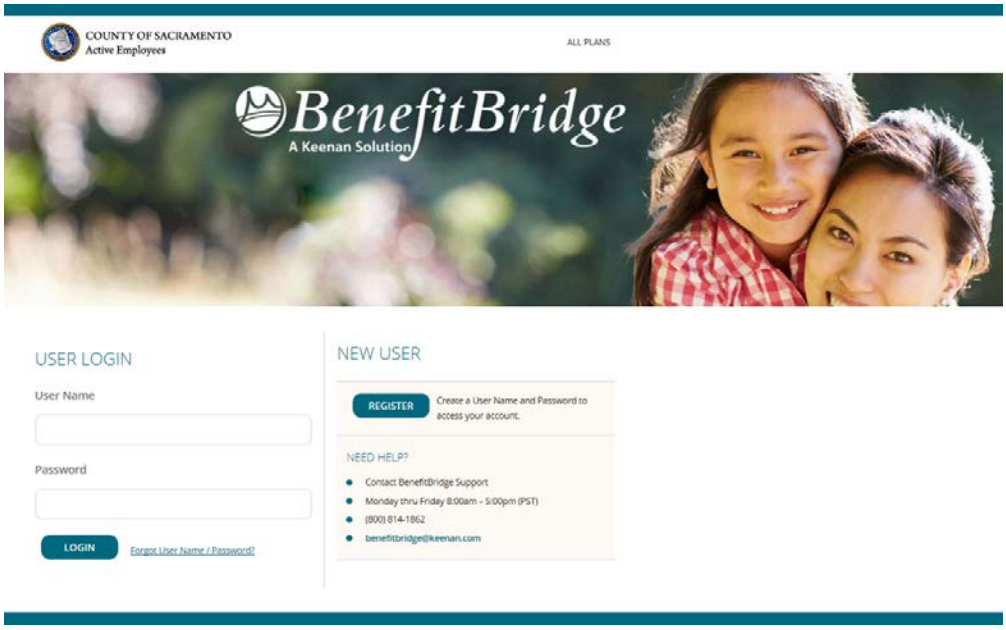
SACRAMENTO COUNTY

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.



