROVE), 'STATE:' (CA), 'ZIP:' (95758), 'PHONE NUMBER:' (empty), and 'EMAIL:' (etest@gmail.com). At the bottom right of this panel are 'Cancel' and 'Continue' buttons.

WELCOME EMPLOYEE TEST Home | Logout | Need Help?

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Active Employees

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Open Enrollment

EMPLOYEE
TIER NAME
DEPENDENTS
BENEFITS
SUMMARY

EMPLOYEE INFORMATION

Change the desired information and select **Continue** to update. Please contact the appropriate department within your organization for any information you are unable to change.

* Indicates required fields

* FIRST NAME: MIDDLE NAME:
EMPLOYEE M

* LAST NAME:
TEST

* DATE OF BIRTH: * GENDER:
03/03/1963 Male

* ADDRESS 1:
4711 POWDER COURT

ADDRESS 2:

* CITY:
ELK GROVE

* STATE: * ZIP: PHONE NUMBER:
CA 95758

EMAIL:
etest@gmail.com

Cancel Continue

If you need to make changes to your phone number or email address, make the changes and click "CONTINUE". Your email address is used to send you a response about your Open Enrollment request after it has been reviewed and processed by the Employee Benefits Office

For name and address changes, you must contact your Department of Personnel Services Service Team representative for instructions.

A progress bar on the left of the screen keeps you informed of your position through the election process.

TIER

You might have the option to move to Tier B. It is a voluntary decision that can be made only once and is irrevocable once made. There is no cashback or PSI if you are Tier B. Select the appropriate package and click "CONTINUE".

Life Event

EMPLOYEE ✓

TIER NAME

DEPENDENTS

BENEFITS

SUMMARY

SELECT YOUR TIER

- You have the option to move to Tier B during Open Enrollment and certain life events. Once you enroll in Tier B, you will not be able to return to Tier A. Employees in Tier B are not eligible for Cash Back or PSI, therefore surrender all entitlements to Cash Back and PSI.

| TIER NAME | DESCRIPTION | SELECT |
|------------------------|---|----------------------------------|
| 2018-BG80-NO CASH BACK | This option is your Tier A package. Select this option to remain in Tier A. | <input type="radio"/> |
| 2018-BG80-TO TIRB | Select this option to move to Tier B. Once made, the change is irrevocable. | <input checked="" type="radio"/> |

Cancel

Continue

DEPENDENTS

In this tab you should list any eligible dependent that will be enrolled in any of your coverages. If the dependent(s) listed are accurate, click **"CONTINUE"**.

The screenshot shows the 'Open Enrollment' page for the County of Sacramento Active Employees. The 'DEPENDENTS' tab is selected in the left sidebar. The main content area is titled 'DEPENDENTS' and includes a 'REQUIRED DOCUMENTATION' note: 'A marriage certificate/birth certificate/state registration must be submitted to the Benefits Office within 7 days of completing your enrollment or coverage for your dependent will not be approved.' Below this is a table with columns: DEPENDENT, SSN, RELATION, AGE, and OPTIONS. Two dependents are listed: 'SPOUSE TEST' (SSN: **-0000, RELATION: SPOUSE, AGE: 53) and 'CHILD TEST' (SSN: **-0000, RELATION: CHILD, AGE: 23). Each row has a 'Select' dropdown in the OPTIONS column. At the bottom right is an 'Add Dependent' button. Below the table is a link 'Please provide documentation if required by your Employer' and an 'Add Documents' button. At the very bottom are 'Cancel' and 'Continue' buttons.

| DEPENDENT | SSN | RELATION | AGE | OPTIONS |
|-------------|----------|----------|-----|---------|
| SPOUSE TEST | ** -0000 | SPOUSE | 53 | Select |
| CHILD TEST | ** -0000 | CHILD | 23 | Select |

To add a dependent that is not listed:

- Click "Add Dependent", enter the required dependent information for each family member
- Click "Add this Dependent" (marriage cert, child's birth cert, and/or SSN are required)

To edit existing dependent information:

- Click "Edit" in the Select dropdown box next to that dependent's name, make the changes, click "Update"

To remove a dependent because s/he is no longer your eligible dependent:

- Click "Remove Dependent" next to the dependent to be removed and provide the required reason and effective date, then check the yes box
- Click "Remove Dependent"

To remove a dependent from coverage but keep him/her eligible for future enrollment:

- Do not remove him/her here, uncheck him/her from the appropriate benefit coverage in the next section

Once you are satisfied with dependent details, click **"CONTINUE"**.

IMPORTANT:


Adding a dependent to this screen **DOES NOT** enroll or remove them from coverage. You must complete the enrollment/removal process in the Benefits section AND submit the changes in the Summary section.

BENEFITS

This is where you change coverage, and enroll or remove dependents.

