






# OPEN ENROLLMENT INSTRUCTIONS

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

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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](mailto:benefitbridge@keenan.com)

For benefits effective in


# 2022

Start by navigating to the website at [www.benefitbridge.com/saccounty](http://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.

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COUNTY OF SACRAMENTO  
Active Employees


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Open Enrollment  
is currently *open*.

Open enrollment will end in:

26 days on Oct 29, 2021



Make Changes  
to My Benefits

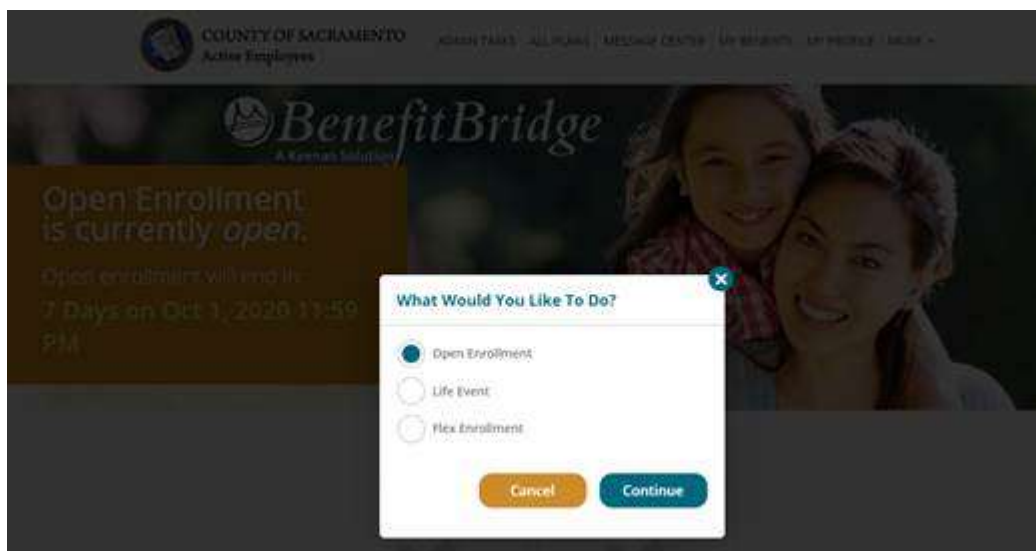


Flex Enrollment  
Only

Please select **Open Enrollment** if you're making an Open Enrollment election. Open Enrollment changes are effective 1/1/2022.

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 2022.



**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. PLEASE SEE NOTE AT THE END REGARDING REVIEWING YOUR SUBMISSION.**

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

**NOTE: You cannot “waive” Dental, EAP and Group Term Life as these benefits are free of charge to you.**

# EMPLOYEE INFORMATION

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

The screenshot displays the 'EMPLOYEE INFORMATION' form within the 'Open Enrollment' section of the County of Sacramento Active Employees portal. The form is divided into two main sections: a left sidebar with navigation tabs (EMPLOYEE, TIER NAME, DEPENDENTS, BENEFITS, SUMMARY) and a main content area. The main content area contains a progress bar on the left and a form with various input fields. The form includes fields for 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. A right-hand panel contains fields for CITY (ELK GROVE), STATE (CA), ZIP (95758), PHONE NUMBER, and EMAIL (etest@gmail.com). At the bottom right, there are 'Cancel' and 'Continue' buttons. The form also includes a note about required fields and a disclaimer about updating information.

WELCOME EMPLOYEE TEST Home | Logout | Need Help?

COUNTY OF SACRAMENTO  
Active Employees

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

Open Enrollment

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

If you are currently Tier A, 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 you made the changes. There is no cashback or PSI if you are enrolled in Tier B.

Note: **If you were hired after 2007, you are automatically enrolled in Tier B .**

Please 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 'DEPENDENTS' tab in the 'Open Enrollment' section. On the left is a sidebar with links: EMPLOYEE, TIER NAME, DEPENDENTS (highlighted), BENEFITS, and SUMMARY. The main content area has a header 'DEPENDENTS' and a note about required documentation: 'REQUIRED DOCUMENTATION: 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. Below the table is a link 'Show More' and a button 'Add Dependent'. At the bottom, there is a text prompt 'Please provide documentation if required by your Employer', a button 'Add Documents', and two buttons: 'Cancel' and 'Continue'.

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" and enter the required dependent information for each family member
- Click "Add Documents" to upload documents (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 the box 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 table shows you the current cost of your benefits, and what the rates for next year will be.

WELCOME EMPLOYEE TEST

Home | Logout | Need Help?