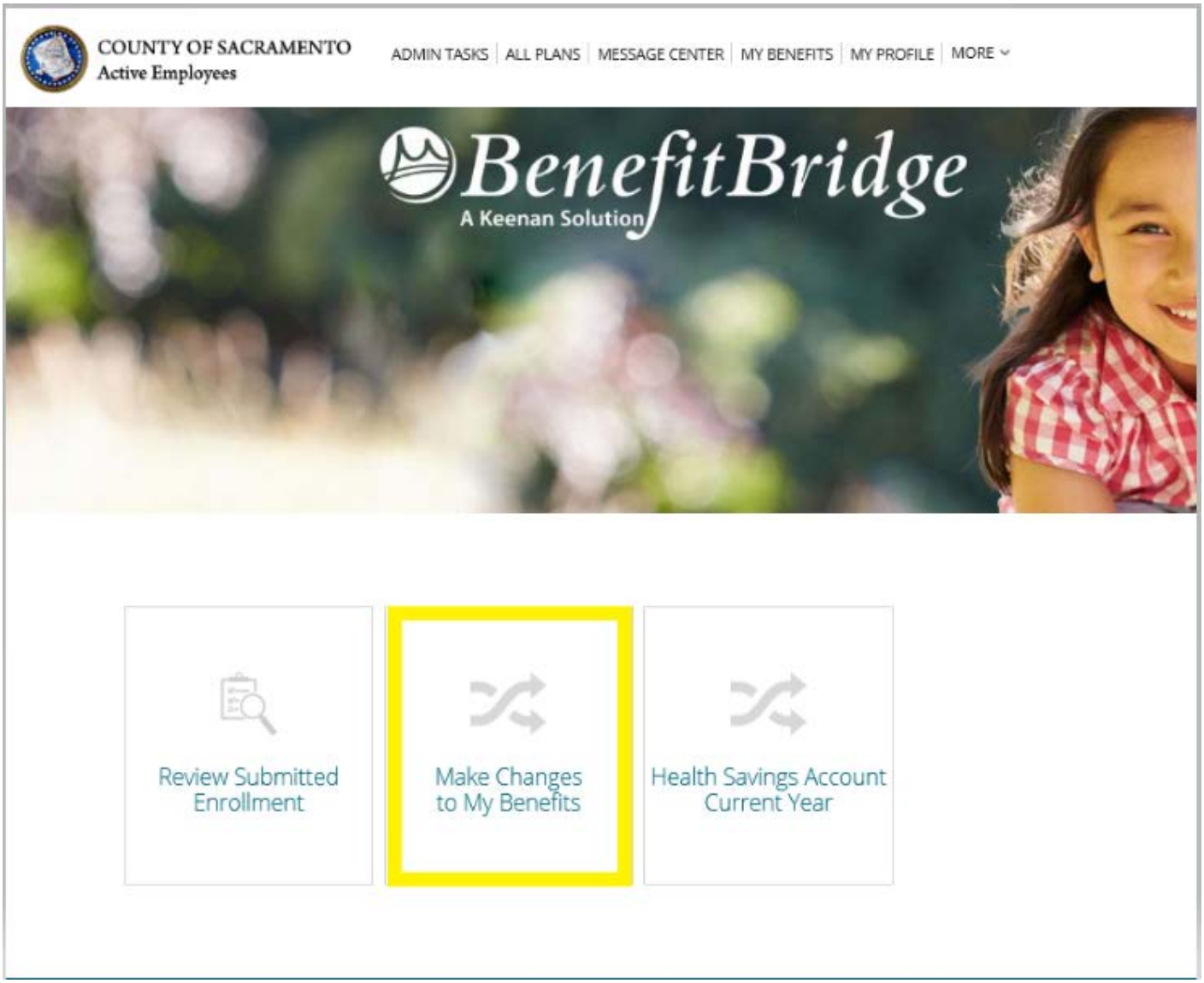
For benefits effective in

2021

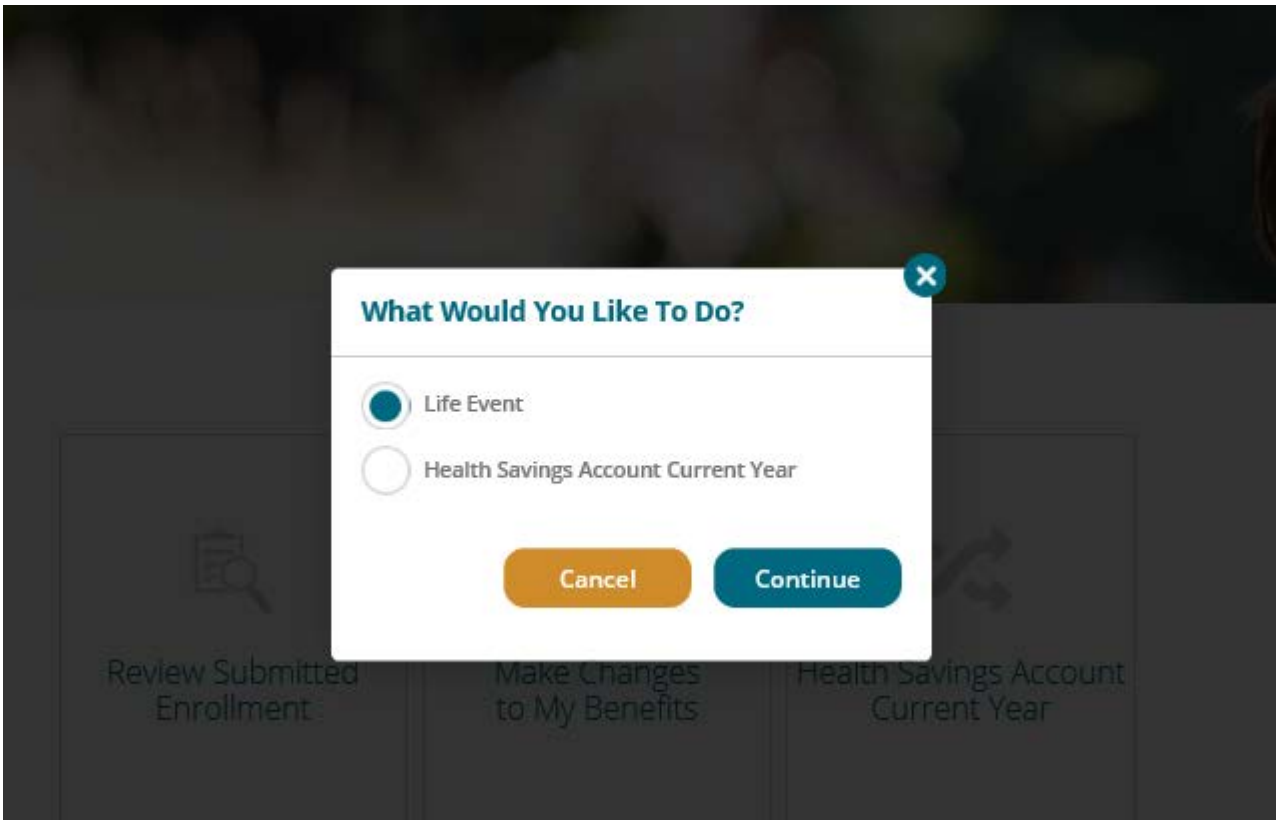
Start by navigating to the website at www.benefitbridge.com/saccounty