WELCOME EMPLOYEE TEST

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COUNTY OF SACRAMENTO
Active Employees

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OPEN ENROLLMENT

Here is a summary of what's new for your employer group benefits this year

Plans with price changes

You can keep the same plans as last year, but new prices apply.

| PLAN | Last Year YOUR COST PER PAY PERIOD | Next Year YOUR COST PER PAY PERIOD | Net Change YOUR COST PER PAY PERIOD |
|-------------------------|---------------------------------------|---------------------------------------|--|
| Medical | \$0.00 | \$0.00 | \$0.00 |
| County Active-Waive (1) | | | |
| Dental | \$0.00 | \$0.00 | \$0.00 |
| Delta Dental Active | | | |
| Voluntary Term Life | \$27.85 | \$27.85 | \$0.00 |
| Optional Life-Option 3 | | | |
| Group Term Life | \$0.00 | \$0.00 | \$0.00 |
| Basic Life-\$18K | | | |

No Changes to Family or Benefits

I want to keep the same coverage as last year.

Review and Select Plans

I want to review all options before deciding on what change to make.

Select **REVIEW AND SELECT PLANS** to start your Open Enrollment. Selecting **CHANGE** will also allow you to add or remove dependents from coverage.

If you only want to change one benefit, you can step directly to the benefit type you want to make changes to by clicking on the benefit type on the left side grid.

If you are waiving voluntary term life insurance coverage, select **CLEAR**.


NOTE: You cannot change the Dental plan; you can only change the dependents that are enrolled.

BENEFITS (Medical Enrollment)

For medical, check the box next to the dependents that should be enrolled, then choose the medical plan you wish to enroll in.

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Open Enrollment

EMPLOYEE ✓
TIER NAME ✓
DEPENDENTS ✓
MEDICAL
DENTAL ✓
VOLUNTARY TERM LIFE ✓
GROUP TERM LIFE ✓
FLEXIBLE SPENDING ACCOUNT ✓
CRITICAL ILLNESS
VOLUNTARY VISION
SUMMARY

2018-BG001-TO TIRB

Last Year You Chose

| PLAN | COST PER PAY PERIOD |
|-------------------------|---|
| County Active-Waive (1) | \$0.00 (24 deductions per year) |



This Year's Health Insurance Options

- Coverage levels shown are based on your selection of dependents below (if applicable.) Select/deselect the checkbox next to the dependent(s) name to add or remove coverage. If you add or remove a dependent, you must update your benefit election.
- If you are adding a dependent, your enrollment will not be approved without proper documentation (e.g., marriage certificate, birth certificate.) Please provide required documentation to the Benefits Office within 7 days of completing your enrollment.
- To change your current election, select the appropriate plan.
- If you DO NOT want to change your current election, select **Continue**.

2017 HDHP deductible is \$1,300.00 for Employee only and \$2,600.00 for Employee+Two Plus


2018 HDHP deductible is \$1,350.00 for Employee only and \$2,700.00 for Employee+Two Plus

Hide ▴
Coverage for:
Employee: **EMPLOYEE TEST**
☐ SPOUSE: SPOUSE TEST
☐ CHILD: CHILD TEST

| PLAN | COST PER PAY PERIOD |
|--|---|
| <input type="checkbox"/> Compare  KAISER PERMANENTE Authorized Agent Kaiser Permanente High Deductible -Tier B | \$12.25 (24 deductions per year) Select |
| <input type="checkbox"/> Compare  KAISER PERMANENTE Authorized Agent Kaiser Permanente Traditional \$15 Copay HMO -Tier B | \$95.11 (24 deductions per year) Select |

Plans Selected
(5 of 8)
Sub Total:
\$30.91 / PAY PERIOD

* Required Enrollment
✓ Selection Completed

☐ Compare
 **Sutter Health Plus**
We Plus You
Sutter Health Plus High Deductible HMO-Tier B **\$0.00** (24 deductions per year) **Select** || ☐ Compare **Sutter Health Plus** We Plus You Sutter Health Plus Traditional \$15 Copay HMO Tier B | **\$79.42** (24 deductions per year) **Select** |
| ☐ Compare **Western Health Advantage** Western Health Advantage High Deductible HMO-Tier B | **\$0.00** (24 deductions per year) **Select** |
| ☐ Compare **Western Health Advantage** Western Health Advantage Traditional \$15 HMO-Tier B | **\$70.96** (24 deductions per year) **Select** |
| ☐ Compare **County- Active Waive (3)** | **\$0.00** (24 deductions per year) **Select** |
| **Cancel** **Continue** | |

BENEFITS (Medical Enrollment)

For WHA and Sutter only--Enter the Provider ID that can be retrieved from the provider search links within the instructions and check the box if this is your current doctor. Click "**Continue**".

Primary Care Physician (PCP) Details

PCP SELECTION

VERY IMPORTANT - PLEASE READ CAREFULLY!