COUNTY OF SACRAMENTO  
Active Employees




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

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
<b>Medical</b>  County Active Waive (1)	\$0.00	\$0.00	<b>\$0.00</b>
<b>Dental</b>   Delta Dental Active	\$0.00	\$0.00	<b>\$0.00</b>
<b>Voluntary Term Life</b>   Optional Life Option B	\$27.85	\$27.85	<b>\$0.00</b>
<b>Group Term Life</b>   Basic Life \$18K	\$0.00	\$0.00	<b>\$0.00</b>

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, first check the box next to the dependents that should be enrolled, then choose the medical plan you wish to enroll in. **You must select a medical option. If you want to waive, select the last option. Additional documentation will be required.**

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 ☒  
FLEXIBLE SPENDING ACCOUNT ☒  
CRITICAL ILLNESS ☒  
VOLUNTARY VISION ☒  
SUMMARY

\* Required Enrollment  
✓ Selection Completed

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

2018-BG001-TO TIRB

Last Year You Chose

PLAN	COST PER PAY PERIOD
County Active-Waive (1)	<b>\$0.00</b> (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 <b>Kaiser Permanente</b> Authorized Agent Kaiser Permanente High Deductible -Tier B	<b>\$12.25</b> (24 deductions per year)
<input type="checkbox"/> Compare <b>Kaiser Permanente</b> Authorized Agent Kaiser Permanente Traditional \$15 Copay HMO -Tier B	<b>\$95.11</b> (24 deductions per year)

☐ 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**

County Active-Waive (3)

**\$0.00**  
(24 deductions per year)

**Select**

**Cancel** **Continue**

Select the family members you want to cover

Employee:

SPOUSE:



Select the family members you want to cover

Employee:

SPOUSE: ☒



## 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. **If you do not select a doctor, you will be automatically assigned one by the carrier.** 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.

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


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	<b>\$0.00</b> (24 deductions per year)
Delta Dental-Active	

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
Enrolled Plan:  DELTA DENTAL	<b>\$0.00</b> (24 deductions per year)
Delta Dental-Active	

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. For a Life Event, refer to your Employee Handbook for the guaranteed amounts. **Any changes made outside of a life event are subject to Evidence of Insurability questionnaires for all amounts.** Be sure the box is checked for any dependent you want covered by the Optional Life plan.

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

Life Event

[View/Change Details](#)

EMPLOYEE ✓

DEPENDENTS ✓

\* MEDICAL ✓

\* DENTAL ✓

VOLUNTARY TERM LIFE

\* GROUP TERM LIFE ✓

HEALTH SAVINGS ACCOUNT ✓

\* EAP ✓

FLEXIBLE SPENDING ACCOUNT

CRITICAL ILLNESS ✓

VOLUNTARY VISION ✓

SUMMARY

This Year's Coverage Options

Options available to you are shown in the "Plan" Options.

Option A - 1x annual salary up to \$50,000 (including your basic coverage).

VOYA Voluntary Term Life - you can elect up to 7 times your annual salary up to \$1,000,000, plus your basic coverage.

This coverage would pay the beneficiary(ies) tax-free money in the event of death. The dependent life coverage would pay you the loss of a Spouse/Domestic Partner/Dependent.

Hide ^

PLAN	COST PER PAY PERIOD
<div><div>VOYA FINANCIAL</div><div>Voya-Voluntary Term Life (1 x salary)</div></div>	<div>\$0.00</div> <div>(24 deductions per year)</div> <div>Select</div>
<div><div>VOYA FINANCIAL</div><div>VOYA-Optional Life Optional Life Option 1A ( With 18K)</div></div>	<div>\$0.00</div> <div>(24 deductions per year)</div> <div>Select</div>

Select the family members you want to cover

Employee: ☐

Spouse: ☐

SPOUSE: ☐

\* Required Enrollment

✓ Selection Completed

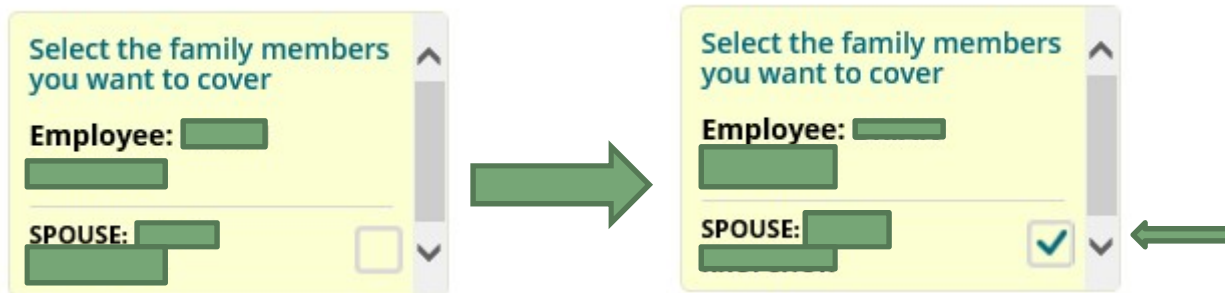
Plans Selected

(7 of 9)

Sub Total:

\$22.00 / PAY PERIOD

To make changes, you will want to hit the "select" button near the option you want to change. If you are making a change for a dependent as well, please make sure their name is checked in the yellow box on the right side of the screen. For information on the options, refer to the Employee Summary.