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.

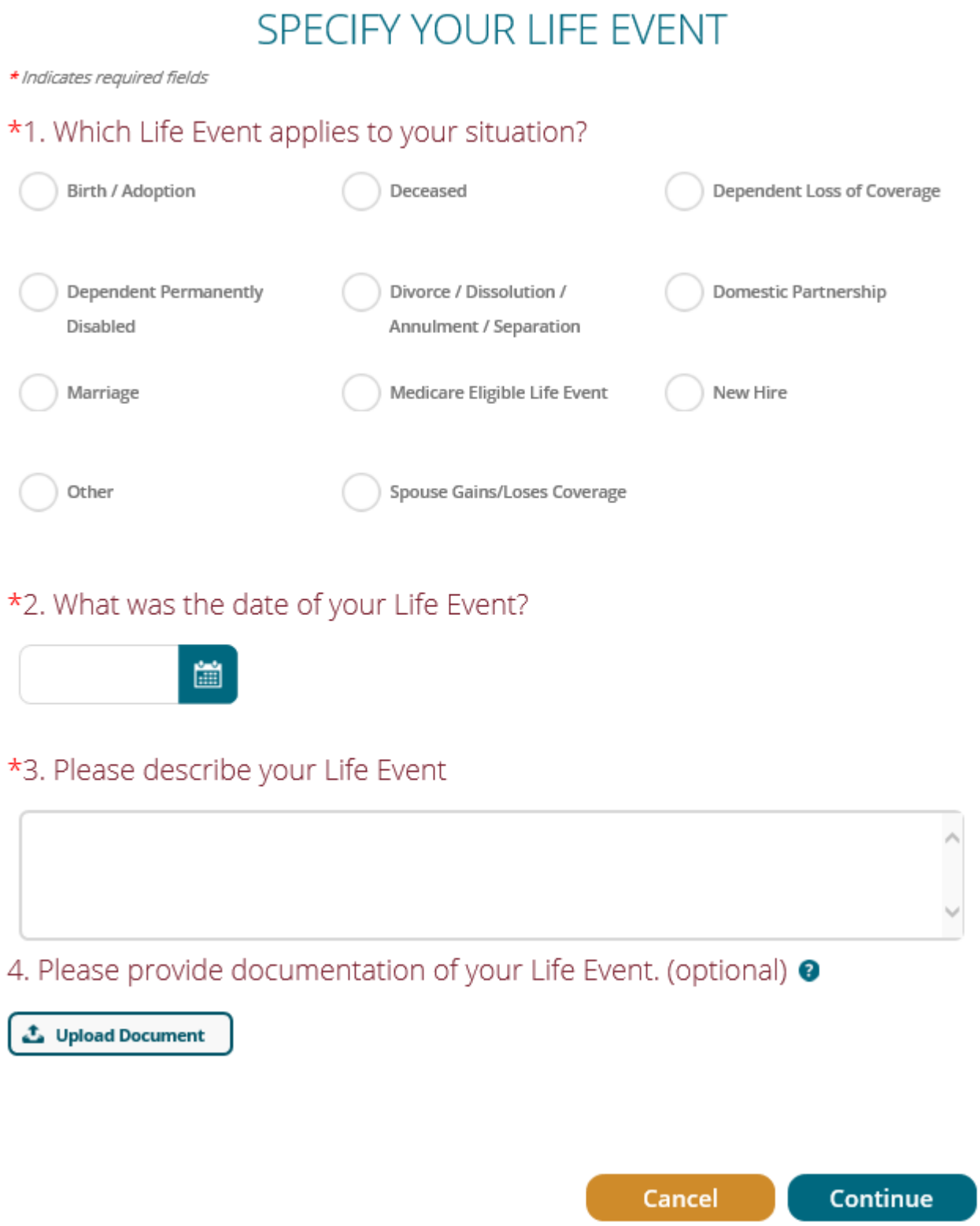
Once you have logged on, close the pop up window by clicking on the "X" in the top corner. You then will click Make Changes to My Benefits , highlighted below, to make changes.



