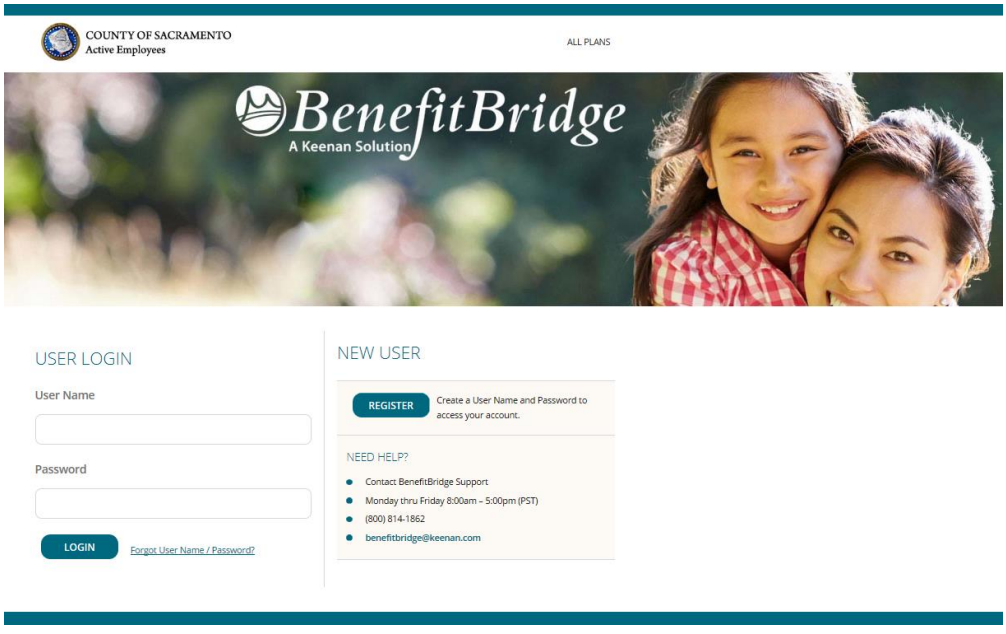
SACRAMENTO COUNTY

OPEN ENROLLMENT INSTRUCTIONS

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



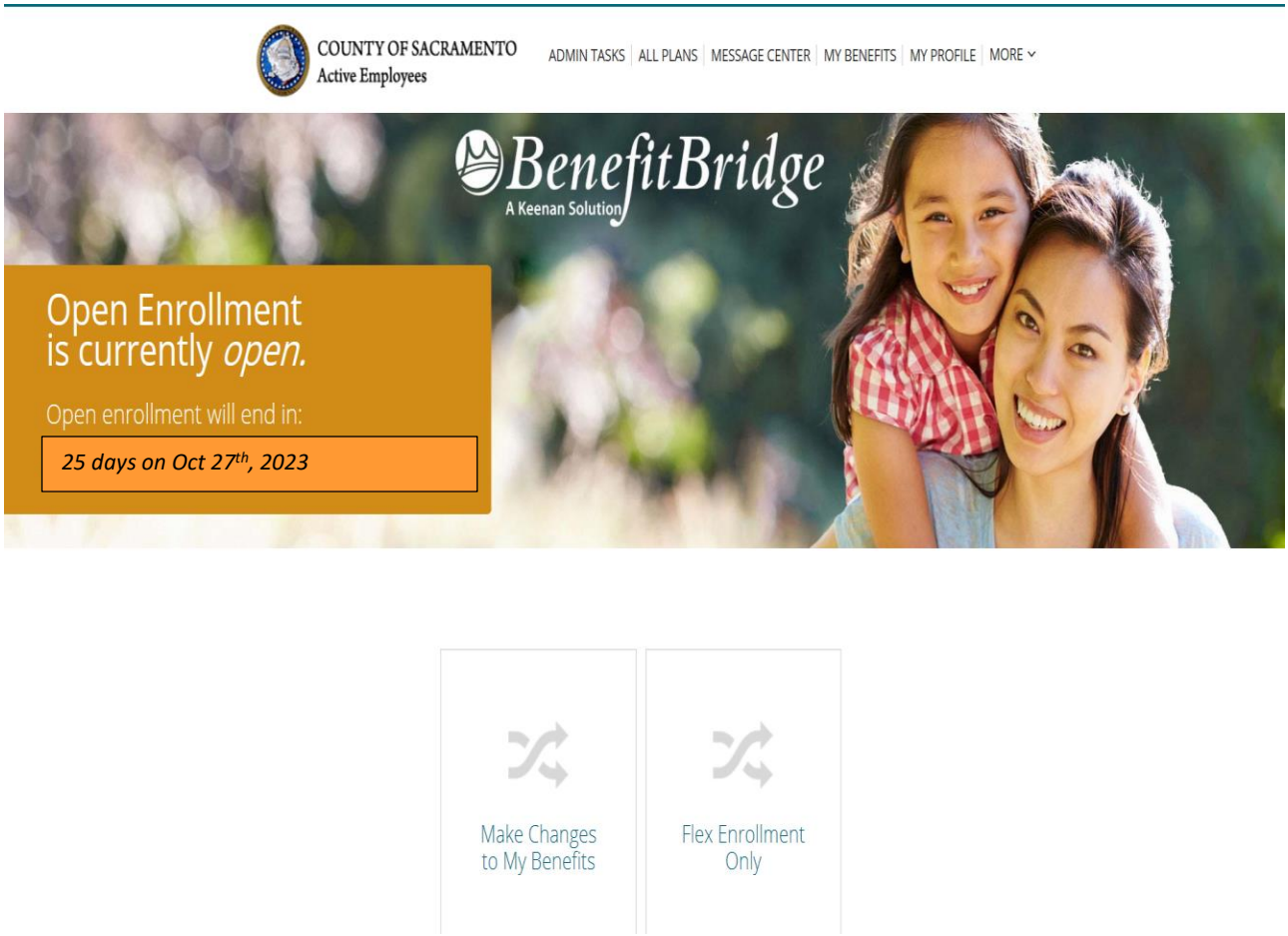
For benefits effective in

2024

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

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

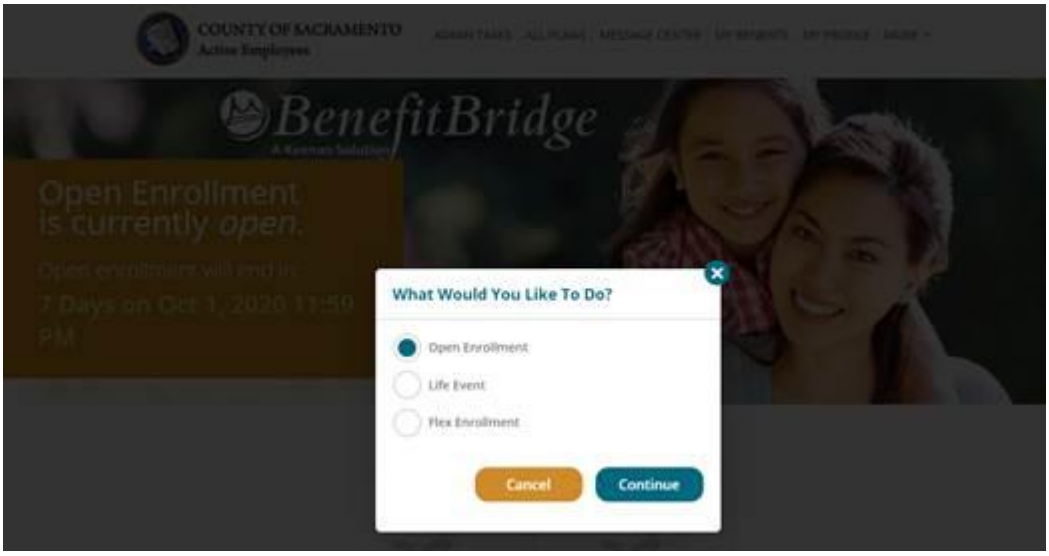
Click Make Changes to My Benefits to make changes.



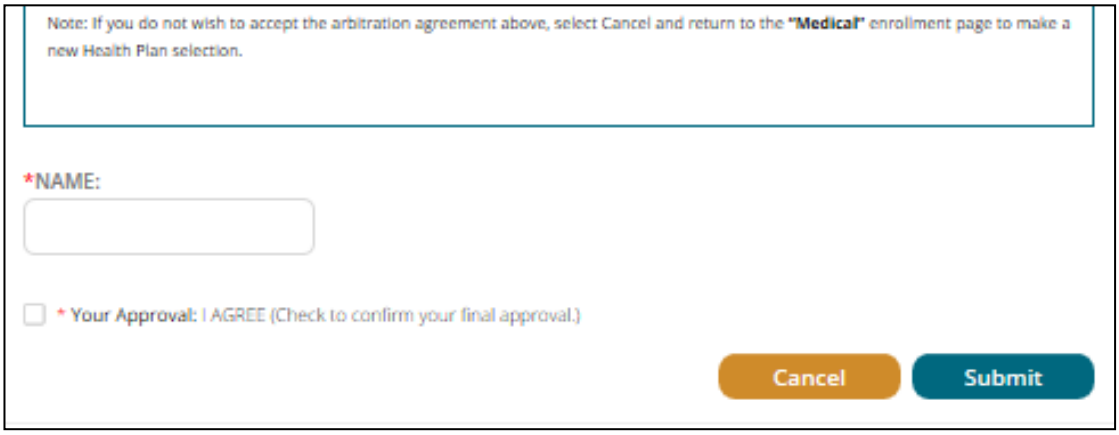
Please select **Open Enrollment** if you're making an Open Enrollment election. Open Enrollment changes are effective 1/1/2024.