For more information on the different options, please refer to the Voya website <https://presents.voya.com/EBRC/saccounty> or contact the Employee Benefits Office. Once you hit “select”, a new window will pop up for you to make changes

### 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**

\$302,000

**SPOUSE COVERAGE: SPOUSE TEST**

\$30,000

**Cancel** **Continue**

### 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.

**Cancel** **I Agree**

Click on the drop down menu to select the amount of coverage you want. If you are making changes to a dependent, you will not be able to make changes until your insurance is selected.

Once you are done, hit continue.

You will then be asked to designate your beneficiaries. You may see beneficiaries listed that are no longer valid. While you can't delete them, just set them to "0" in the distribution and they will not be considered a beneficiary.

Active Employees

## Your Beneficiaries

Primary and Secondary must each add up to 100%

Current Coverage Amount \$421,000

- Select primary and/or secondary beneficiaries and enter distribution percentages
- To add a beneficiary not listed, select **Add Beneficiary**.
- The beneficiary information contained within BenefitBridge will replace all prior beneficiary designations. You may name anyone or any entity as your beneficiary and you may change your beneficiary at any time by completing a new BenefitBridge enrollment:
  - This Beneficiary Designation/Change is immediately effective recorded by the BenefitBridge system.
  - If you are married, your spouse may have a legal interest in this designation of beneficiary. A beneficiary can be challenged if your spouse receives less than their proportionate share of the benefit attributable to community property.
  - If you are married and designate your spouse as a beneficiary and later divorce, upon your death, your beneficiary designation of your spouse will be deemed revoked.
  - You will need to submit a new Beneficiary Designation/Change to designate a new beneficiary(ies). If, upon your death, you have not designated a new beneficiary, benefits will be paid in accordance with the terms of certain Group Contract providers, plan terms, or California laws governing probate and estates.
  - If you name a minor child under the age of 18, the insurer will have to ask a court to appoint a guardian to receive the benefits. However, you may name a custodian for the minor child but you must include the following language in the relationship field "As Custodian for [name of child] under the California Uniform Transfers to Minors Act."
  - Payment will be made to the named beneficiary. If you do not name a beneficiary, or the named beneficiary(ies) predeceases you, benefits will be paid in accordance with the terms of the Group Contract, the plan documents and California laws governing probate and estates.

NAME	RELATION	BENEFICIARY	DISTRIBUTION	OPTIONS
<div></div>	SPOUSE	Select one	0 %	
<div></div>	SPOUSE	Select one	0 %	

Add Beneficiary

Cancel

Save

If they are already listed, just change the "beneficiary" drop down to "Primary" and enter 100 into the "distribution" column. If you have more than one person as a

beneficiary, you will mark them as Primary and then enter the percentage you want them to receive. All primary beneficiaries must 100% between them.

If you need to add them, just select the "Add Beneficiary" button. You can have an individual, a trust, or a charity as a beneficiary. You will then need to enter the information for them:

Beneficiary Details

BENEFICIARY TYPE:

☒ INDIVIDUAL ☐ TRUST ☐ CHARITY/ORGANIZATION

\*FIRST NAME:

MIDDLE INITIAL:

\*LAST NAME:

\*DATE OF BIRTH:

\*SOCIAL SECURITY NUMBER:

\*RELATION:

Child

GENDER:

☐ MALE ☐ FEMALE

ADDRESS 1:

ADDRESS 2:

CITY:

STATE:

Select

ZIP:

\*PHONE NUMBER:

Cancel

Save



### Beneficiary Details

BENEFICIARY TYPE:

☐ INDIVIDUAL ☐ TRUST ☒ CHARITY/ORGANIZATION

\*NAME OF CHARITY/ORGANIZATION:

ADDRESS 1:

ADDRESS 2:

CITY:

STATE:

ZIP:

### Beneficiary Details

BENEFICIARY TYPE:

☐ INDIVIDUAL ☒ TRUST ☐ CHARITY/ORGANIZATION

\*DATE OF TRUST:

\*NAME OF TRUST:

ADDRESS 1:

ADDRESS 2:



CITY:

STATE:

ZIP:

If you select a child under 18 as a primary beneficiary, you must also add a custodian. Currently we do not have the option on Benefit Bridge, so you will just select the "Charity/Organization" option and enter the custodian's information there. In the "Name of Charity/Organization", you will put the custodian's name and the text "as custodian for [name of child]". You will not need to select a beneficiary option or distribution percentage for them. **Note: You must have a primary beneficiary designated in order to continue.**



NAME	RELATION	BENEFICIARY	DISTRIBUTION	OPTI
<div></div>	SPOUSE	Primary	100 %	
<div></div>	SPOUSE	Select one	0 %	
<div>AS CUSTODIAN FOR <div></div> UNDER THE CALIFORNIA UNIFORM TRANSFERS TO MINORS ACT TRUST</div>	N/A	Select one	0 %	