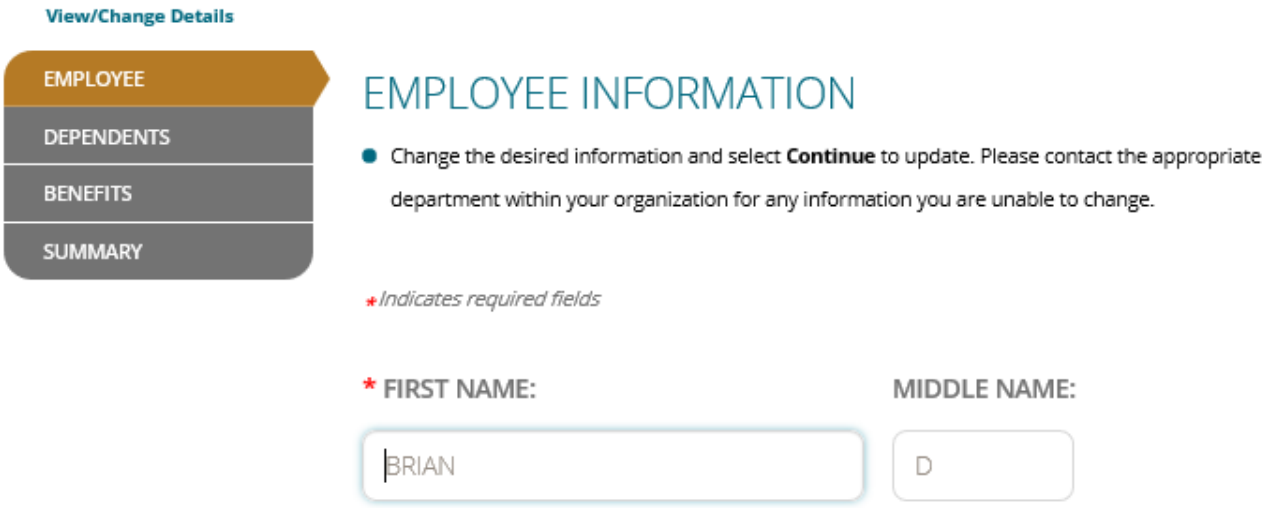
Please select **Life Event**.