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 2024.



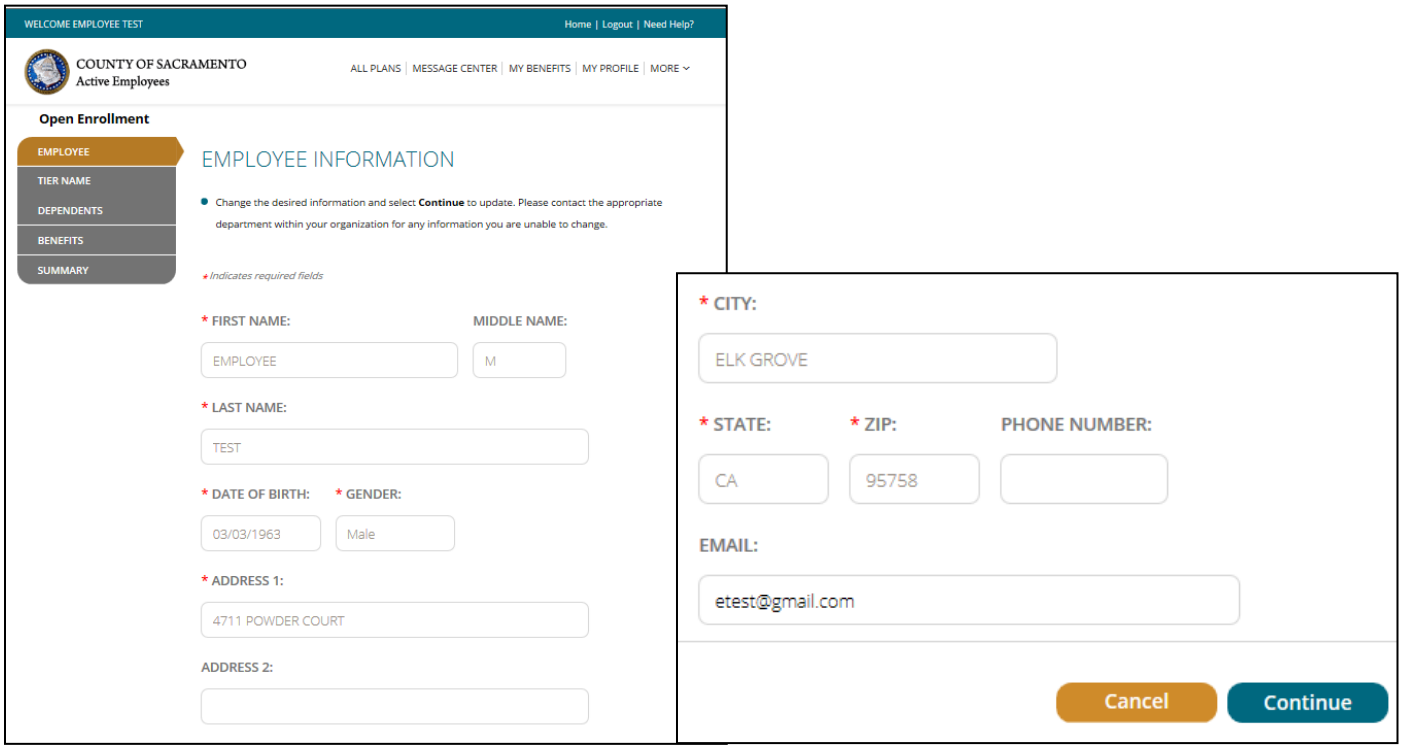
Important Reminder: no matter where you stop in your Open Enrollment steps, your enrollment request is not complete until you get to the Summary tab at the end of your enrollment, check the "Your Approval: I agree" box and click the "SUBMIT" button to complete your Open Enrollment request. PLEASE SEE NOTE AT THE END REGARDING REVIEWING YOUR SUBMISSION.



NOTE: 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.



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

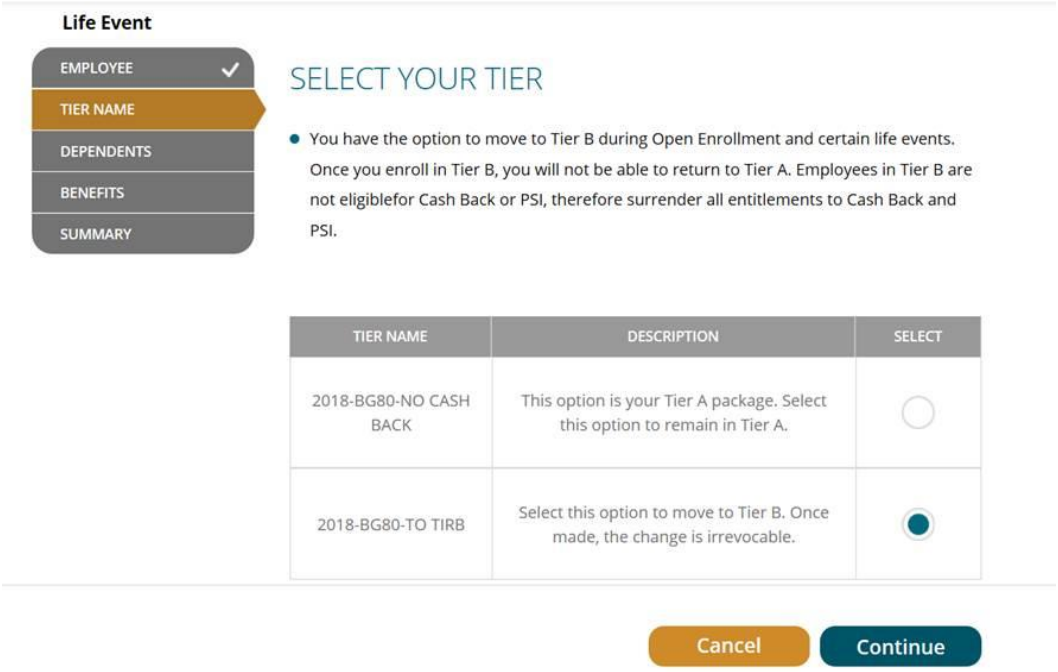
For name and address changes, you must contact your Department of Personnel Services Service Team representative for instructions.

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

TIER

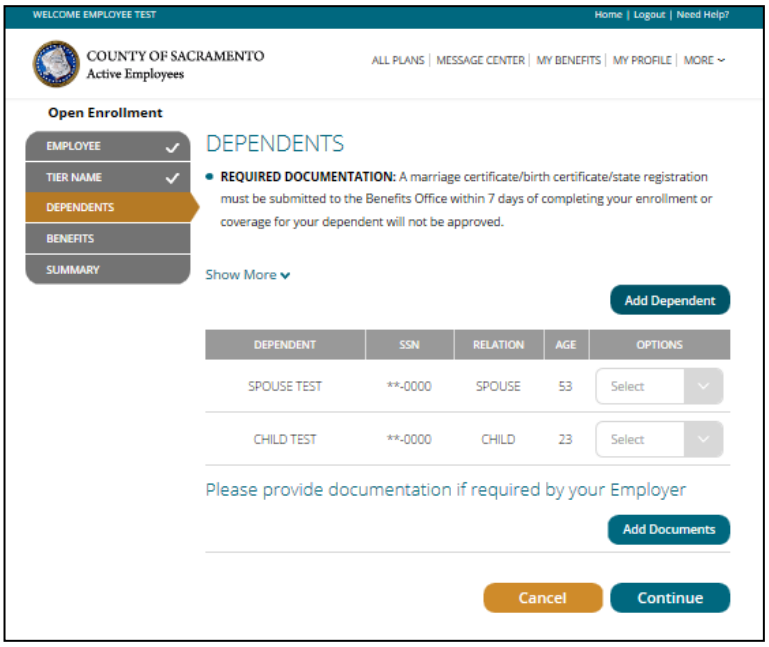
If you are currently Tier A, you might have the option to move to Tier B. It is a voluntary decision that can be made only once and is irrevocable once you made the changes. There is no cashback or PSI if you are enrolled in Tier B.

Note: **If you were hired after 2007, you are automatically enrolled in Tier B .**
Please select the appropriate package and click "CONTINUE".



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**".



