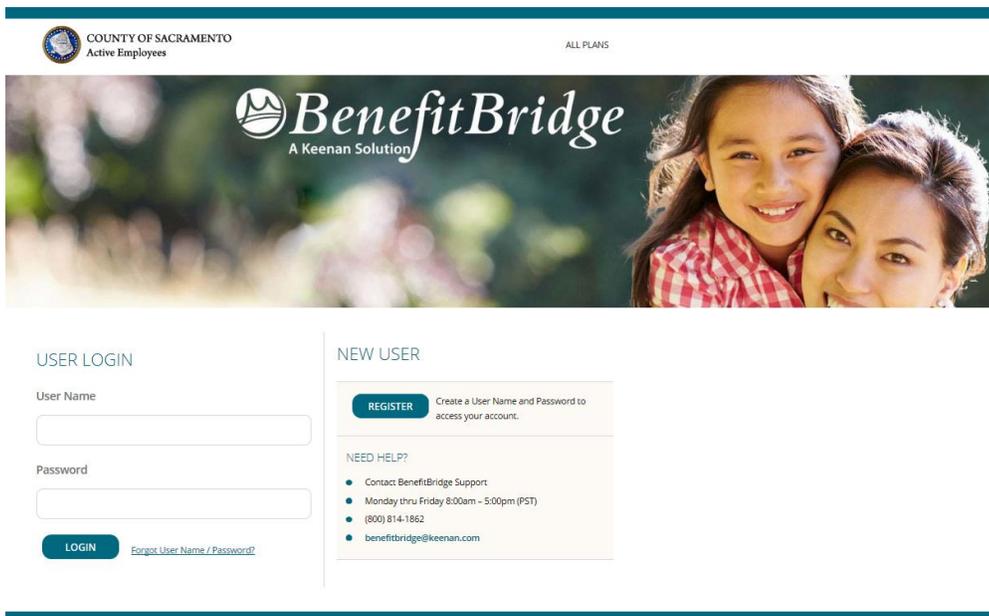




LIFE EVENT INSTRUCTIONS

These instructions will help you navigate through BenefitBridge in making your elections for qualifying life events



The screenshot shows the top of the BenefitBridge website. At the top left is the County of Sacramento logo and the text "COUNTY OF SACRAMENTO Active Employees". At the top right is the text "ALL PLANS". Below this is a banner image of a smiling woman and child with the BenefitBridge logo and the text "BenefitBridge A Keenan Solution". Below the banner are two columns: "USER LOGIN" with input fields for "User Name" and "Password", and a "LOGIN" button; and "NEW USER" with a "REGISTER" button and a "NEED HELP?" section containing contact information for 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

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 life event changes.



Important Reminder: no matter where you stop in your life event 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 life event 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.

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
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: EMPLOYEE MIDDLE NAME: M

* LAST NAME: TEST

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

* ADDRESS 1: 4711 POWDER COURT

ADDRESS 2:

* CITY: ELK GROVE

* STATE: CA * ZIP: 95758 PHONE NUMBER:

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 life event 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**".

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
BENEFITS
SUMMARY

DEPENDENTS

- **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.

Show More ▾

Add Dependent

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

Please provide documentation if required by your Employer

Add Documents

Cancel Continue

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 (Medical Enrollment)

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

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.

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

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

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 Kaiser Permanente High Deductible -Tier B	\$12.25 (24 deductions per year) Select
<input type="checkbox"/> Compare Kaiser Permanente Kaiser Permanente Traditional \$15 Copay HMO -Tier B	\$95.11 (24 deductions per year) Select

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**

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.

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

**Required Enrollment*
✓ Selection Completed

Plans Selected
(4 of 8)
Sub Total:
\$27.85 /PAY PERIOD

2015-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
Enrolled Plan DELTA DENTAL Delta Dental-Active	\$0.00 (24 deductions per year) <input type="button" value="Clear"/>

COVERED	RELATION
EMPLOYEE TEST	EMPLOYEE
SPOUSE TEST	SPOUSE
CHILD TEST	CHILD

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 life events. 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**.