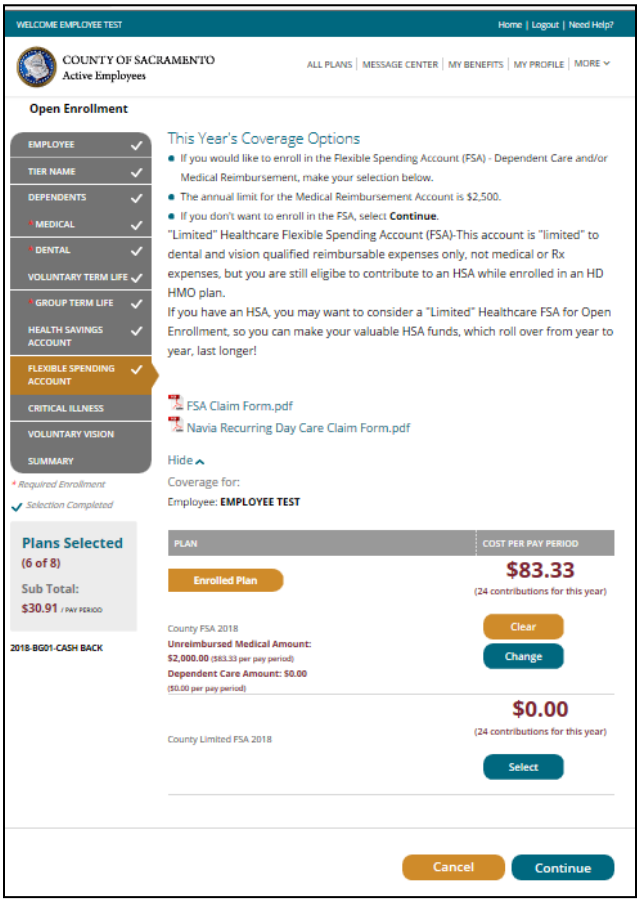
The LIFE EVENT that applies to this situation is "Other" and you will use the previous day's date in the "Date of your Life Event". Please put "FSA or Dependent Care Change" in the "Describe your Life Event" box. Then hit Continue.



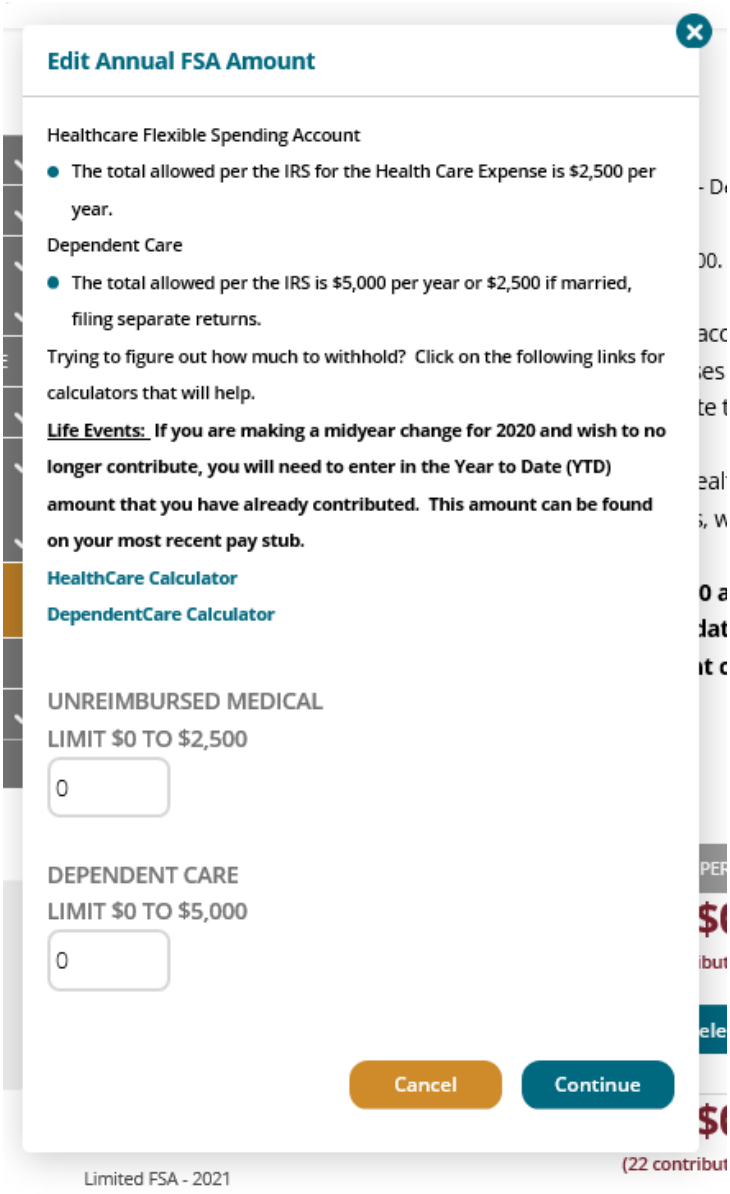
You will then be taken to a screen showing your Employee Information.



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.



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.

