



# Making Changes to your FSA and DCRA

These instructions will help you navigate through BenefitBridge in making your changes to your Flex Spending Account and/or Dependent Care Reimbursement Account.

A screenshot of the BenefitBridge user interface. At the top left, it says "COUNTY OF SACRAMENTO Active Employees" and "ALL PLANS" at the top right. The main header features the BenefitBridge logo and a photo of a woman and a child. Below the header, there are two columns: "USER LOGIN" and "NEW USER". The "USER LOGIN" section has fields for "User Name" and "Password", and a "LOGIN" button. The "NEW USER" section has a "REGISTER" button and a "NEED HELP?" section with contact information for BenefitBridge Support.

COUNTY OF SACRAMENTO  
Active Employees

ALL PLANS

**BenefitBridge**  
A Keenan Solution

**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](http://www.benefitbridge.com/saccounty)

Please log on using your User Name and Password. If you have forgot your user name and password, please click on the link next to the LOGIN button.

LOGIN

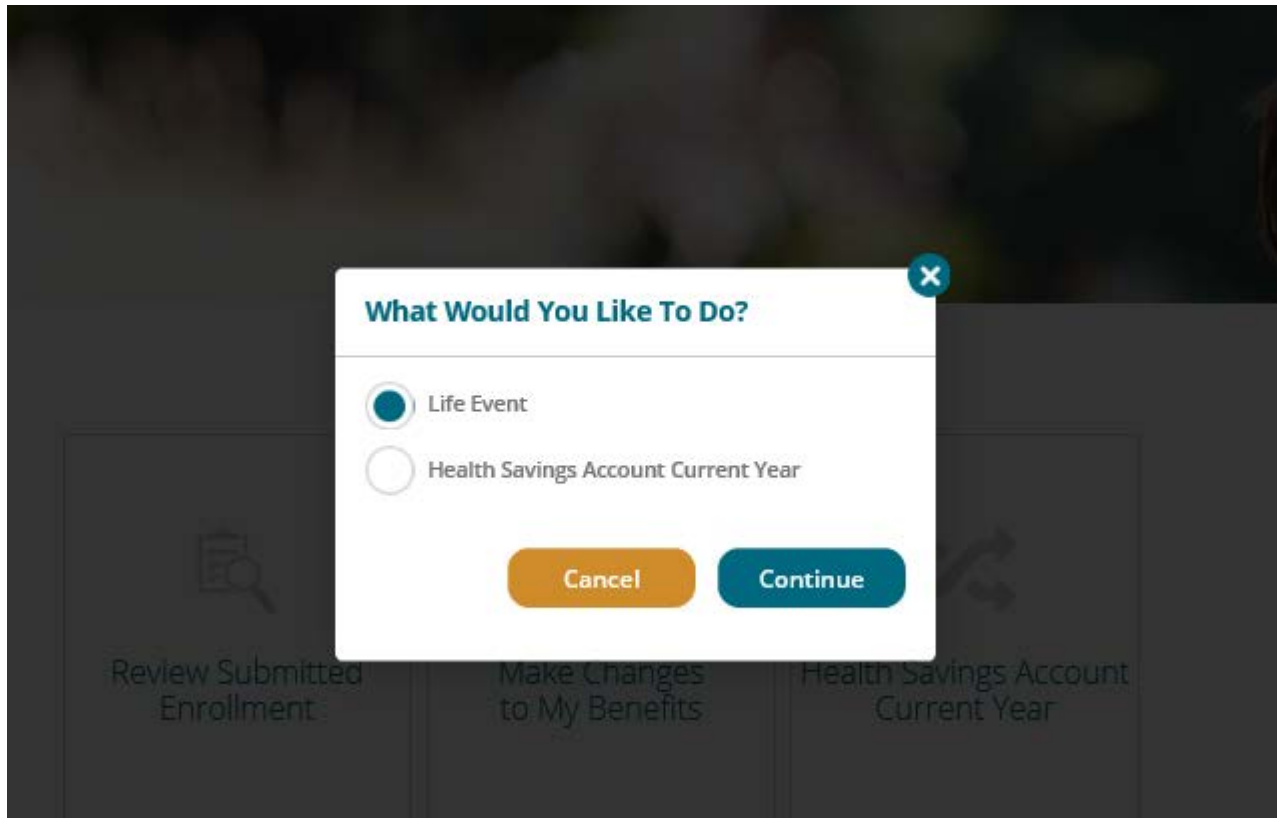
[Forgot User Name / Password?](#)



Once you have logged on, close the pop up window by clicking on the "X" in the top corner. You then will click **Make Changes to My Benefits**, highlighted below, to make changes.