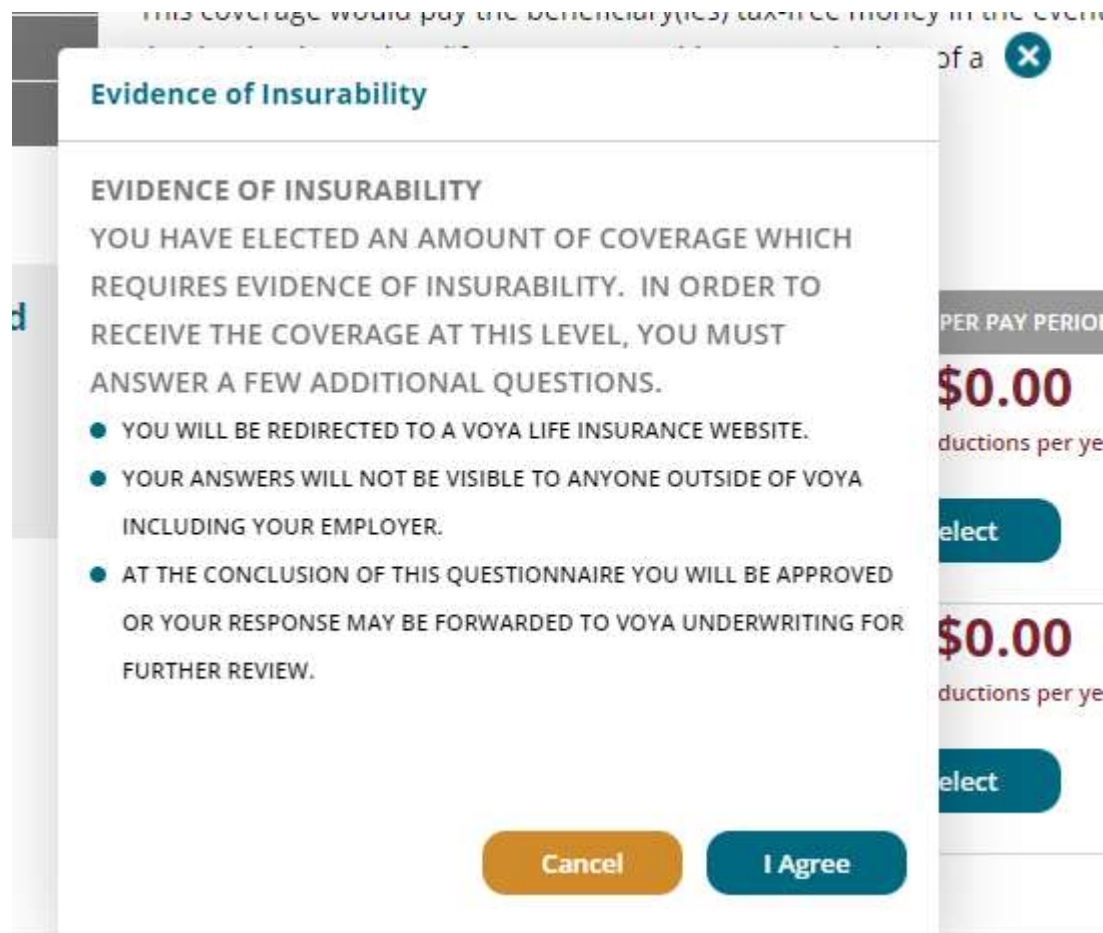
Add Beneficiary

Cancel

Save

When you have entered all of the information and selected your primary beneficiary(s), hit "Save"

If you have selected an amount greater than the guaranteed amount, you will have to go through the Evidence of Insurability questionnaire.



**Evidence of Insurability**

**EVIDENCE OF INSURABILITY**

YOU HAVE ELECTED AN AMOUNT OF COVERAGE WHICH REQUIRES EVIDENCE OF INSURABILITY. IN ORDER TO RECEIVE THE COVERAGE AT THIS LEVEL, YOU MUST ANSWER A FEW ADDITIONAL QUESTIONS.

- YOU WILL BE REDIRECTED TO A VOYA LIFE INSURANCE WEBSITE.
- YOUR ANSWERS WILL NOT BE VISIBLE TO ANYONE OUTSIDE OF VOYA INCLUDING YOUR EMPLOYER.
- AT THE CONCLUSION OF THIS QUESTIONNAIRE YOU WILL BE APPROVED OR YOUR RESPONSE MAY BE FORWARDED TO VOYA UNDERWRITING FOR FURTHER REVIEW.

[Cancel](#) [I Agree](#)

Hit the “I Agree” button, and you will be taken to the Voya questionnaire:

1 Employee  
Fill your employee details

2 Coverage  
Choose your coverages

3 Questions  
Answer health questions

4 Summary  
Confirm and sign

## Step 1: Employee Information

\* Indicates required field

First Name\*

Middle Initial

Last Name\*

Date of Birth\* /  / 19

Social Security Number\* -  -

Gender\*

☒ Male ☐ Female

Country\*

UNITED STATES

Address Line 1\*

Address Line 2

City\*

SACRAMENTO

State/Province\*

CA

Zip/Postal Code\*

Home Phone Number\*

916

 -  -

Cell Phone Number\* -  -

Email Address\*

This email address will be used for all electronic communications:

Job Title

Employee ID

Annual Salary\*\*\*\*\*.00

Hire Date (Full-time)

01

 / 

02

 / 20

Save

Next

It will be pre-populated with your information. Just verify the information and then hit the "next" button.