- If you are currently participating in a Sutter Health Plus or Western Health HMO plan, you do not need to select a new PCP.
- If you are currently participating in anything other than a Sutter Health Plus or Western Health HMO plan and are electing this HMO for the first time, you will need to provide a PCP provider code. Look up a PCP provider code at <http://www.sutterhealthplus.org/providersearch> (ID number is 4 to 8 digits) or <https://www.westernhealth.com/search-for-providers/> (ID number is 10 digits). To change your primary provider, contact the carrier directly.
- Enter the required PCP details for this plan to continue with your enrollment.
- No PCP number required for Kaiser enrollees.

| Name | Relation | PCP # | Existing Provider? |
|-----------|----------|----------------------|--------------------------|
| AMY HAYES | EMPLOYEE | <input type="text"/> | <input type="checkbox"/> |

Cancel


Continue

BENEFITS (Dental Enrollment)

You are then brought back to the BENEFITS page where you can continue making changes to other benefits as necessary. Be sure the box is checked for any dependent you want covered by the DENTAL plan.

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Open Enrollment

EMPLOYEE ✓

TIER NAME ✓

DEPENDENTS ✓

MEDICAL ✓

DENTAL ✓

VOLUNTARY TERM LIFE ✓

GROUP TERM LIFE ✓

HEALTH SAVINGS ACCOUNT

FLEXIBLE SPENDING ACCOUNT

CRITICAL ILLNESS

VOLUNTARY VISION

SUMMARY

★ Required Enrollment


✓ Selection Completed

Plans Selected
(4 of 8)

Sub Total:
\$27.85 / PAY PERIOD

2018-BG01-CASH BACK

Last Year You Chose

| PLAN | COST PER PAY PERIOD |
|--|---|
|  DELTA DENTAL Delta Dental-Active | \$0.00 (24 deductions per year) |

| COVERED | RELATION |
|---------------|----------|
| EMPLOYEE TEST | EMPLOYEE |
| ANGIE ACOSTA | SPOUSE |
| LAUREN ACOSTA | CHILD |

This Year's Health Insurance Options

- Coverage levels shown are based on your selection of dependents below (if applicable.) Select/deselect the checkbox next to the dependent(s) name to add or remove coverage. If you add or remove a dependent, you must update your benefit election.
- If you are adding a dependent, your enrollment will not be approved without proper documentation (e.g., marriage certificate, birth certificate.) Please provide required documentation to the Benefits Office within 7 days of completing your enrollment.
- To change your current election, select the appropriate plan.
- If you DO NOT want to change your current election, select **Continue**.


Hide ▴

Coverage for:

Employee: **EMPLOYEE TEST**

☒ SPOUSE: SPOUSE TEST

☒ CHILD: CHILD TEST

| PLAN | COST PER PAY PERIOD |
|---|---|
| <div>Enrolled Plan</div> <div> DELTA DENTAL Delta Dental-Active</div> | \$0.00 (24 deductions per year) |

Clear

| COVERED | RELATION |
|---------------|----------|
| EMPLOYEE TEST | EMPLOYEE |
| SPOUSE TEST | SPOUSE |
| CHILD TEST | CHILD |

Cancel

Continue

Once you have all family members selected, click "**CONTINUE**".


BENEFITS (Optional Life Insurance)

You will again be brought back to the BENEFITS page.

Changes to life insurance can be made at any time and are not limited to Open Enrollment. Decreases should be made online and are automatically approved. Be sure the box is checked for any dependent you want covered by the Optional Life plan.

If you are waiving voluntary term life insurance coverage, select **CLEAR**.

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Active Employees

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Open Enrollment

EMPLOYEE ✓

TIER NAME ✓

DEPENDENTS ✓

MEDICAL ✓

DENTAL ✓

VOLUNTARY TERM LIFE ✓

GROUP TERM LIFE ✓

HEALTH SAVINGS ACCOUNT


FLEXIBLE SPENDING ACCOUNT

CRITICAL ILLNESS

VOLUNTARY VISION

SUMMARY

Last Year You Chose

| PLAN | COST PER PAY PERIOD |
|---|--|
| <input type="checkbox"/> Compare  Optional Life-Option 3 | \$27.85 (24 deductions per year) |


| COVERED | RELATION | COVERAGE |
|---------------|----------|-----------|
| EMPLOYEE TEST | EMPLOYEE | \$273,000 |


This Year's Coverage Options
Options available to you are shown in the "Plan" Options.

- Option 1 A - 1x annual salary up to \$50,000 (including your basic coverage)
- Option 1 - 1x annual salary up to \$600,000, plus your basic coverage
- Option 2 - 2x annual salary up to \$600,000, plus your basic coverage
- Option 3 - 3x annual salary up to \$600,000, plus your basic coverage
- Option 4 - 4x annual salary up to \$600,000, plus your basic coverage
- Option 5 - 5x annual salary up to \$600,000, plus your basic coverage

If you have not already enrolled in Optional Life, you may enroll in Option 1A or 1 (up to 1 times annual salary) in this year's Open Enrollment with no medical underwriting questions as long as you have not been previously declined.