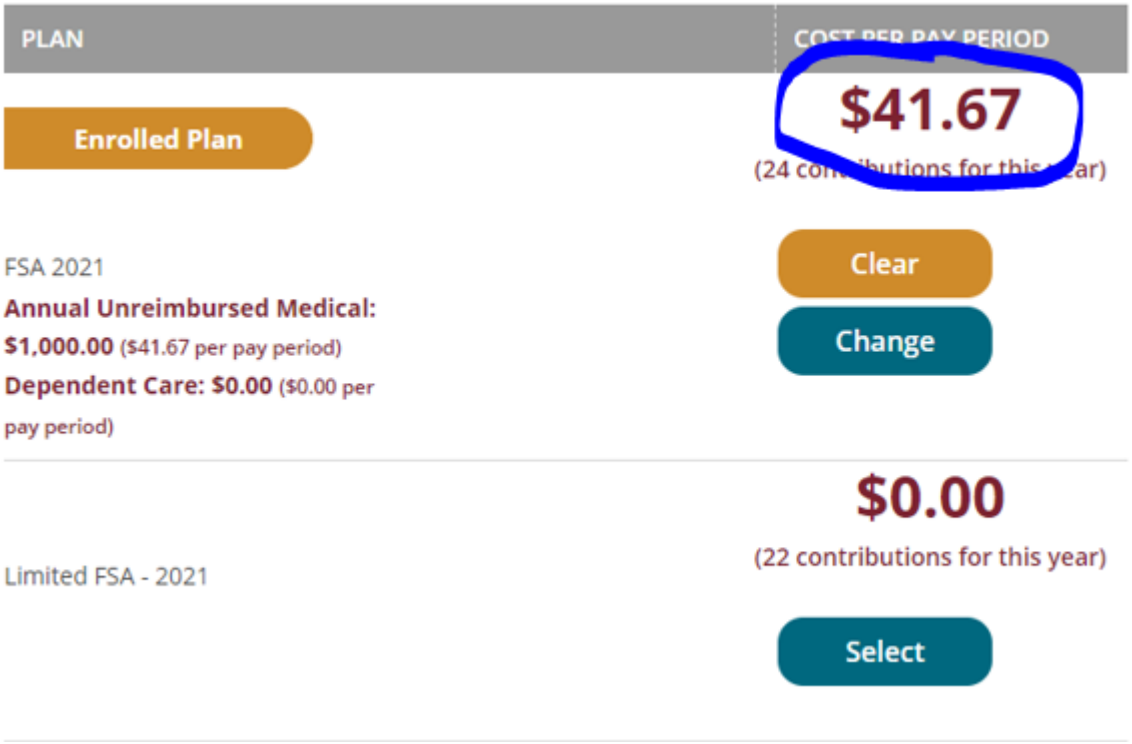


Enter the amount in the correct box for the new **amount you want for the year 2021**. The balance between what you have contributed and what you want to have will be divided over the remaining pay periods. For example:

You have contributed $1000 as of March 1st. 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.