The next screen will then show the amount you are requesting.

## My Evidence of Insurability

**1 Employee**  
Fill your employee  
details

**2 Coverage**  
Choose your  
coverages

**3 Questions**  
Answer health  
questions

**4 Summary**  
Confirm and sign

### Step 2: Coverage Information

Please Complete/review the fields below for your elected coverages.

Employee Coverage	<u>Total Amount Desired</u>	-	<u>Current Amount</u>	-	<u>Guaranteed Issue Amount</u>	=	<u>Amount to be Underwritten</u>
<input checked="" type="checkbox"/> Supplemental Life	\$ 421,000.00		\$ 350,000.00		\$ 0.00		\$ 71,000.00
Spouse	<u>Total Amount Desired</u>	-	<u>Current Amount</u>	-	<u>Guaranteed Issue Amount</u>	=	<u>Amount to be Underwritten</u>
<input type="checkbox"/> Supplemental Life							

Save

Previous

Next

Verify this amount and then hit the “next” button.

You will be then taken to the questionnaire.

Primary Health Practitioner (PHP):

Name	Phone	Street Address	City	State	Zip	No PHP
<div style="background-color: blue; height: 1.2em; width: 100%;"></div>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

EMPLOYEE HEALTH QUESTIONS

Employee  
(EE)

*Must be answered for coverage that is not Guaranteed Issue.*

1. Within the last 5 years have you been treated for or been diagnosed by a member of the medical profession or health practitioner as having AIDS (Acquired Immunodeficiency Syndrome)? ☐ Yes ☐ No
2. Within the last 5 years have you been treated for, any of the following: Insulin dependent diabetes, heart attack, coronary bypass/angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient? ☐ Yes ☐ No
3. Employee: Height  ft.  in. Weight  lbs.
4. In the past 5 years have you been diagnosed or treated by a health practitioner, or taken medication for any of the following:
  - a. Any disease or abnormality of the heart or blood vessels (excluding controlled high blood pressure), or any heart rhythm abnormality? ☐ Yes ☐ No
  - b. Any disease of the lung (excluding asthma), liver (excluding hepatitis A), pancreas or intestine? ☐ Yes ☐ No
  - c. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes? ☐ Yes ☐ No
  - d. Cancer or tumor, rheumatoid arthritis, connective tissue disease, neurological disease (excluding headaches), autoimmune disease or any disease of the blood cells or serum including, but not limited to, anemia, polycythemia, or bleeding or clotting disorder? ☐ Yes ☐ No
  - e. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction? ☐ Yes ☐ No
  - f. Polycystic kidney disease or kidney failure? ☐ Yes ☐ No
5. Within the last 5 years have you been diagnosed or treated by a physician or other health practitioner for:
  - a. Chest pain, heart trouble or circulatory disorder? ☐ Yes ☐ No
  - b. Anemia or leukemia? ☐ Yes ☐ No
  - c. Sleep apnea, asthma or other respiratory disease? ☐ Yes ☐ No
  - d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disease? ☐ Yes ☐ No
  - e. Stomach disease? ☐ Yes ☐ No
  - f. Brain or seizure disorder? ☐ Yes ☐ No
  - g. Mental or nervous disorder? ☐ Yes ☐ No
  - h. Arthritis, paralysis or any muscle weakness impacting your ability to perform daily activities? ☐ Yes ☐ No
  - i. Abnormal urine specimen or urinary tract disorder? ☐ Yes ☐ No
  - j. Prostate or other reproductive organ disorder? ☐ Yes ☐ No
6. Are you pregnant? Due Date  Pre-pregnancy weight  lbs. ☐ Yes ☐ No
7. Are you currently taking medication prescribed or provided by a physician or other health practitioner for any disorder, condition, or disease not shown above? ☐ Yes ☐ No
8. Within the last 5 years have you received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a health practitioner to discontinue the use of such substances? ☐ Yes ☐ No

Save

Previous

Next

Answer the questions and then hit the "next" button. You will then be taken to the summary page, and you will need to scroll down.

**1 Employee**  
Fill your employee  
details

**2 Coverage**  
Choose your  
coverages

**3 Questions**  
Answer health  
questions

**4 Summary**  
Confirm and sign

## Step 4: Summary

### Instructions

Please read and review the information captured on the following Evidence of Insurability (EOI) application(s). Once you have confirmed that all of the information is complete and true to the best of your knowledge and belief, please provide your signature in the Employee Signature section.

After submitting, you will have the ability to select a method by which you would like to receive a completed copy of your EOI application(s) for your records.