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:

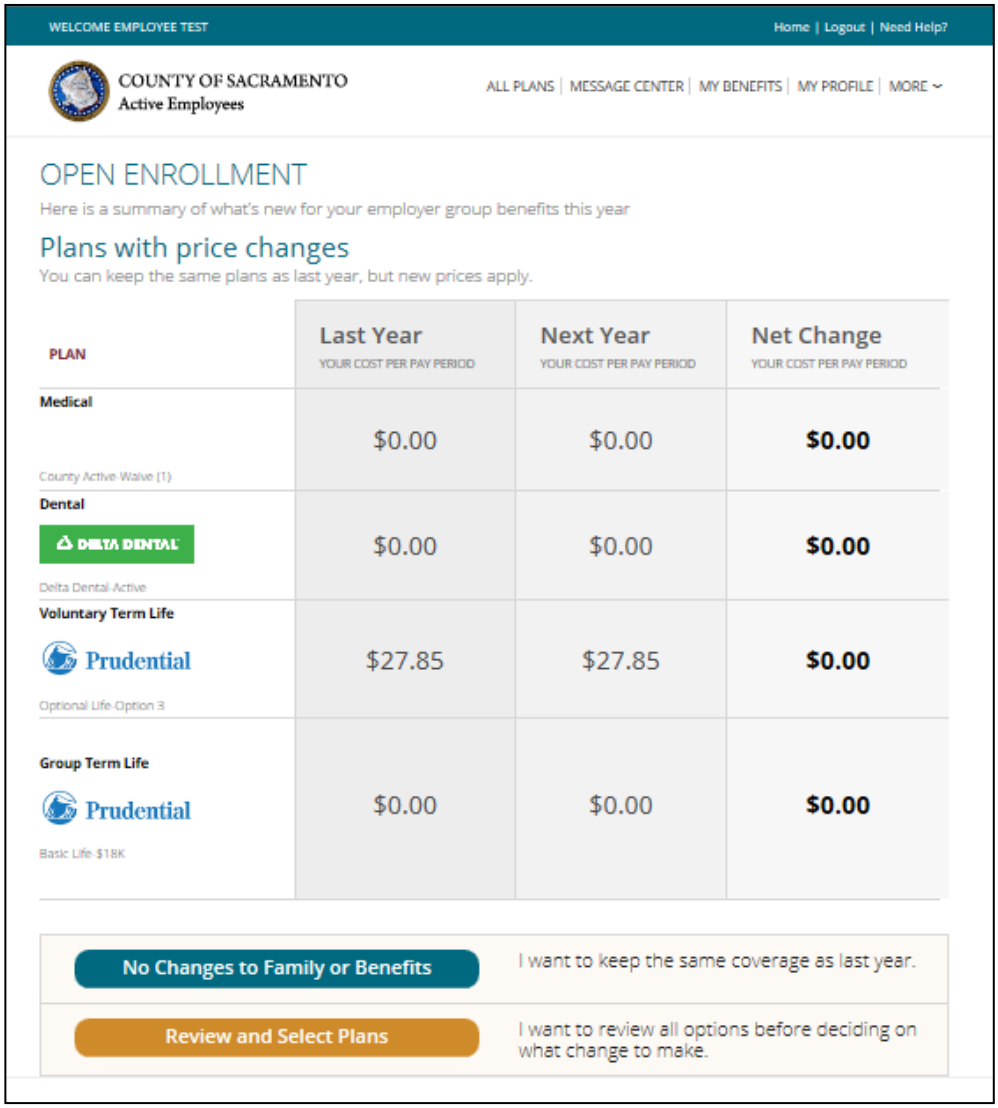
- Do not remove him/her here, uncheck the box from the appropriate benefit coverage in the next section

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.



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

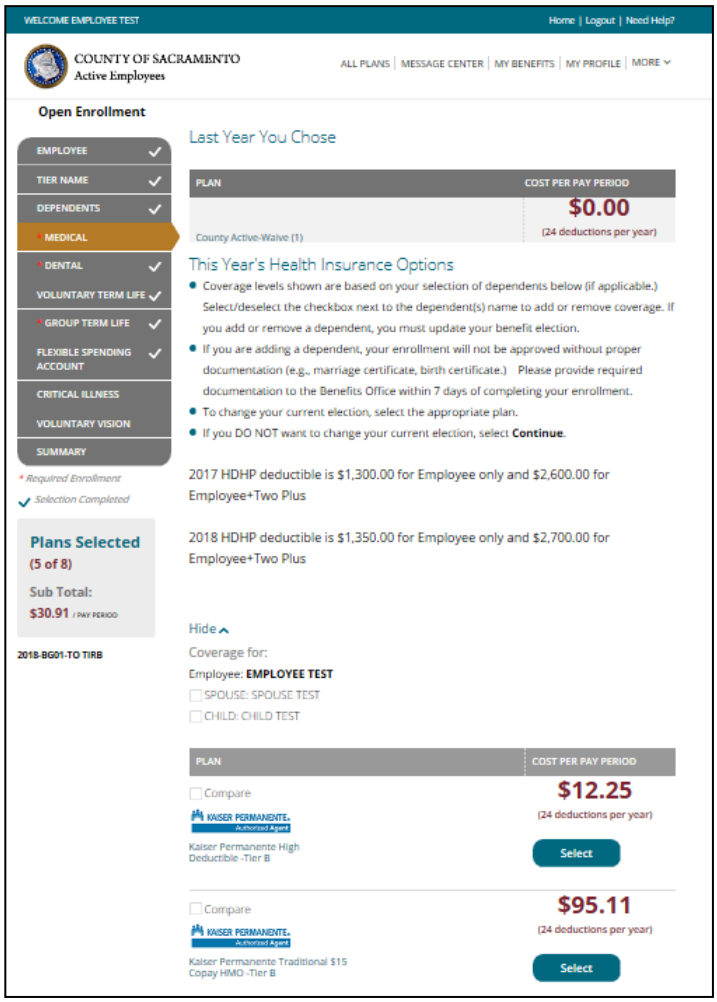
If you only want to change one benefit, you can step directly to the benefit type you want to make changes to by clicking on the benefit type on the left side grid.

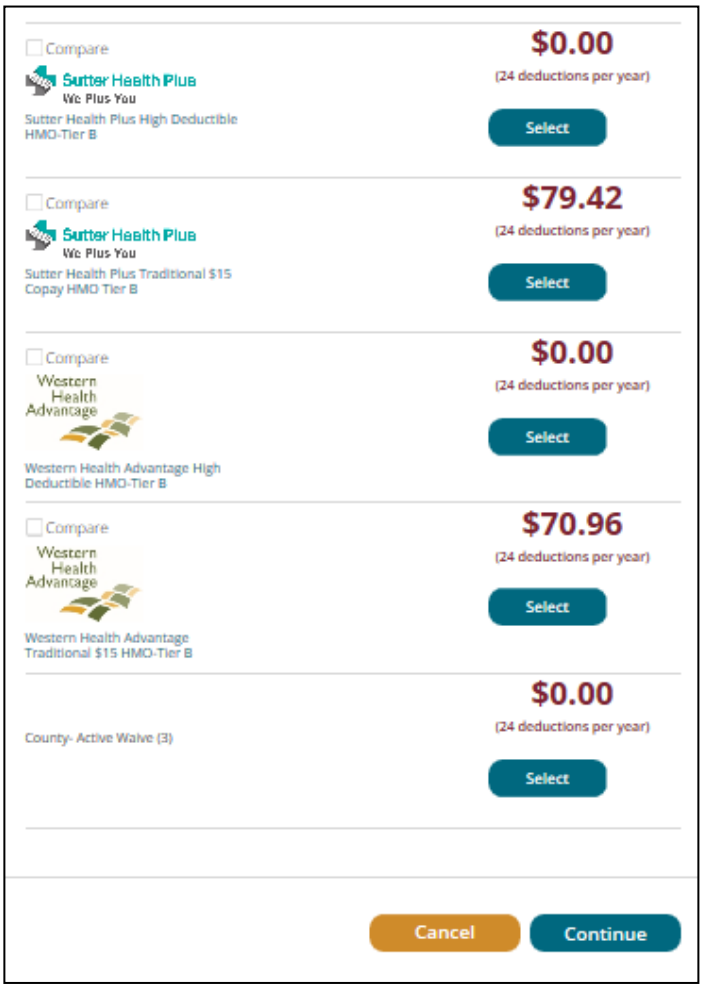
If you are waiving voluntary term life insurance coverage, select **CLEAR**.