The screenshot shows the top navigation bar with the County of Sacramento logo and the text "COUNTY OF SACRAMENTO Active Employees". To the right are links for "ADMIN TASKS", "ALL PLANS", "MESSAGE CENTER", "MY BENEFITS", "MY PROFILE", and "MORE". Below the navigation bar is a large banner with the "BenefitBridge A Keenan Solution" logo and a photo of a smiling young girl. At the bottom, there are three main action buttons: "Review Submitted Enrollment" (with a magnifying glass icon), "Make Changes to My Benefits" (with a double-headed arrow icon and highlighted with a yellow border), and "Health Savings Account Current Year" (with a double-headed arrow icon).

Please select **Life Event**.



The LIFE EVENT that applies to this situation is "Other" and you will use the previous day's date in the "Date of your Life Event". Please put "FSA or Dependent Care Change" in the "Describe your Life Event" box. Then hit Continue.

## SPECIFY YOUR LIFE EVENT

*\* Indicates required fields*

\*1. Which Life Event applies to your situation?

- |  |  |  |
|--|--|--|
| <input type="radio"/> Birth / Adoption               | <input type="radio"/> Deceased                                       | <input type="radio"/> Dependent Loss of Coverage |
| <input type="radio"/> Dependent Permanently Disabled | <input type="radio"/> Divorce / Dissolution / Annulment / Separation | <input type="radio"/> Domestic Partnership       |
| <input type="radio"/> Marriage                       | <input type="radio"/> Medicare Eligible Life Event                   | <input type="radio"/> New Hire                   |
| <input type="radio"/> Other                          | <input type="radio"/> Spouse Gains/Loses Coverage                    |  |

\*2. What was the date of your Life Event?



\*3. Please describe your Life Event

4. Please provide documentation of your Life Event. (optional) 

Cancel

Continue

You will then be taken to a screen showing your Employee Information.

[View/Change Details](#)

- EMPLOYEE
- 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:

BRIAN

D

At the bottom of the screen is a "Continue" button. Please hit continue, you will be taken through the different Benefit options. **NOTE: You cannot make changes to any other benefits except during Open Enrollment or a qualified Life Event.** Keep hitting the continue button until you come to the Flex Spending Account page.

WELCOME EMPLOYEE TEST Home | Logout | Need Help?

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**

- 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**

PLAN	COST PER PAY PERIOD
<b>Enrolled Plan</b>	<b>\$83.33</b> (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	<b>\$0.00</b> (24 contributions for this year)
	Select

2018 8601-CASH BACK

Plans Selected (6 of 8)  
Sub Total: \$30.91 / PAY PERIOD

Selection Completed

Cancel Continue

To make a change, you will click on the blue "Change" button, and a pop up window will let you make adjustments to your FSA/Dependent Care.

**Edit Annual FSA Amount**

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.

**Life Events:** If you are making a midyear change for 2020 and wish to no longer contribute, you will need to enter in the Year to Date (YTD) amount that you have already contributed. This amount can be found on your most recent pay stub.