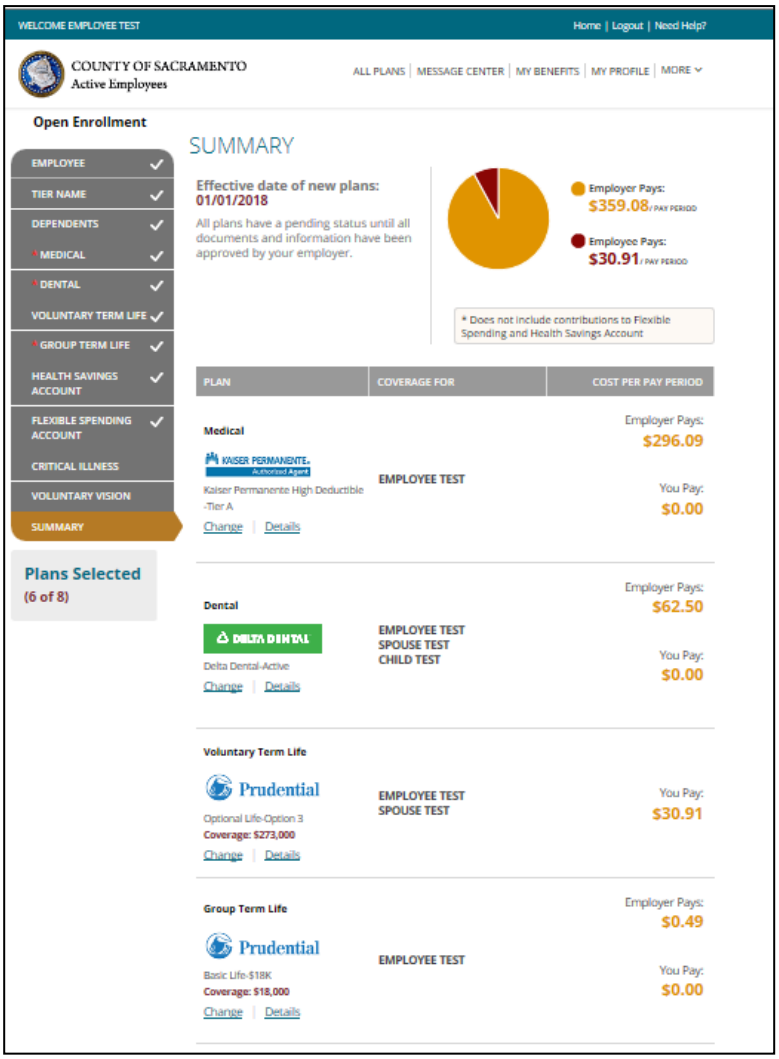
Once you are done, hit continue. You will see a new amount under the “Cost per Pay Period”. Please note this amount may be incorrect because it is estimating the cost over 24 pay periods, not the remaining pay periods. For the correct amount, you may contact the Benefits Office.

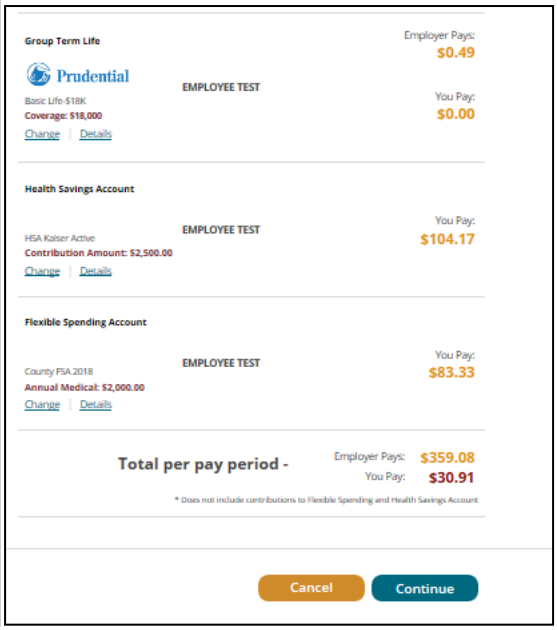


Once you have made your change, hit continue until you come to the Review page.

REVIEW & FINAL APPROVAL

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

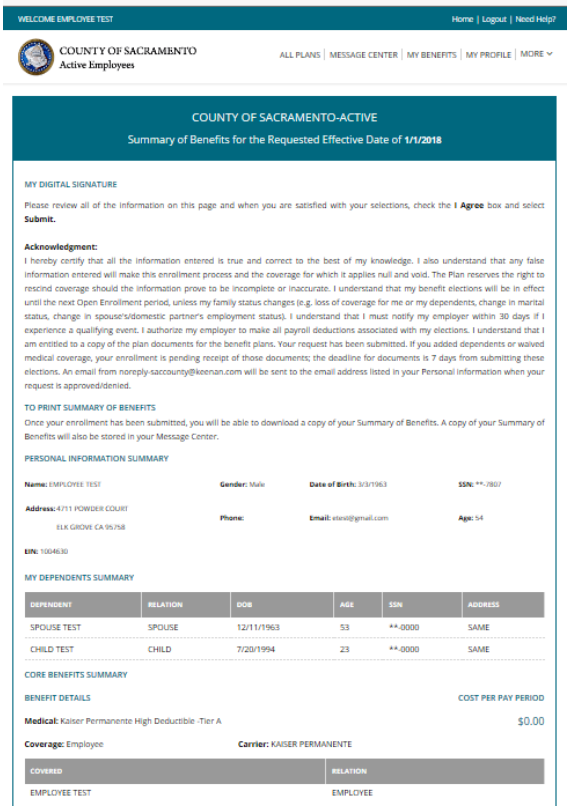




Carefully read the Personal Information Summary to confirm your change is showing. **<u>This is your opportunity to ensure the elections you made accurately reflect your intentions</u>.** Any submitted enrollment will be considered reviewed and approved by the employee.