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

BENEFITS (Medical Enrollment)

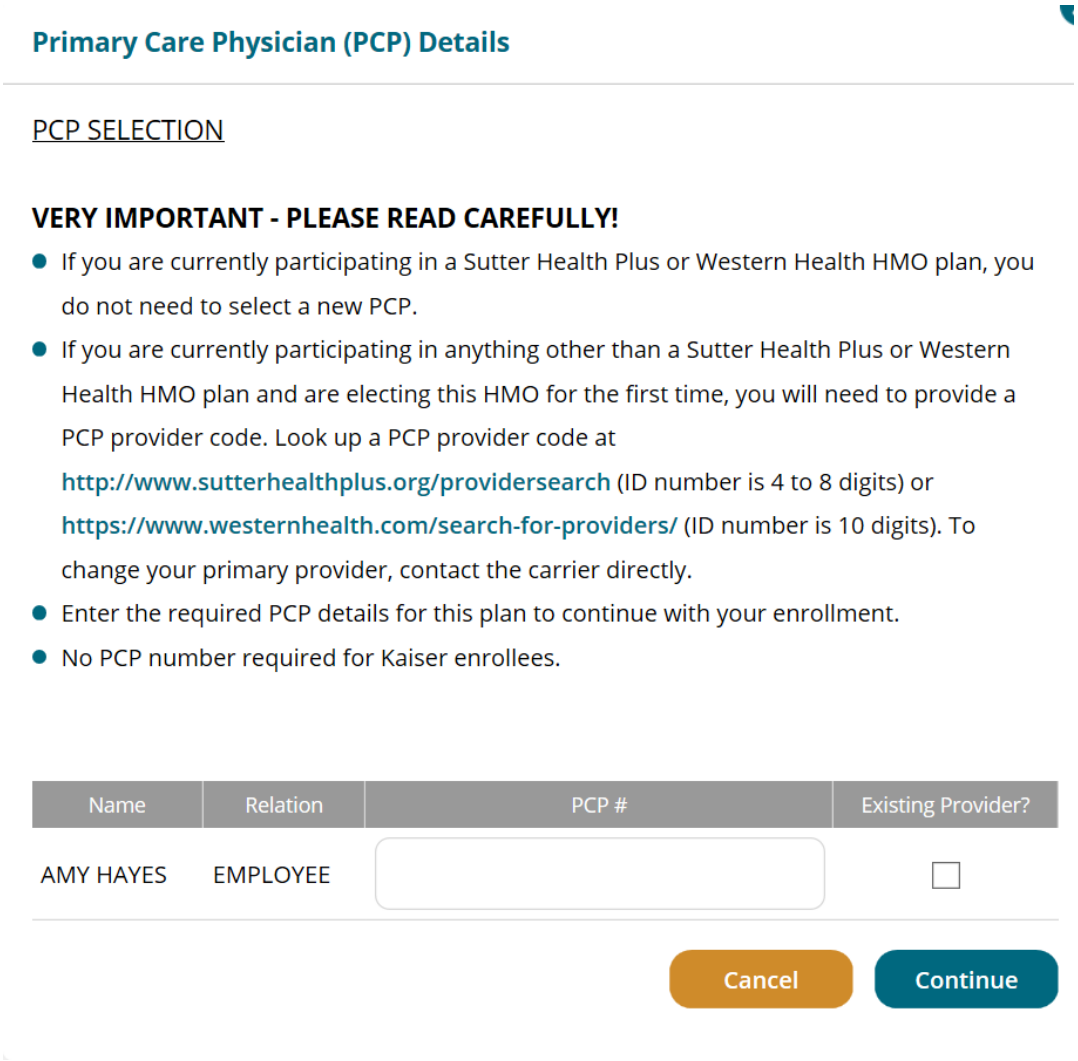
For medical, first check the box next to the dependents that should be enrolled, then choose the medical plan you wish to enroll in. **You must select a medical option. If you want to waive, select the last option. Additional documentation will be required.**





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!

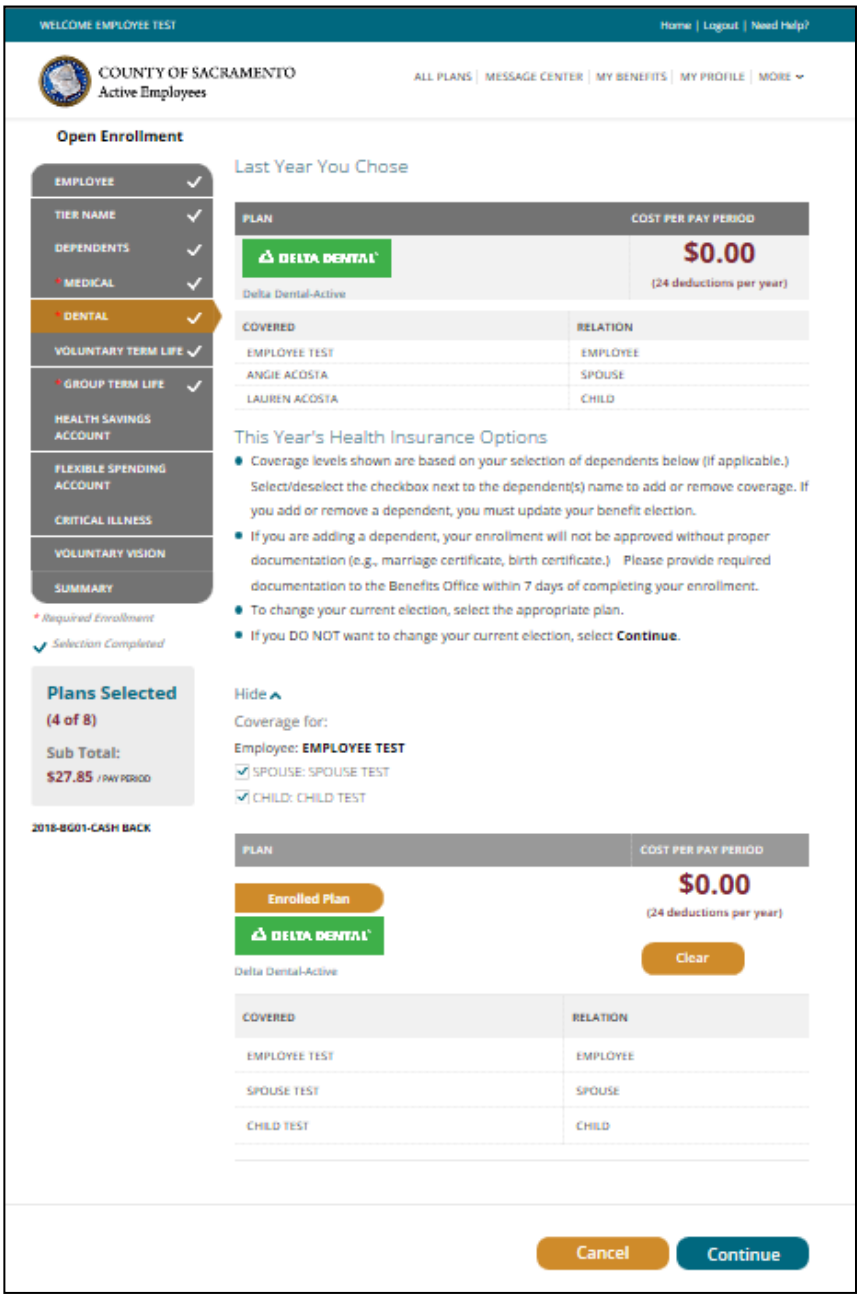
- If you are currently participating in a Sutter Health Plus or Western Health HMO plan, you do not need to select a new PCP.
- If you are currently participating in anything other than a Sutter Health Plus or Western Health HMO plan and are electing this HMO for the first time, you will need to provide 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		☐

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. DENTAL cannot be waived, as it is a County paid benefit).



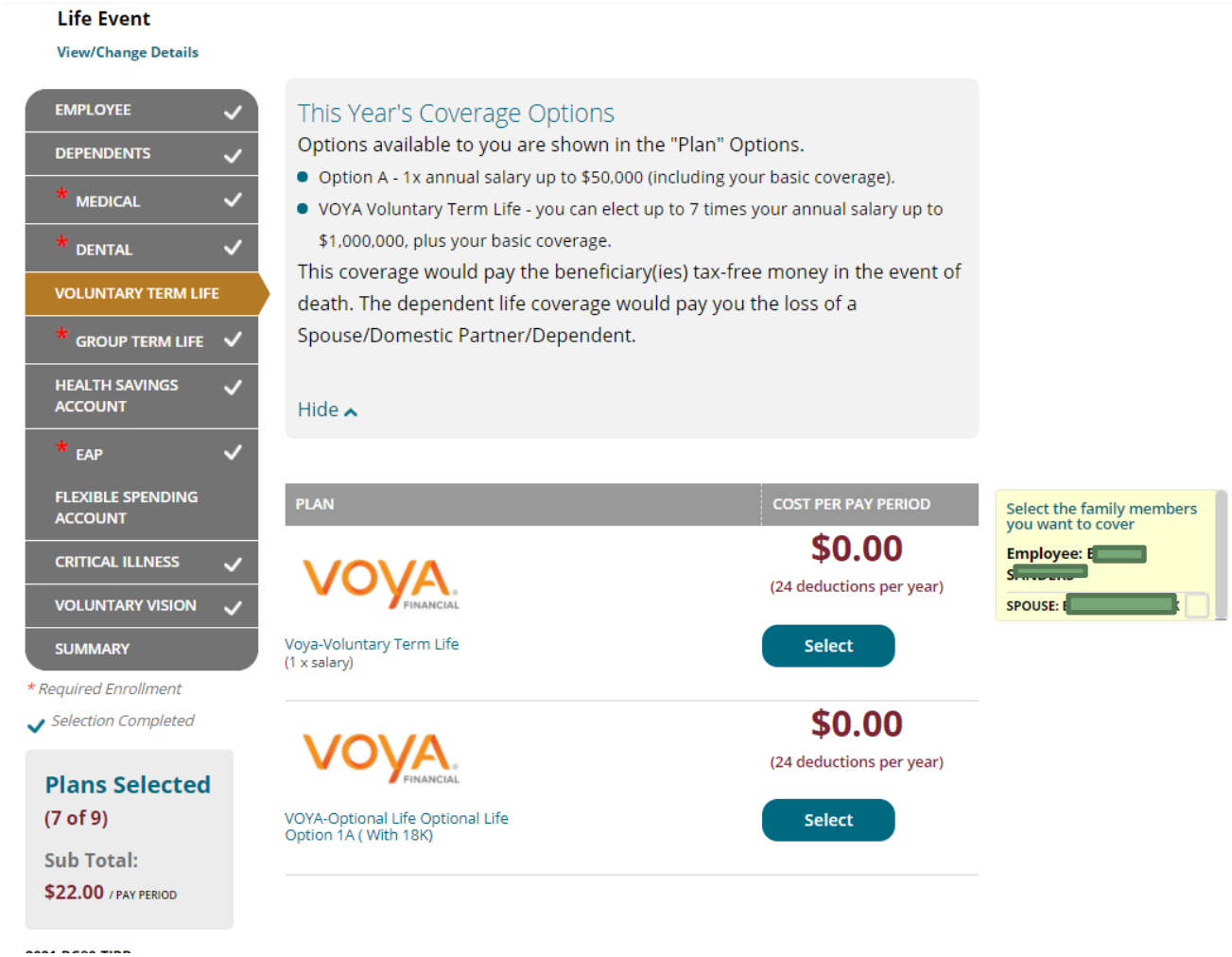
Once you have all family members selected, click "**CONTINUE**".