**Note:** if you need to make any changes to your information, please return to the appropriate screen and update your information prior to signing and submitting your EOI application(s). Once you have signed and submitted your EOI application(s), you will not be able to make changes in the system.

### Read and Review Evidence of Insurability Application

#### ELECTRONIC SIGNATURE PROCEDURES AND SECURITY MEASURES

ReliaStar Life Insurance Company, Minneapolis, MN  
ReliaStar Life Insurance Company of New York, Woodbury, NY  
*Members of the Voya family of companies*

ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York use electronic signatures to expedite the submission process. These procedures are provided for your review so you may better understand the use of electronic signatures and the protections provided.

#### ELECTRONIC SIGNATURE

Once you have completed the form you will be prompted to enter your signature. Your signature is captured by entering your password to gain access to complete the form, and then after reviewing the information contained on the form and a message alerting you to the effect of your signature, clicking on the "I Accept" box displayed on the screen.

165529

Page 1 of 1

Order #165529 09/01/2014

☐ I Agree

Yes, I have reviewed and understand all of the documents provided to me and agree to be bound by all of the terms and conditions therein.

Save

Previous

Click on the "I Agree" check box.



☒ **I Agree** Yes, I have reviewed and understand all of the documents provided to me and agree to be bound by all of the terms and conditions therein.

☐ **I Accept** By checking this box and clicking Submit (1) I understand that my electronic signature will be applied to all documents requiring my signature and (2) I declare that all information provided by me is complete and true to the best of my knowledge and belief.

**Save** **Previous**

You will then click on the “I Accept” box.

☒ **I Agree** Yes, I have reviewed and understand all of the documents provided to me and agree to be bound by all of the terms and conditions therein.

☒ **I Accept** By checking this box and clicking Submit (1) I understand that my electronic signature will be applied to all documents requiring my signature and (2) I declare that all information provided by me is complete and true to the best of my knowledge and belief.

**Previous** **Submit**

Once you’ve done that, you’ll have the option to submit your questionnaire. Hit “Submit”



**You will be taken to a screen where you can get a copy of the questionnaire you just filled out. Once you've gotten a copy (if you want one), hit "Next".**

PLAN | INVEST | PROTECT

## My Evidence of Insurability

**A Copy of your Completed Evidence of Insurability Application(s) is now Available!**

Please choose from the options below to retain a copy of your completed Evidence of Insurability application(s) for your records, then click on the "Next" button to continue to the confirmation page:

Print

Save

Mail a copy


**Please click the Next button to review the status of your submitted EOI Application(s).**

Please Note: You will be notified via postal mail of the final decision. Please save that notice with your submitted EOI for your records.

Next

**The last screen will let you know if you are approved, or if more information is needed. Once you have reviewed this screen, hit "Finish".**

## My Evidence of Insurability

Confirmation and Status			
Coverage	Proposed Insured	Underwritten Amount	Decision
Employee Supplemental Life		\$71,000	Approved
A Final Action Notice detailing this decision will be mailed to the address you provided.			

Reference Number: 3658277

**ALL LIFE INSURANCE COVERAGE IS SUBJECT TO YOUR EMPLOYER'S BENEFIT PLAN LIMITS.** The amount of coverage we may approve and the amount of coverage your employer determines you are eligible for may not be the same. If your life insurance coverage is limited by your employer's benefit plan, the death benefit under your policy (including any refund of premiums) will be adjusted at the time of claim payment. Please contact your employer for specific details regarding your employer's benefit plan limits.

**PLEASE NOTE THAT APPROVED LIFE INSURANCE COVERAGE IS NOT EFFECTIVE IMMEDIATELY.** The effective date of your coverage is determined by your employer's benefit plan and the group contract. The Company will have no liability for any claim on account of death occurring prior to the effective date of coverage. Please contact your employer for specific details regarding your coverage effective date.

Questions regarding the decisions communicated can be submitted to Voya Medical Underwriting at P.O. Box 20, Route 7812, Minneapolis, MN 55440-9978 or call 1-800-537-5024, option 4.

[Finish](#)

You will then be notified your logout is complete. Hit the "Finish Questionnaire" button in the top right corner.

[Finish Questionnaire](#)

## My Evidence of Insurability

Logout Complete

You may close this browser tab or window now

### Contact Us

Contact us at (800) 748-4444 for questions or require assistance.