To increase coverage more than one step, or enrolling for the first time as a late entrant without a qualifying event, please complete the forms below and fax to 916-874-4621.


 Life Insurance Beneficiary.pdf

 Life Insurance Form.pdf

Hide ▴

Coverage for:
Employee: **EMPLOYEE TEST**

☐ SPOUSE: SPOUSE TEST
☐ CHILD: CHILD TEST

| PLAN | COST PER PAY PERIOD |
|---|---|
| Enrolled Plan | \$27.85 (24 deductions per year) |
| <input type="checkbox"/> Compare  Optional Life-Option 3 | <input type="button" value="Clear"/> <input type="button" value="Change"/> |

Guaranteed Coverage: \$273,000


* Required Enrollment

✓ Selection Completed


Plans Selected
(4 of 8)

Sub Total:
\$27.85 / PAY PERIOD


2018-BG01-CASH BACK

☐ Compare

Optional Life Option 1A (with \$18K BL)


\$0.00
(24 deductions per year)

☐ Compare

Optional Life-Option 1


\$0.00
(24 deductions per year)

☐ Compare

Optional Life-Option 2

\$0.00
(24 deductions per year)

☐ Compare

Optional Life-Option 4

\$0.00
(24 deductions per year)

☐ Compare

Optional Life-Option 5



\$0.00
(24 deductions per year)

BENEFITS (Optional Life Insurance)

Edit Coverage Amount

● If you elect to enroll in or make changes to Voluntary Term Life coverage, please select the Benefit Amount for Employee and Dependents, if applicable.

Need help estimating an appropriate amount of coverage? Click on the following link for a helpful calculator:
[Life Insurance Calculator](#)

 [Life Insurance Beneficiary.pdf](#)
 [Life Insurance Form.pdf](#)

COST PER PAY PERIOD: \$33.87 per pay period

EMPLOYEE COVERAGE: EMPLOYEE TEST

SPOUSE COVERAGE: SPOUSE TEST

CancelContinue

Evidence of Insurability

Coverage Details

| Name | Relation | Guaranteed | Requested |
|----------|----------|--------------|--------------|
| EMPLOYEE | Employee | \$273,000.00 | \$302,000.00 |
| Spouse | Spouse | \$0.00 | \$30,000.00 |

☒ * I UNDERSTAND THAT THIS ENROLLMENT INCLUDES COVERAGE THAT REQUIRES CARRIER APPROVAL. I FURTHER UNDERSTAND THAT THE COVERAGE PROVIDED UNTIL SUCH APPROVAL HAS BEEN GRANTED OR DENIED WILL BE THE GUARANTEED ISSUE AMOUNT STATED HEREIN.

CancelI Agree

Increases in coverage must be applied for on the two PDF paper forms in this section (Short form & Life insurance enrollment form). Submit these forms to the Benefits Office by fax or email.

Once you are satisfied with your voluntary life options click "**Continue**".

BENEFITS (Basic Life Insurance)


Please complete and submit the Life Insurance Beneficiary Form to update your beneficiary.

Beneficiary forms are accepted year round and should be updated as your life circumstances change!

Submit this completed form by fax or email to the Benefits Office anytime. Click "**Continue**".

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Open Enrollment

EMPLOYEE ✓

TIER NAME ✓

DEPENDENTS ✓

* MEDICAL ✓

* DENTAL ✓

VOLUNTARY TERM LIFE ✓

* GROUP TERM LIFE ✓

HEALTH SAVINGS ACCOUNT


FLEXIBLE SPENDING ACCOUNT

CRITICAL ILLNESS

VOLUNTARY VISION

SUMMARY


Last Year You Chose

| PLAN | COST PER PAY PERIOD |
|---|---|
|  Basic Life-\$18K | \$0.00 (24 deductions per year) |

| COVERED | RELATION | COVERAGE |
|---------------|----------|----------|
| EMPLOYEE TEST | EMPLOYEE | \$18,000 |


This Year's Coverage Options

- Basic Group Life is paid for by the County. If plan is not selected below, make your selection, then select **Continue**.

 Life Insurance Beneficiary.pdf

Hide ▲

Coverage for:
Employee: **EMPLOYEE TEST**

| PLAN | COST PER PAY PERIOD |
|--|---|
| <div>Enrolled Plan</div>  Basic Life-\$18K | \$0.00 (24 deductions per year) |

Clear

Change

Coverage: **\$18,000**

* Required Enrollment

✓ Selection Completed

Plans Selected
(4 of 8)

Sub Total:
\$30.91 / PAY PERIOD

2018-BG01-CASH BACK

Cancel

Continue

BENEFITS (HSA)

You will again be brought back to the BENEFITS page. You can now enroll in or change your HSA. If you are already enrolled in the HSA and want to change the amount you are contributing, click **CHANGE**.