BENEFITS (Optional Life Insurance)

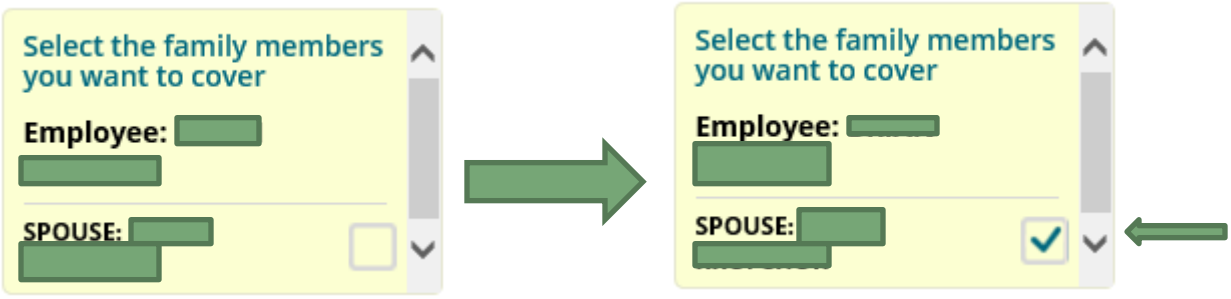
You will again be brought back to the BENEFITS page.

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 questionaires for all amounts.** Be sure the box is checked for any dependent you want covered by the Optional Life plan.

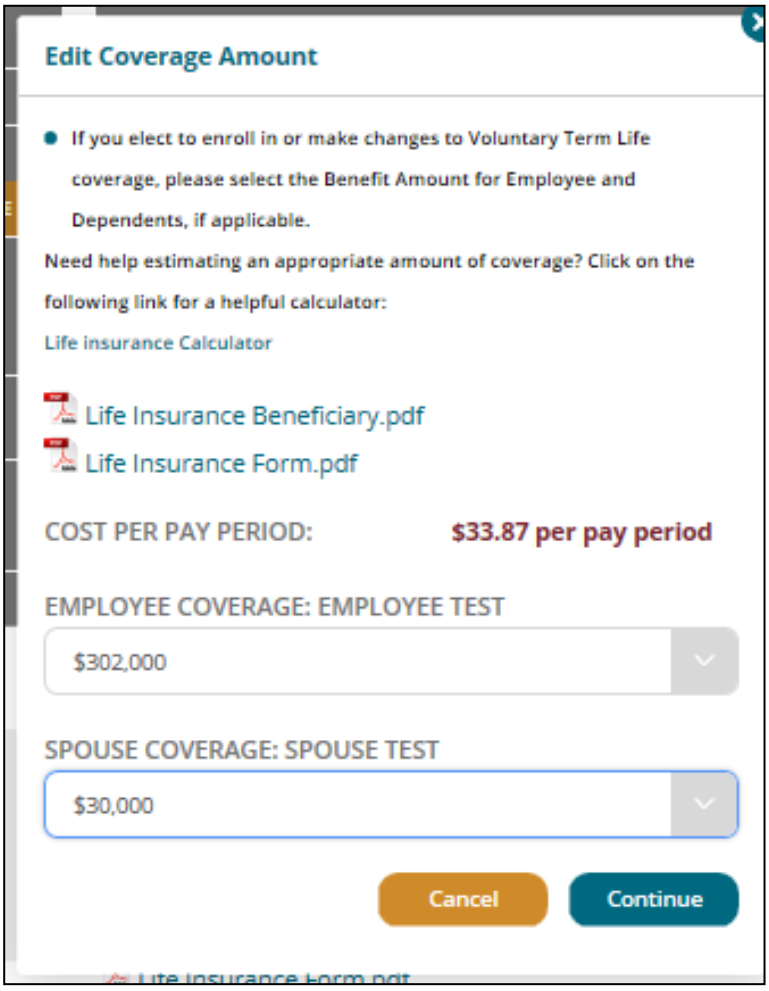
Note: If you are waiving *existing* voluntary term life insurance coverage, select **CLEAR**.

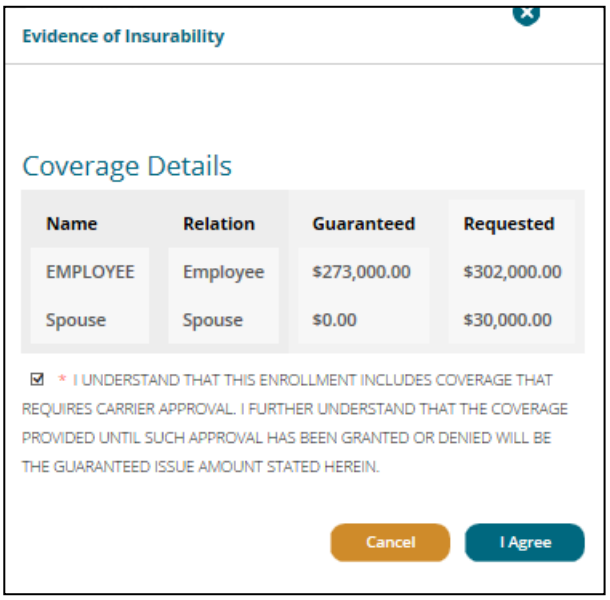


To make changes, you will want to hit the "select" button near the option you want to change. If you are making a change for a dependent as well, please make sure their name is checked in the yellow box on the right side of the screen. For information on the options, refer to the Employee Summary.



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

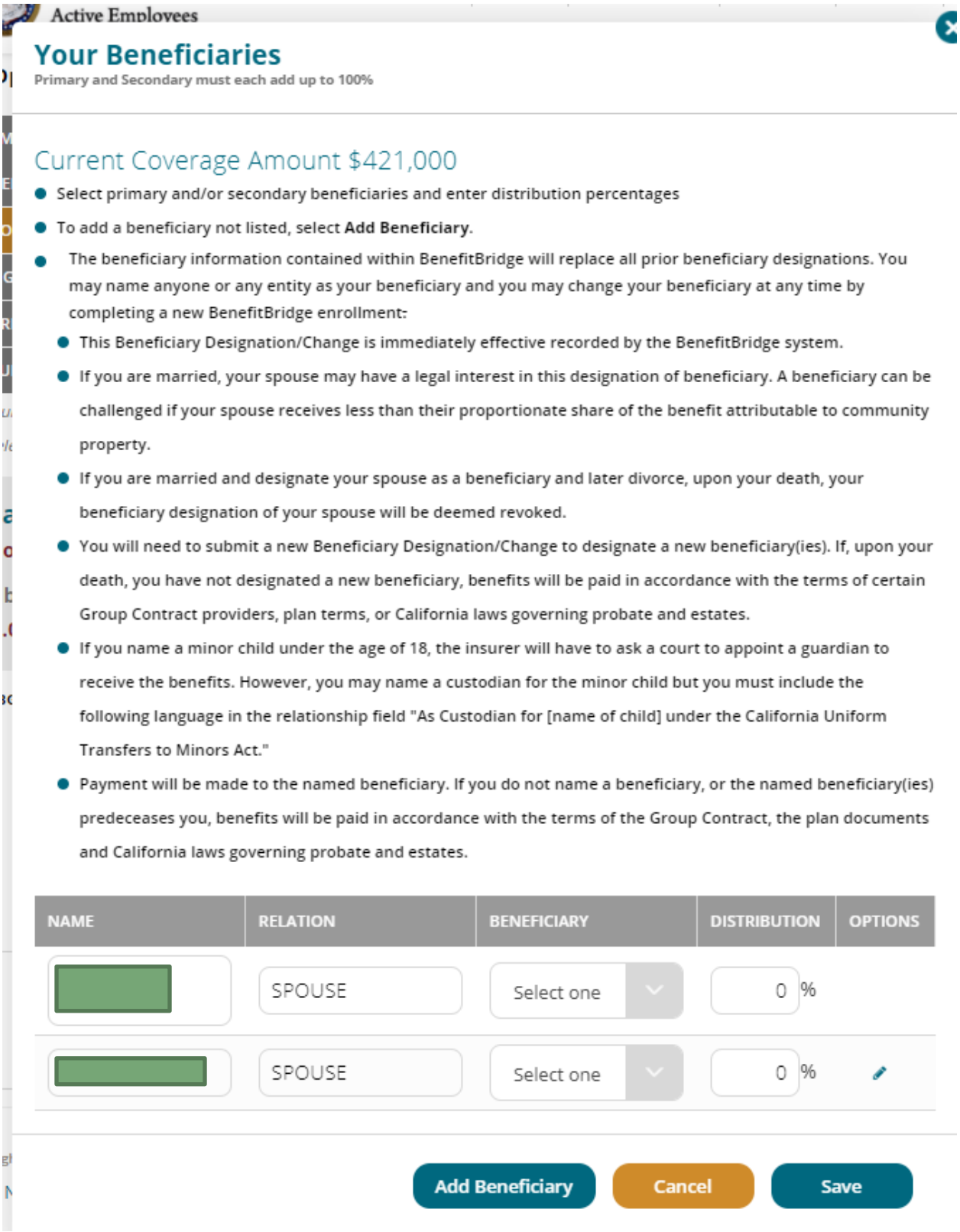




Click on the drop down menu to select the amount of coverage you want. If you are making changes to a dependent, you will not be able to make changes until your insurance is selected.