### Instructions

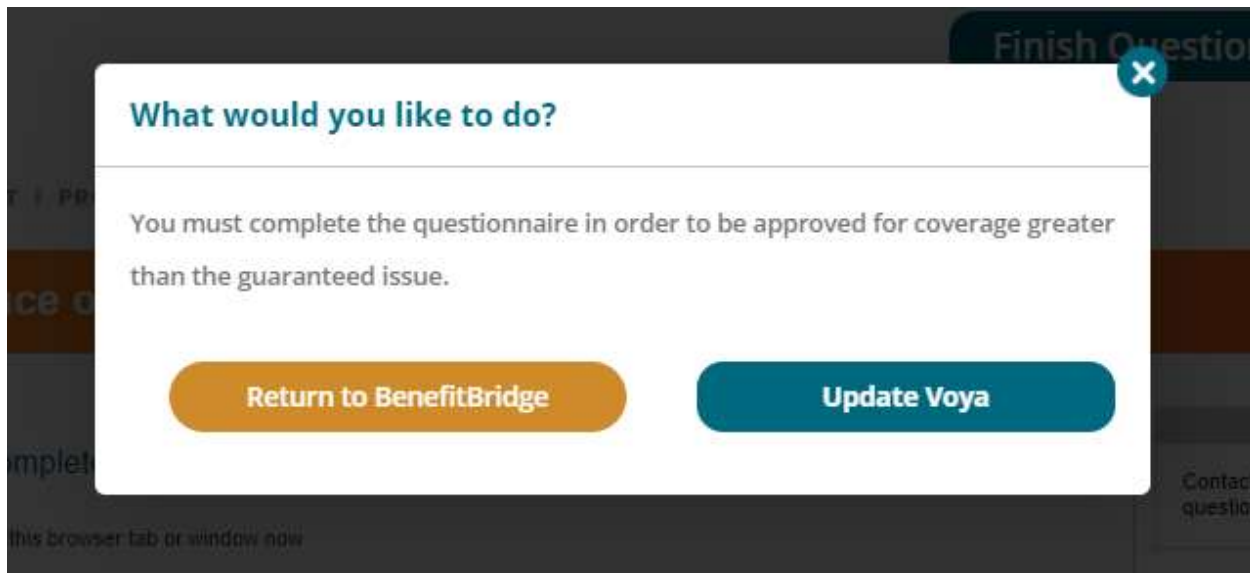
To get started, choose the "Finish Questionnaire" button in the status column.

Note: You will be returned to the main page after your submission.

### General Information

Note: For your protection, this session will be terminated automatically for a period of 15 minutes if you are inactive.

**A pop up window will ask if you want to return to BenefitBridge. Select this option.**




**You will then be returned to the Voluntary Life Insurance page, with all of the information updated.**

**NOTE: If you are insuring a Spouse/Domestic Partner for more than the guaranteed amount, they will have to fill out their own Evidence of Insurability (EOI) questionnaire. Once you have submitted your request for coverage, a separate email will be sent to you containing the link to the Spouse EOI. You will need to register as a new user.**

The screen will now reflect the requested amount. Please note that the cost per pay period shown only reflects the guaranteed coverage, not the full requested amount. Once approved by VOYA, you will receive a letter in the mail and your payroll premium deductions will be updated.

PLAN

Enrolled Plan



Voya-Voluntary Term Life  
(6 x salary)

COST PER PAY PERIOD

\$9.80

(24 deductions per year)

Clear

Change


Guaranteed Coverage: \$350,000

Requested Coverage: \$421,000

NAME	RELATION	BENEFICIARY	%
	SPOUSE	Primary	100 %

Add/Change Beneficiaries and Distribution

+



VOYA-Optional Life Optional Life  
Option 1A ( With 18K)

\$0.00

(24 deductions per year)

Select

Cancel

Continue

Hit continue.

The next screen is your basic life insurance that is provided to you by the County. Just select continue down at the bottom, as you cannot make changes to this.

## Life Event

[View/Change Details](#)

EMPLOYEE ✓

DEPENDENTS ✓

\* MEDICAL ✓

\* DENTAL ✓

VOLUNTARY TERM LIFE

\* GROUP TERM LIFE ✓

HEALTH SAVINGS  
ACCOUNT ✓

\* EAP ✓

FLEXIBLE SPENDING  
ACCOUNT

CRITICAL ILLNESS ✓

VOLUNTARY VISION ✓

SUMMARY

\* Required Enrollment

✓ Selection Completed

### Plans Selected

(7 of 9)

Sub Total:

**\$22.00** / PAY PERIOD

2021-BG80-TIRB

### 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**.

[Hide](#) ^

PLAN

COST PER PAY PERIOD

Enrolled Plan

**\$0.00**

(24 deductions per year)

**VOYA**  
FINANCIAL

VOYA-Basic Life \$18K

Clear

Change

**Coverage: \$18,000**

NAME	RELATION	BENEFICIARY	%
	SPOUSE	Primary	100 %

Add/Change Beneficiaries and Distribution

+

You will then be taken to Health Savings Account Page if you elected a HDHP plan. you can change the amount or elect the amount you would like per pay period.

# 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**. If you no longer want to contribute, select "\$0" as the amount. **NOTE: This will not close the Account**

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

- 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.

Hide

Coverage for:  
Employee: **EMPLOYEE TEST**

PLAN	COST PER PAY PERIOD
HSA Kaiser Active	<b>\$0.00</b> (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

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

- 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.