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 | Logout | Need Help?

COUNTY OF SACRAMENTO
Active Employees

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

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's/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@keenan.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

Name: EMPLOYEE TEST **Gender:** Male **Date of Birth:** 3/3/1963 **SSN:** **-7807
Address: 4711 POWDER COURT ELK GROVE CA 95758 **Phone:** **Email:** etest@gmail.com **Age:** 54
EIN: 1004630

MY DEPENDENTS SUMMARY

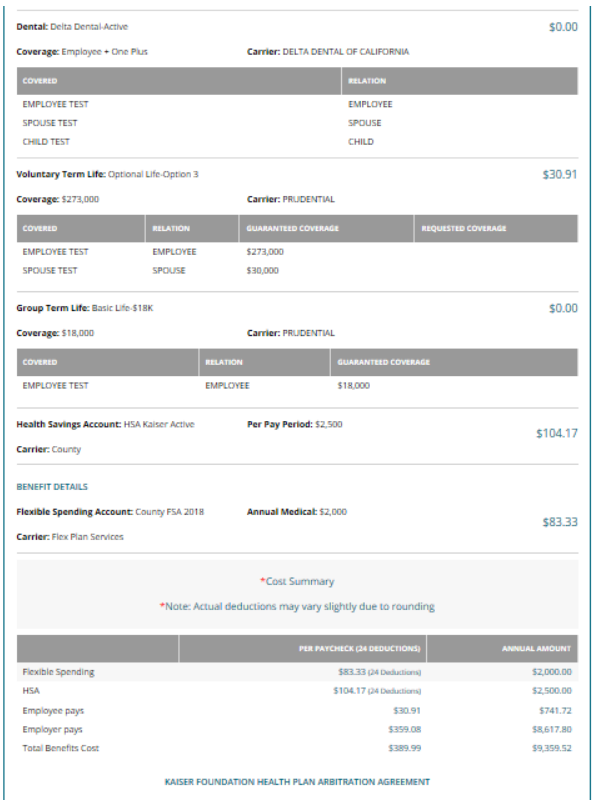
DEPENDENT	RELATION	DOB	AGE	SSN	ADDRESS
SPOUSE TEST	SPOUSE	12/11/1963	53	**-0000	SAME
CHILD TEST	CHILD	7/20/1994	23	**-0000	SAME

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

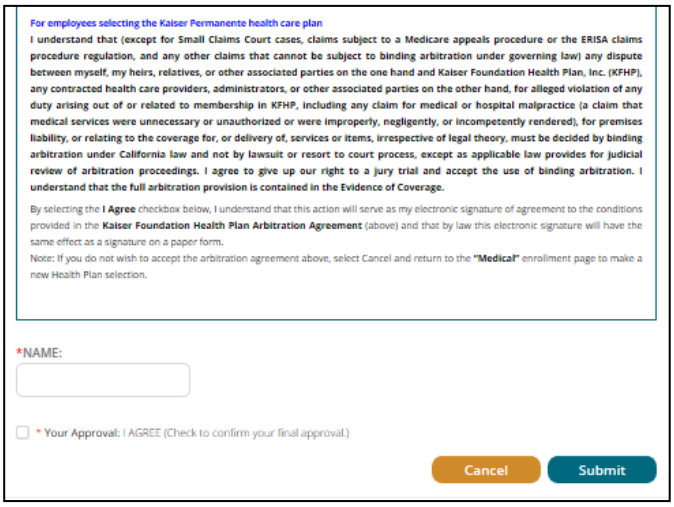
Flexible Spending Account: County FSA 2018 **Annual Medical:** $2,000 — $83.33
Carrier: Flex Plan Services

*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

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 1st of the month *following* the election.