Once you are done, hit continue.

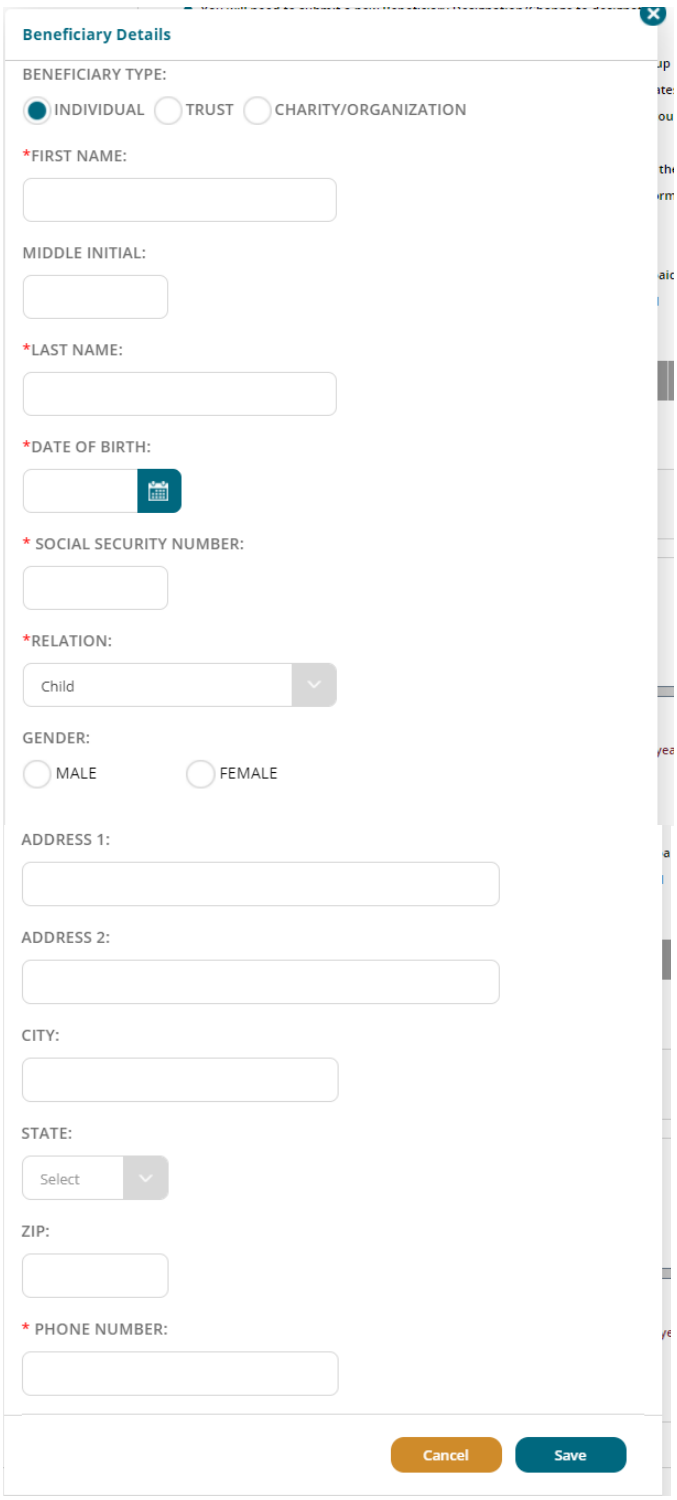
You will then be asked to designate your beneficiaries. You may see beneficiaries listed that are no longer valid. While you can't delete them, just set them to "0" in the distribution and they will not be considered a beneficiary.

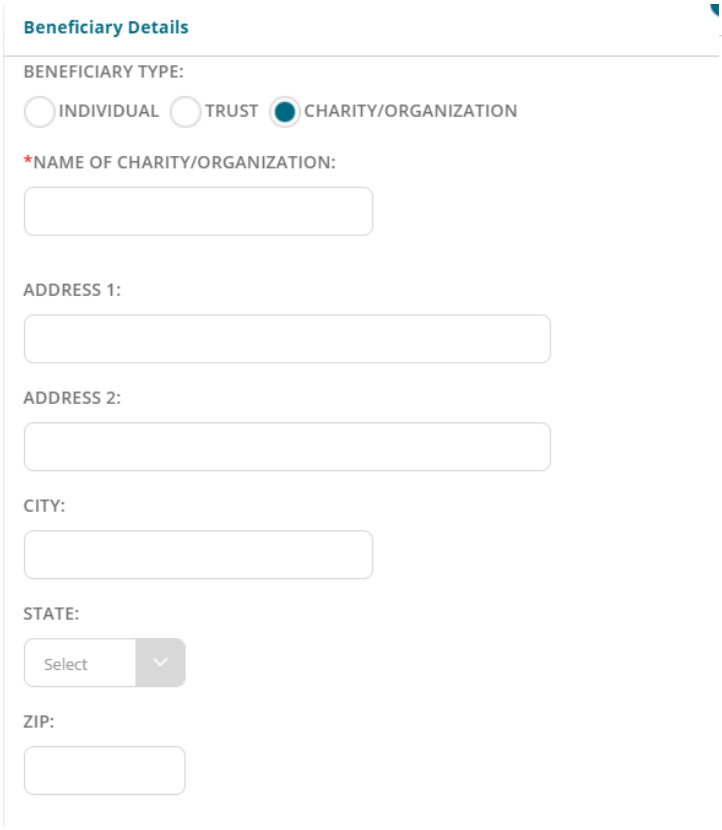


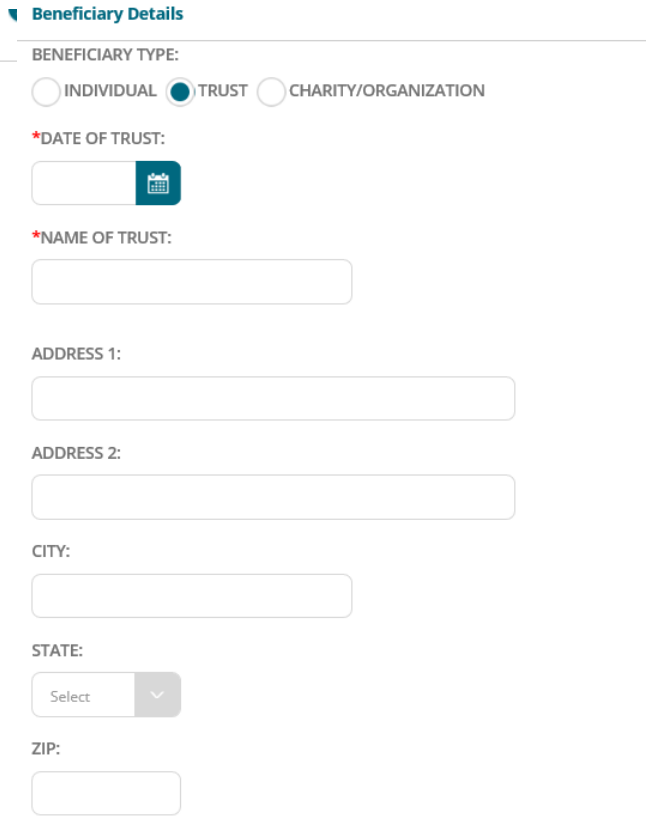
If they are already listed, just change the "beneficiary" drop down to "Primary" and enter 100 into the "distribution" column. If you have more than one person as a