Hide

Coverage for:  
Employee: **EMPLOYEE TEST**

PLAN	COST PER PAY PERIOD
HSA Kaiser Active	<b>\$104.17</b> (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 2022 are listed below:

## Under age 55

Single: \$3,650 (\$152/pay period)

Family: \$7,300 (\$304.16/pay period)

## Over age 55

Single: \$4,650 (\$193.75/pay period)

Family: \$8,300 (\$345.83/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 2022**", 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 2022**", then click "Continue". Follow the same steps as above.

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**

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

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**

Plans Selected

(6 of 8)

Sub Total:

\$30.91 / PAY PERIOD

2018-BG01-CASH BACK

Enrolled Plan

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)

Critical Illness Insurance pays out a tax free lump sum payment upon the diagnosis of certain illnesses. For more information, please contact the Employee Benefits Office or refer the Employee Summary.

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".

Life Event

View/Change Details

EMPLOYEE ✓

DEPENDENTS ✓

\* MEDICAL ✓

\* DENTAL ✓

VOLUNTARY TERM LIFE

\* GROUP TERM LIFE ✓

HEALTH SAVINGS ACCOUNT ✓

\* EAP ✓

FLEXIBLE SPENDING ACCOUNT

CRITICAL ILLNESS ✓

VOLUNTARY VISION ✓

SUMMARY

\* Required Enrollment

✓ Selection Completed

This Year's Coverage Options

By electing coverage under the VOYA 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").

To be eligible for the basic or supplemental life insurance coverage or critical illness coverage, your dependent children must be:

- Under age 26;
- Unmarried
- Not in a domestic partnership or civil union that is recognized as equivalent to marriage in the state with governing jurisdiction.

This voluntary plan provides tax-free lump sum payments upon the occurrence of certain illnesses and can provide critical financial assistance when dealing with medical related issues and absences. Some categories of coverage have also been improved and Active at Work and home/hospital confinement rules apply before coverage increases can go into effect.

Hide ^

Plans Selected

(7 of 9)

Sub Total:

\$22.00 / PAY PERIOD

2021-BG80-TIRB

PLAN

COST PER PAY PERIOD

Enrolled Plan

VOYA

FINANCIAL

VOYA-Critical Illness

Coverage: \$10,000

\$2.30

(24 deductions per year)

Clear

Change

Select the family members you want to cover

Employee:

SPOUSE:

Cancel

Continue

Once you have made your selection, please hit "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

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 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	<b>\$2.60</b> (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

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

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

Plans Selected  
(6 of 8)

Group Term Life

 Prudential  
Basic Life-\$18K  
Coverage: \$18,000

EMPLOYEE TEST

Employer Pays:  
\$0.49

You Pay:  
\$0.00

Health Savings Account

HSA Kaiser Active  
Contribution Amount: \$2,500.00

EMPLOYEE TEST

You Pay:  
\$104.17

Flexible Spending Account

County PSA 2018  
Annual Medical: \$2,000.00

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

COUNTY OF SACRAMENTO  
Active Employees

[Home](#) | [Logout](#) | [Need Help?](#)

[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 benefits 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 benefits 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@sacountyofkeenan.com](mailto:noreply@sacountyofkeenan.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:** \*\*-\*\*-0000

**Address:** 4111 POWDER COURT      **Phone:**      **Email:** [enroll@gmail.com](mailto:enroll@gmail.com)      **Age:** 54

**City:** GILROY CA 95020

**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 B      \$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 5:00 pm on November 5, 2021. 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](mailto:MyBenefits@saccounty.net). **Include your employee ID on all documents.**

Once you hit the submit button, you should see a screen letting you know you have successfully submitted your Life Event.

It is recommended that you save a copy of your enrollment changes for your records. A copy is also available any time on Benefit Bridge.

## Congratulations!

You have successfully submitted your Open Enrollment Change.

### **WHAT HAPPENS NEXT**

Once you have submitted any needed documentation and we have confirmed your enrollment, you will get an email from Benefit Bridge letting you know your benefits have been approved.

If you made a change to life insurance that required you or your spouse to fill out the Evidence of Insurability questionnaire, *the approval from Benefit Bridge does not guarantee approval from VOYA*. You will receive a separate email/letter from VOYA letting you know if your request has been approved or more information is needed.

If your request for Open Enrollment is denied, you can make any needed changes and resubmit as long as it is completed prior to 11:59pm on October 29<sup>th</sup>.

**DO NOT GO BACK IN AND REVIEW UNLESS YOU ARE INTENDING TO MAKE CHANGES! If you make any changes, you must go all the way to the end and resubmit, otherwise your enrollment will not be processed. If you just want to verify your enrollment *prior to us approving it*, you can contact our office. If we have approved it, you can view it by logging on to Benefit Bridge and clicking on Message Center and selecting “Messages” and then you’ll see a “Your Pending Benefits Enrollment” with the date and time it was submitted.**

Please contact the Employee Benefits Office with any questions.

**Phone:** 916-874-2020    **Email:** [Mybenefits@saccounty.net](mailto:Mybenefits@saccounty.net)    **Fax:** 916-874-4621