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Open Enrollment

EMPLOYEE ✓
TIER NAME ✓
DEPENDENTS ✓
MEDICAL ✓
DENTAL ✓
VOLUNTARY TERM LIFE ✓
GROUP TERM LIFE ✓
HEALTH SAVINGS ACCOUNT ✓
FLEXIBLE SPENDING ACCOUNT
CRITICAL ILLNESS
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This Year's Coverage Options

- Select the option that best describes the Medical plan you elected, your Individual or Family coverage and your age.
- Participants in an HSA may not also participate in a Flexible Spending Account (FSA) for Medical Reimbursement. If you are changing from an FSA to an HSA during Open Enrollment, please note that you cannot start contributions to an HSA until April 1 unless the balance in your MRA is \$0 on December 31.
- If you wish to cancel for 2017, please select the "Clear" button.
- No enrollment form is required for Sutter US Bank HSA

Coverage for:
Employee: **EMPLOYEE TEST**

| PLAN | COST PER PAY PERIOD |
|-------------------|--|
| HSA Kaiser Active | \$0.00 (24 contributions per year) |

Select

Required Enrollment
Selection Completed

Plans Selected
(4 of 8)
Sub Total:
\$30.91 / PAY PERIOD

2018-BG01-CASH BACK

Cancel Continue

Edit Contribution Amount

YOUR CONTRIBUTION:

CONTRIBUTION
LIMIT \$0 TO \$3,400

2500 Annual

Cancel Continue

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Open Enrollment

EMPLOYEE ✓
TIER NAME ✓
DEPENDENTS ✓
MEDICAL ✓
DENTAL ✓
VOLUNTARY TERM LIFE ✓
GROUP TERM LIFE ✓
HEALTH SAVINGS ACCOUNT ✓
FLEXIBLE SPENDING ACCOUNT
CRITICAL ILLNESS
VOLUNTARY VISION
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This Year's Coverage Options

- Select the option that best describes the Medical plan you elected, your Individual or Family coverage and your age.
- Participants in an HSA may not also participate in a Flexible Spending Account (FSA) for Medical Reimbursement. If you are changing from an FSA to an HSA during Open Enrollment, please note that you cannot start contributions to an HSA until April 1 unless the balance in your MRA is \$0 on December 31.
- If you wish to cancel for 2017, please select the "Clear" button.
- No enrollment form is required for Sutter US Bank HSA

Coverage for:
Employee: **EMPLOYEE TEST**

| PLAN | COST PER PAY PERIOD |
|-------------------|--|
| HSA Kaiser Active | \$104.17 (24 contributions per year) |

Clear

Change

Required Enrollment
Selection Completed

Plans Selected
(5 of 8)
Sub Total:
\$30.91 / PAY PERIOD

2018-BG01-CASH BACK

Cancel Continue

The HSA annual limits for 2021 are listed below:

Under age 55

Over age 55

Single: \$3,600 (\$150/pay period) Single: \$4,600 (\$191.67/pay period)

Family: \$7,200 (\$300/pay period) Family: \$8,200 (\$341.67/pay period)

The HSA is normally deducted over 24 pay periods; the annual amount you enter will be divided by 24 and deducted each pay period in the year. You can change the amount you contribute to your HSA anytime during the year with no life event required. Enter the per pay period amount you want to contribute to your HSA based on your eligibility status, then click **"CONTINUE"**.

OPTIONAL (FSA)

Click **Select** under the Flexible Spending Account to enroll in Medical Reimbursement, Dependent Care, or Limited Medical Reimbursement.

To enroll in the Dependent Care Account or Limited Purpose Medical Reimbursement Account, select "**County Limited FSA 2021**", and then click Continue.

Note: a General Purpose MRA will turn off your HSA contributions, but you can keep HSA contributions going with a Limited MRA, where reimbursable expenses are limited to only dental and vision expenses.

Enter your annual election in the box provided. Your pay check deduction amount will be based on your annual election, deductions are generally taken twice each month (24 pay periods).

To enroll in the Dependent Care Account or General Purpose Medical Reimbursement Account, select "**County FSA 2021**", then click "Continue". Follow the same steps as above.

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Open Enrollment

EMPLOYEE

TIER NAME

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GROUP TERM LIFE

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SUMMARY

This Year's Coverage Options

- If you would like to enroll in the Flexible Spending Account (FSA) - Dependent Care and/or Medical Reimbursement, make your selection below.
- The annual limit for the Medical Reimbursement Account is \$2,500.
- If you don't want to enroll in the FSA, select **Continue**.

"Limited" Healthcare Flexible Spending Account (FSA)-This account is "limited" to dental and vision qualified reimbursable expenses only, not medical or Rx expenses, but you are still eligible to contribute to an HSA while enrolled in an HD HMO plan.

If you have an HSA, you may want to consider a "Limited" Healthcare FSA for Open Enrollment, so you can make your valuable HSA funds, which roll over from year to year, last longer!