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

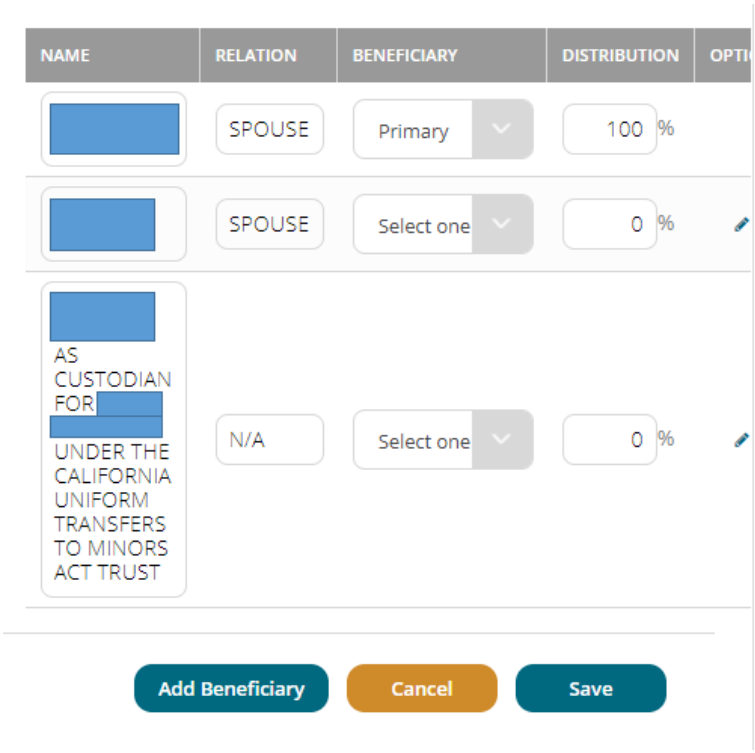
If you need to add them, just select the "Add Beneficiary" button. You can have an individual, a trust, or a charity as a beneficiary. You will then need to enter the information for them:







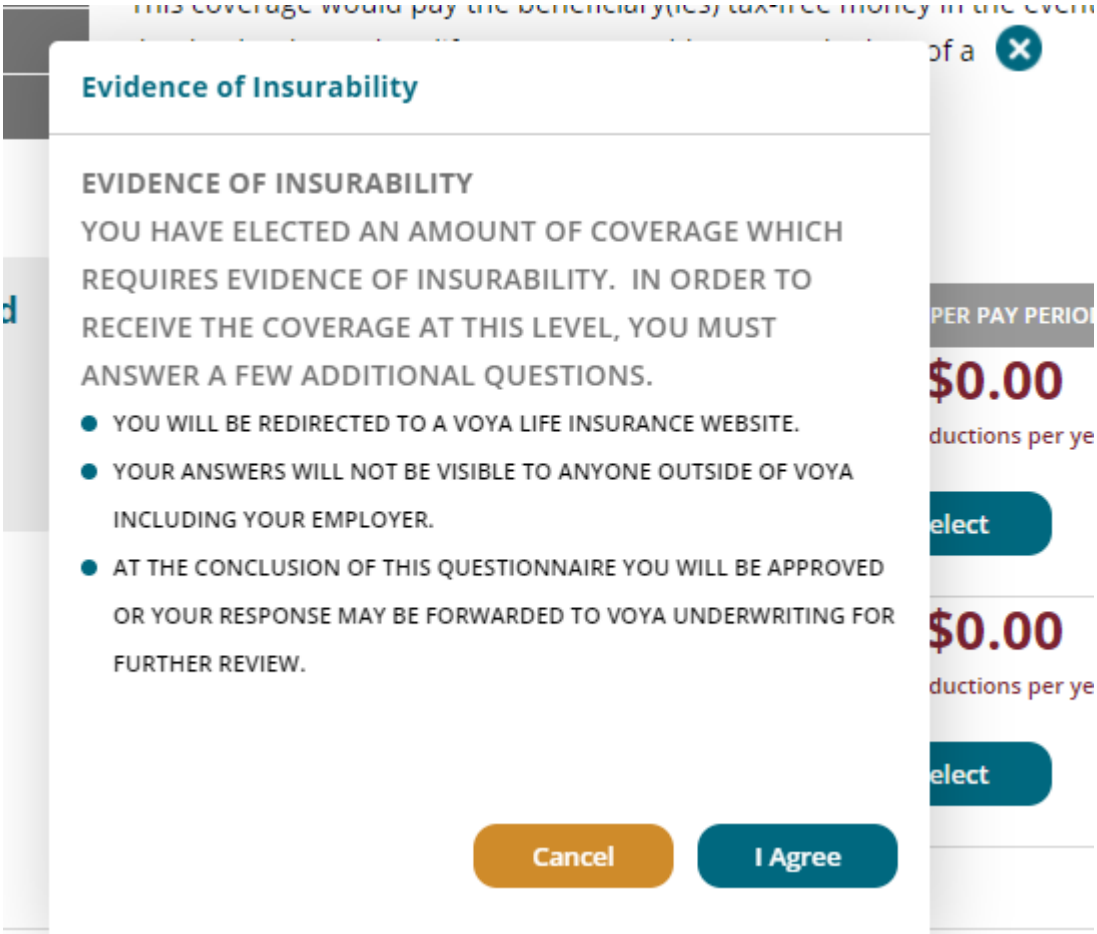
If you select a child under 18 as a primary beneficiary, you must also add a custodian. Currently we do not have the option on Benefit Bridge, so you will just select the "Charity/Organization" option and enter the custodian's information there. In the "Name of Charity/Organization", you will put the 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.**



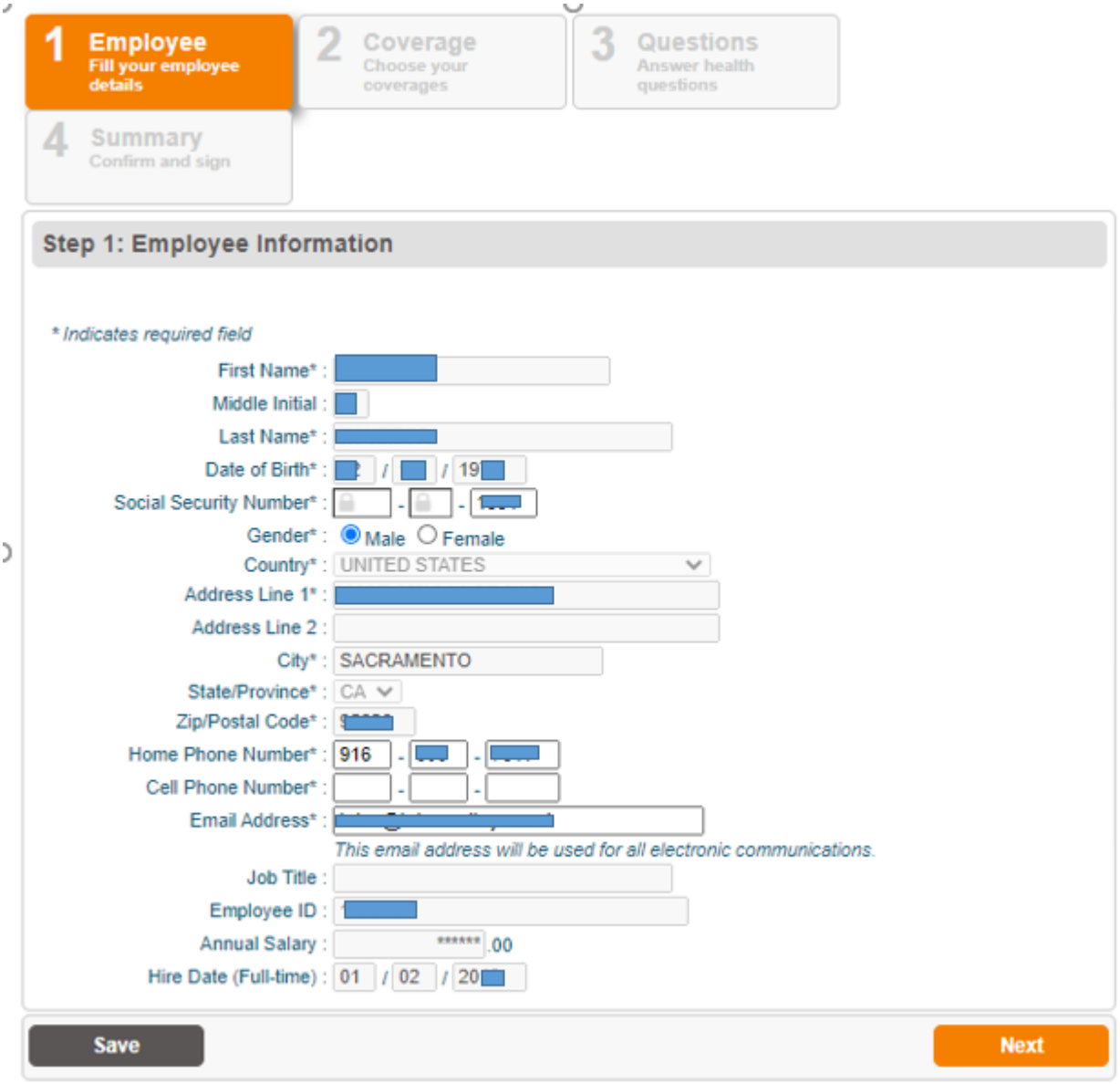
.

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.