[HealthCare Calculator](#)

[DependentCare Calculator](#)

UNREIMBURSED MEDICAL  
LIMIT \$0 TO \$2,500

DEPENDENT CARE  
LIMIT \$0 TO \$5,000

Cancel Continue

Limited FSA - 2021 (22 contribut

Enter the amount in the correct box for the new **amount you want for the year 2021**. The balance between what you have contributed and what you want to have will be divided over the remaining pay periods. For example:

You have contributed \$1000 as of March 1<sup>st</sup>. You want to change your contribution to \$1500 for 2021. The difference of \$500 will be divided over the remaining pay periods. (\$500/20 pay periods remaining = \$25/pay period)

***If you are making a midyear change for 2021 and wish to no longer contribute, you will need to enter in the Year to date (YTD) amount that you have already contributed. This amount can be found on your most recent pay stub. There will be no refunds for amounts already contributed.***

Once you are done, hit continue. You will see a new amount under the "Cost per Pay Period". Please note this amount may be incorrect because it is estimating the cost over 24 pay periods, not the remaining pay periods. For the correct amount, you may contact the Benefits Office.

PLAN	COST PER PAY PERIOD
<b>Enrolled Plan</b>	<b>\$41.67</b> (24 contributions for this year)
FSA 2021 <b>Annual Unreimbursed Medical:</b> <b>\$1,000.00</b> (\$41.67 per pay period) <b>Dependent Care: \$0.00</b> (\$0.00 per pay period)	<b>Clear</b> <b>Change</b>
Limited FSA - 2021	<b>\$0.00</b> (22 contributions for this year) <b>Select</b>

Once you have made your change, hit continue until you come to the Review page.

# REVIEW & FINAL APPROVAL

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

WELCOME EMPLOYEE TEST Home | Logout | Need Help?

COUNTY OF SACRAMENTO Active Employees ALL PLANS | MESSAGE CENTER | MY BENEFITS | MY PROFILE | MORE

### Open Enrollment

#### 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
<b>Medical</b> Kaiser Permanente Kaiser Permanente High Deductible -Tier A <a href="#">Change</a>   <a href="#">Details</a>	EMPLOYEE TEST	Employer Pays: <b>\$296.09</b> You Pay: <b>\$0.00</b>
<b>Dental</b> Delta Dental Delta Dental-Active <a href="#">Change</a>   <a href="#">Details</a>	EMPLOYEE TEST SPOUSE TEST CHILD TEST	Employer Pays: <b>\$62.50</b> You Pay: <b>\$0.00</b>
<b>Voluntary Term Life</b> Prudential Optional Life-Option 3 Coverage: \$273,000 <a href="#">Change</a>   <a href="#">Details</a>	EMPLOYEE TEST SPOUSE TEST	You Pay: <b>\$30.91</b>
<b>Group Term Life</b> Prudential Basic Life-\$18K Coverage: \$18,000 <a href="#">Change</a>   <a href="#">Details</a>	EMPLOYEE TEST	Employer Pays: <b>\$0.49</b> You Pay: <b>\$0.00</b>

**Plans Selected (6 of 8)**

Group Term Life Employer Pays: **\$0.49**

Basic Life-\$18K Coverage: \$18,000  
You Pay: **\$0.00**

Health Savings Account  
HSA Kaiser Active Contribution Amount: \$2,500.00  
You Pay: **\$104.17**

Flexible Spending Account  
County FSA 2018 Annual Medical: \$2,000.00  
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 change is showing. **This is your opportunity to ensure the elections you made accurately reflect your intentions.** Any submitted enrollment will be considered reviewed and approved by the employee.

Hit Continue one more time, and then you'll be at the final summary page. Please review again for correctness, and then continue to the bottom of the page.



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
Home | Log out | Need Help?

**COUNTY OF SACRAMENTO**  
 Active Employees

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

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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@sacounty.com](mailto:noreply@sacounty.com) 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**

<b>Name:</b> EMPLOYEE TEST	<b>Gender:</b> Male	<b>Date of Birth:</b> 3/31/1963	<b>SSN:</b> **-**-7807
<b>Address:</b> 4711 POWDER COURT 11K GROVE CA 95728	<b>Phone:</b>	<b>Email:</b> enro@gmail.com	<b>Age:</b> 54
<b>EPN:</b> 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

**Carrier:** County \$104.17

**BENEFIT DETAILS**

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

**Carrier:** Flex Plan Services \$83.33

**\*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

**Important Reminder: 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. All Changes will take effect the 1<sup>st</sup> of the month following the election.**