FSA Claim Form.pdf

Navia Recurring Day Care Claim Form.pdf

Hide

Coverage for:
Employee: **EMPLOYEE TEST**

Plans Selected

PLAN

COST PER PAY PERIOD

Healthcare Flexible Spending Account

- The total allowed per the IRS for the Health Care Expense is \$2,500 per year.

Dependent Care

- The total allowed per the IRS is \$5,000 per year or \$2,500 if married, filing separate returns.

Trying to figure out how much to withhold? Click on the following links for calculators that will help.

FSA Health Care Calculator

FSA Dependent Care Calculator

FSA Claim Form.pdf

Navia Recurring Day Care Claim Form.pdf

UNREIMBURSED MEDICAL

LIMIT \$0 TO \$2,500

2000

DEPENDENT CARE

LIMIT \$0 TO \$5,000

0

Cancel

Continue

WELCOME EMPLOYEE TEST

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COUNTY OF SACRAMENTO

Active Employees

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Open Enrollment

EMPLOYEE

TIER NAME

DEPENDENTS

MEDICAL

DENTAL

VOLUNTARY TERM LIFE

GROUP TERM LIFE

HEALTH SAVINGS ACCOUNT

FLEXIBLE SPENDING ACCOUNT

CRITICAL ILLNESS

VOLUNTARY VISION

SUMMARY

This Year's Coverage Options

- If you would like to enroll in the Flexible Spending Account (FSA) - Dependent Care and/or Medical Reimbursement, make your selection below.
- The annual limit for the Medical Reimbursement Account is \$2,500.
- If you don't want to enroll in the FSA, select **Continue**.

"Limited" Healthcare Flexible Spending Account (FSA)-This account is "limited" to dental and vision qualified reimbursable expenses only, not medical or Rx expenses, but you are still eligible to contribute to an HSA while enrolled in an HD HMO plan.

If you have an HSA, you may want to consider a "Limited" Healthcare FSA for Open Enrollment, so you can make your valuable HSA funds, which roll over from year to year, last longer!

FSA Claim Form.pdf

Navia Recurring Day Care Claim Form.pdf

Hide

Coverage for:
Employee: **EMPLOYEE TEST**

Plans Selected

(6 of 8)

Sub Total:

\$30.91 / PAY PERIOD

2018-BG01-CASH BACK

PLAN

COST PER PAY PERIOD

Enrolled Plan

\$83.33

(24 contributions for this year)

County FSA 2018

Unreimbursed Medical Amount:

\$2,000.00 (\$83.33 per pay period)

Dependent Care Amount: \$0.00

(\$0.00 per pay period)

Clear

Change

County Limited FSA 2018

\$0.00

(24 contributions for this year)

Select

Cancel


Continue

OPTIONAL (Critical Illness)

Click **Select** under the Critical Illness to enroll. Be sure the box is checked for any dependent you want covered by the Critical Illness plan. Click "Continue".

WELCOME EMPLOYEE TEST

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COUNTY OF SACRAMENTO
Active Employees

ALL PLANS | MESSAGE CENTER | MY BENEFITS | MY PROFILE | MORE ▾

Open Enrollment

EMPLOYEE ✓

TIER NAME ✓

DEPENDENTS ✓

MEDICAL ✓

DENTAL ✓

VOLUNTARY TERM LIFE ✓

GROUP TERM LIFE ✓

HEALTH SAVINGS ACCOUNT ✓

FLEXIBLE SPENDING ACCOUNT ✓

CRITICAL ILLNESS

VOLUNTARY VISION

SUMMARY

This Year's Coverage Options

By electing coverage under the Prudential Critical illness plan, you agree that you have major medical coverage for you and any dependents you are selecting coverage for. This critical illness coverage is not comprehensive health insurance coverage ("major medical coverage").


Hide ▲

Coverage for:

Employee: **EMPLOYEE TEST**

☐ SPOUSE: SPOUSE TEST

☐ CHILD: CHILD TEST

| PLAN | COST PER PAY PERIOD |
|--|---|
|  Prudential-Critical Illness | \$0.00 (24 deductions per year) |

Select

* Required Enrollment

✓ Selection Completed

Plans Selected
(6 of 8)

Sub Total:
\$30.91 / PAY PERIOD

2018-BG01-CASH BACK

Cancel

Continue

OPTIONAL (Voluntary Vision)

If you're enrolled in Sutter or WHA HMO, the cost and coverage for vision benefits are bundled with your HMO selection.


Vision benefits are not included if you enroll in a high deductible plan or you waive medical coverage, so you will need to select Voluntary Vision to have coverage.

If you are enrolled in Kaiser HMO, you may also elect to purchase additional VSP coverage on top of the Kaiser vision benefit

Click **Select** under the Voluntary Vision to enroll. Be sure the box is checked for any dependent you want covered by the Voluntary Vision plan. Click "Continue".