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

** 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
<input type="checkbox"/> Compare Prudential 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
<input checked="" type="checkbox"/> Enrolled Plan Prudential Optional Life-Option 3	\$27.85 (24 deductions per year)
<input type="checkbox"/> Compare	

Guaranteed Coverage: \$273,000

Compare
Prudential
Optional Life Option 1A (with \$18K BL)
\$0.00
(24 deductions per year)

Compare
Prudential
Optional Life-Option 1
\$0.00
(24 deductions per year)

Compare
Prudential
Optional Life-Option 2
\$0.00
(24 deductions per year)

Compare
Prudential
Optional Life-Option 4
\$0.00
(24 deductions per year)

Compare
Prudential
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

\$302,000

SPOUSE COVERAGE: SPOUSE TEST

\$30,000

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.

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"**.

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

** Required Enrollment*
✓ Selection Completed

Plans Selected (4 of 8)

Sub Total: **\$30.91** / PAY PERIOD

2018-BG01-CASH BACK

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
Enrolled Plan  Basic Life-\$18K	\$0.00 (24 deductions per year)

Coverage: \$18,000

Clear
Change

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**.

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 Hide ▾
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

Coverage for:
Employee: **EMPLOYEE TEST**

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

* Required Enrollment
✓ Selection Completed

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

2018-BG01-CASH BACK

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 Hide ▾
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

Coverage for:
Employee: **EMPLOYEE TEST**

PLAN	COST PER PAY PERIOD
Enrolled Plan	\$104.17 (24 contributions per year)

* Required Enrollment
✓ Selection Completed

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

2018-BG01-CASH BACK

Clear Change

Cancel Continue

Edit Contribution Amount

YOUR CONTRIBUTION:

CONTRIBUTION LIMIT \$0 TO \$3,400

2500 Annual

Cancel Continue

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 2019**", 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 2019**", 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 ✓ 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
		\$0.00 (contributions for this year)
		Select
		\$0.00 (contributions for this year)
		Select
		Continue

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.

[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 ✓ 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)	PLAN	COST PER PAY PERIOD
Sub Total:	Enrolled Plan	\$83.33 (24 contributions for this year)
\$30.91 / PAY PERIOD	County FSA 2018	Clear Change
	Unreimbursed Medical Amount: \$2,000.00 (\$83.33 per pay period)	
	Dependent Care Amount: \$0.00 (\$0.00 per pay period)	
	\$0.00 (24 contributions for this year)	Select
	County Limited FSA 2018	

2018-BG01-CASH BACK

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 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

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.

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".

The screenshot shows the 'Open Enrollment' page for 'EMPLOYEE TEST' at the County of Sacramento. The page is titled 'This Year's Health Insurance Options' and provides instructions on when to enroll in voluntary vision. A table shows the cost for the 'VSP' plan as \$2.60 per pay period (24 deductions per year). A 'Select' button is visible next to the plan. A sidebar on the left lists various benefit categories, with 'VOLUNTARY VISION' highlighted. At the bottom, there is a 'Plans Selected' summary showing 6 of 8 plans selected, a sub-total of \$30.91 per pay period, and a '2018-BG01-CASH BACK' note. 'Cancel' and 'Continue' buttons are at the bottom right.

WELCOME EMPLOYEE TEST Home | Logout | Need Help?

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

Open Enrollment

EMPLOYEE ▾ 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 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.

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

PLAN	COVERAGE FOR	COST PER PAY PERIOD
Medical Kaiser Permanente Kaiser Permanente High Deductible -Tier A	EMPLOYEE TEST	Employer Pays: \$296.09 You Pay: \$0.00
Dental Delta Dental	EMPLOYEE TEST SPOUSE TEST CHILD TEST	Employer Pays: \$62.50 You Pay: \$0.00
Voluntary Term Life Prudential Optional Life-Option 3 Coverage: \$273,000	EMPLOYEE TEST SPOUSE TEST	You Pay: \$30.91
Group Term Life Prudential Basic Life-\$18K Coverage: \$18,000	EMPLOYEE TEST	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 FSA 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 your life event 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"**.

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 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: 3/31/1963	SSN: **-**-7807
Address: 4711 POWDER COURT ELK GROVE CA 95758	Phone:	Email: etest@gmail.com	Age: 54

ETIN: 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.) **within 7 days of the enrollment request.** 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.