WELCOME EMPLOYEE TEST

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Active Employees

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Open Enrollment

EMPLOYEE ✓
TIER NAME ✓
DEPENDENTS ✓
MEDICAL ✓
DENTAL ✓
VOLUNTARY TERM LIFE ✓
GROUP TERM LIFE ✓
HEALTH SAVINGS ACCOUNT ✓
FLEXIBLE SPENDING ACCOUNT ✓
CRITICAL ILLNESS ✓
VOLUNTARY VISION ✓
SUMMARY

This Year's Health Insurance Options

- If you have selected medical coverage under an HMO plan, DO NOT enroll in the voluntary vision plan; your vision is already included with your HMO.
- However, if you have waived medical coverage or enrolled in a High Deductible plan and want vision coverage, you must enroll for voluntary vision.


Hide ▲

Coverage for:

Employee: **EMPLOYEE TEST**

☐ SPOUSE: SPOUSE TEST

☐ CHILD: CHILD TEST

| PLAN | COST PER PAY PERIOD |
|--|---|
|  VSP-Voluntary Vision Active | \$2.60 (24 deductions per year) |

Select

* Required Enrollment

✓ Selection Completed

Plans Selected
(6 of 8)

Sub Total:
\$30.91 / PAY PERIOD

2018-BG01-CASH BACK

Cancel


Continue

REVIEW & FINAL APPROVAL

You are almost finished! Scroll through and review the Acknowledgement provisions.

WELCOME EMPLOYEE TEST

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COUNTY OF SACRAMENTO
Active Employees

ALL PLANS | MESSAGE CENTER | MY BENEFITS | MY PROFILE | MORE ▾

Open Enrollment

EMPLOYEE ✓

TIER NAME ✓

DEPENDENTS ✓

MEDICAL ✓

DENTAL ✓

VOLUNTARY TERM LIFE ✓

GROUP TERM LIFE ✓

HEALTH SAVINGS ACCOUNT ✓

FLEXIBLE SPENDING ACCOUNT ✓

CRITICAL ILLNESS ✓


VOLUNTARY VISION ✓

SUMMARY

SUMMARY

Effective date of new plans:
01/01/2018





All plans have a pending status until all documents and information have been approved by your employer.




Employer Pays:
\$359.08 / PAY PERIOD

Employee Pays:
\$30.91 / PAY PERIOD

* Does not include contributions to Flexible Spending and Health Savings Account

| PLAN | COVERAGE FOR | COST PER PAY PERIOD |
|--|--|--|
| Medical  Kaiser Permanente High Deductible -Tier A Change Details | EMPLOYEE TEST | Employer Pays: \$296.09 You Pay: \$0.00 |
| Dental  Delta Dental-Active Change Details | EMPLOYEE TEST SPOUSE TEST CHILD TEST | Employer Pays: \$62.50 You Pay: \$0.00 |
| Voluntary Term Life  Optional Life-Option 3 Coverage: \$273,000 Change Details | EMPLOYEE TEST SPOUSE TEST | You Pay: \$30.91 |
| Group Term Life  Basic Life-\$18K Coverage: \$18,000 Change Details | EMPLOYEE TEST | Employer Pays: \$0.49 You Pay: \$0.00 |

Plans Selected
(6 of 8)

Group Term Life

Basic Life-\$18K
Coverage: \$18,000
[Change](#) | [Details](#)

EMPLOYEE TEST

Employer Pays:
\$0.49
You Pay:
\$0.00

Health Savings Account
HSA Kaiser Active
Contribution Amount: \$2,500.00
[Change](#) | [Details](#)

EMPLOYEE TEST

You Pay:
\$104.17

Flexible Spending Account
County FSA 2018
Annual Medical: \$2,000.00
[Change](#) | [Details](#)

EMPLOYEE TEST

You Pay:
\$83.33

Total per pay period -

Employer Pays: **\$359.08**
You Pay: **\$30.91**

* Does not include contributions to Flexible Spending and Health Savings Account

Cancel

Continue

Carefully read the Personal Information Summary to confirm your coverage and dependent information are correct. **This is your opportunity to ensure the elections you made accurately reflect your intentions.** You are not able to make changes to your coverage after Open Enrollment closes, so please review this information carefully. Click "Continue".

If the selections reflect the coverage you want, **type in your name, check the "Your Approval: I AGREE" box, and then click "Submit".**

WELCOME EMPLOYEE TEST
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COUNTY OF SACRAMENTO
Active Employees

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COUNTY OF SACRAMENTO-ACTIVE
Summary of Benefits for the Requested Effective Date of 1/1/2018

MY DIGITAL SIGNATURE

Please review all of the information on this page and when you are satisfied with your selections, check the **I Agree** box and select **Submit**.

Acknowledgment:

I hereby certify that all the information entered is true and correct to the best of my knowledge. I also understand that any false information entered will make this enrollment process and the coverage for which it applies null and void. The Plan reserves the right to rescind coverage should the information prove to be incomplete or inaccurate. I understand that my benefit elections will be in effect until the next Open Enrollment period, unless my family status changes (e.g. loss of coverage for me or my dependents, change in marital status, change in spouse/domestic partner's employment status). I understand that I must notify my employer within 30 days if I experience a qualifying event. I authorize my employer to make all payroll deductions associated with my elections. I understand that I am entitled to a copy of the plan documents for the benefit plans. Your request has been submitted. If you added dependents or waived medical coverage, your enrollment is pending receipt of those documents; the deadline for documents is 7 days from submitting these elections. An email from noreply@saccounty.net will be sent to the email address listed in your Personal Information when your request is approved/denied.

TO PRINT SUMMARY OF BENEFITS

Once your enrollment has been submitted, you will be able to download a copy of your Summary of Benefits. A copy of your Summary of Benefits will also be stored in your Message Center.

PERSONAL INFORMATION SUMMARY

Name: EMPLOYEE TEST Gender: Male Date of Birth: 3/1/1963 SSN: **-**-7807

Address: 4711 POWDER COURT Phone: Email: ctest@gmail.com Age: 54

ELK GROVE CA 95758

SSN: 1004630

MY DEPENDENTS SUMMARY

| DEPENDENT | RELATION | DOB | AGE | SSN | ADDRESS |
|-------------|----------|------------|-----|----------|---------|
| SPOUSE TEST | SPOUSE | 12/11/1963 | 53 | **-.0000 | SAME |
| CHILD TEST | CHILD | 7/20/1994 | 23 | **-.0000 | SAME |

CORE BENEFITS SUMMARY

BENEFIT DETAILS COST PER PAY PERIOD

Medical: Kaiser Permanente High Deductible-Tier A \$0.00

Coverage: Employee Carrier: KAISER PERMANENTE

| COVERED | RELATION |
|---------------|----------|
| EMPLOYEE TEST | EMPLOYEE |

Dental: Delta Dental-Active \$0.00

Coverage: Employee + One Plus Carrier: DELTA DENTAL OF CALIFORNIA

| COVERED | RELATION |
|---------------|----------|
| EMPLOYEE TEST | EMPLOYEE |
| SPOUSE TEST | SPOUSE |
| CHILD TEST | CHILD |

Voluntary Term Life: Optional Life-Option 3 \$30.91

Coverage: \$273,000 Carrier: PRUDENTIAL

| COVERED | RELATION | GUARANTEED COVERAGE | REQUESTED COVERAGE |
|---------------|----------|---------------------|--------------------|
| EMPLOYEE TEST | EMPLOYEE | \$273,000 | |
| SPOUSE TEST | SPOUSE | \$30,000 | |

Group Term Life: Basic Life-\$18K \$0.00

Coverage: \$18,000 Carrier: PRUDENTIAL

| COVERED | RELATION | GUARANTEED COVERAGE |
|---------------|----------|---------------------|
| EMPLOYEE TEST | EMPLOYEE | \$18,000 |

Health Savings Account: HSA Kaiser Active Per Pay Period: \$2,500 \$104.17

Carrier: County

BENEFIT DETAILS

Flexible Spending Account: County FSA 2018 Annual Medical: \$2,000 \$83.33

Carrier: Flex Plan Services

***Cost Summary**

*Note: Actual deductions may vary slightly due to rounding.

| | PER PAYCHECK (24 DEDUCTIONS) | ANNUAL AMOUNT |
|---------------------|------------------------------|---------------|
| Flexible Spending | \$83.33 (24 Deductions) | \$2,000.00 |
| HSA | \$104.17 (24 Deductions) | \$2,500.00 |
| Employee pays | \$30.91 | \$741.72 |
| Employer pays | \$359.08 | \$8,617.80 |
| Total Benefits Cost | \$389.99 | \$9,359.52 |

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT

For employees selecting the Kaiser Permanente health care plan

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), 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 by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our 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.

By selecting the **I Agree** checkbox below, I understand that this action will serve as my electronic signature of agreement to the conditions provided in the **Kaiser Foundation Health Plan Arbitration Agreement** (above) and that by law this electronic signature will have the same effect as a signature on a paper form.

Note: If you do not wish to accept the arbitration agreement above, select Cancel and return to the "Medical" enrollment page to make a new Health Plan selection.

*NAME:

☐ * Your Approval: I AGREE (Check to confirm your final approval.)

Cancel Submit

Congratulations, PART 1 of the online enrollment has now been submitted for review!

NOTE: If you added dependents or waived medical coverage, your enrollment is not complete until you provide documentation (birth certificates for children, marriage certificate, proof of other coverage, etc.) by November 6, 2020. If the documentation is not received, your changes will not be approved-no exceptions.

Documentation can be faxed to the Employee Benefits Office at (916) 874-4621 or emailed to MyBenefits@saccounty.net. **Include your employee ID on all documents.**