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

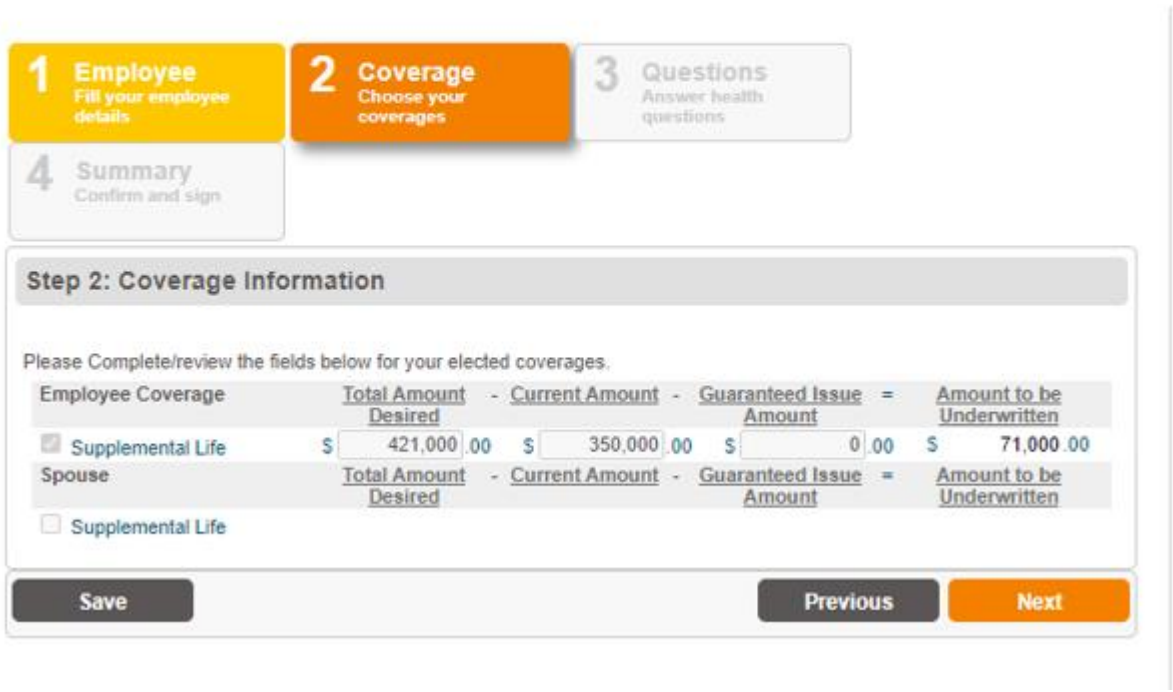


It will be pre-populated with your information. Just verify the information and then hit the "next" button.

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

PLAN | INVEST | PROTECT

My Evidence of Insurability



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
[redacted]						☐

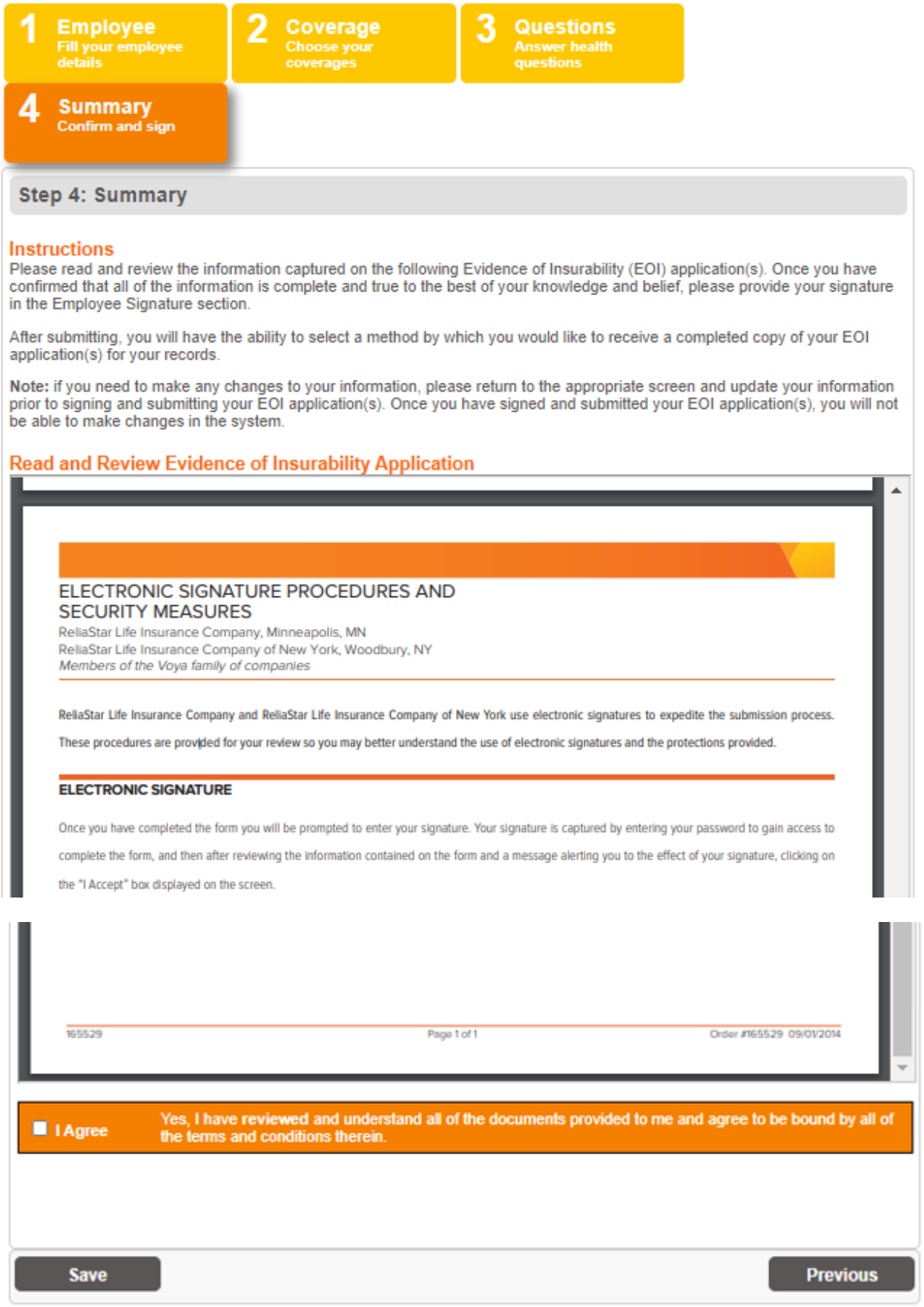
EMPLOYEE HEALTH QUESTIONS — Employee (EE)

Must be answered for coverage that is not Guaranteed Issue.

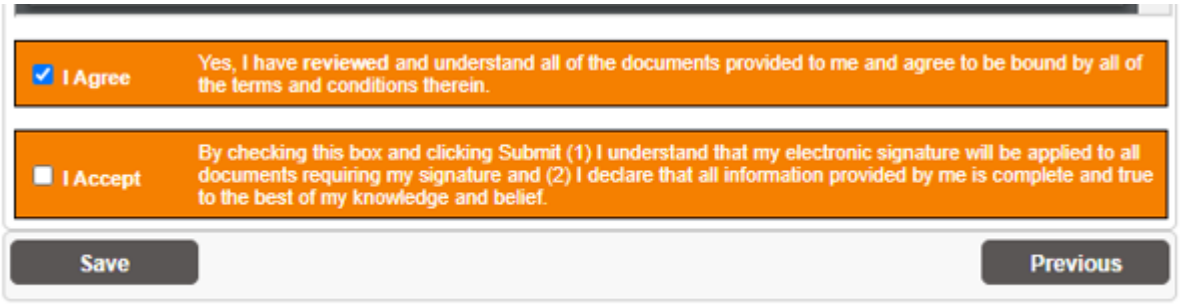
1. Within the last 5 years have you been treated for or been diagnosed by a member of the medical profession or health practitioner as having AIDS (Acquired Immunodeficiency Syndrome)? ○ Yes ○ No
2. Within the last 5 years have you been treated for, any of the following: Insulin dependent diabetes, heart 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 hepatitus 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 healh 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

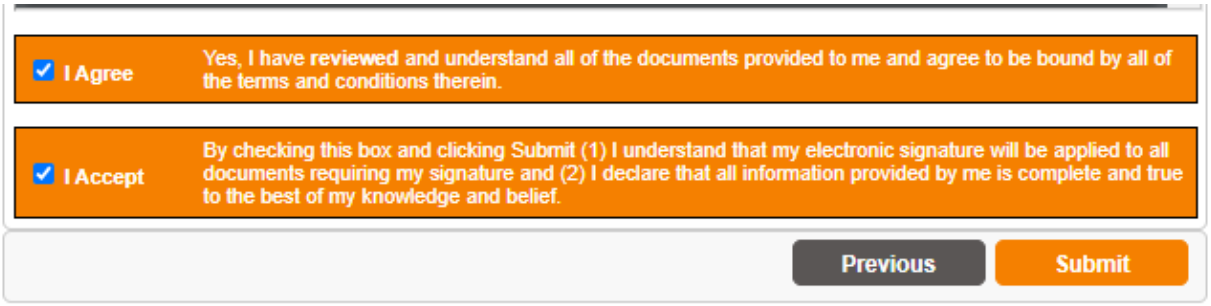
Answer the questions and then hit the "next" button. You will then be taken to the summary page, and you will need to scroll down.



Click on the "I Agree" check box.

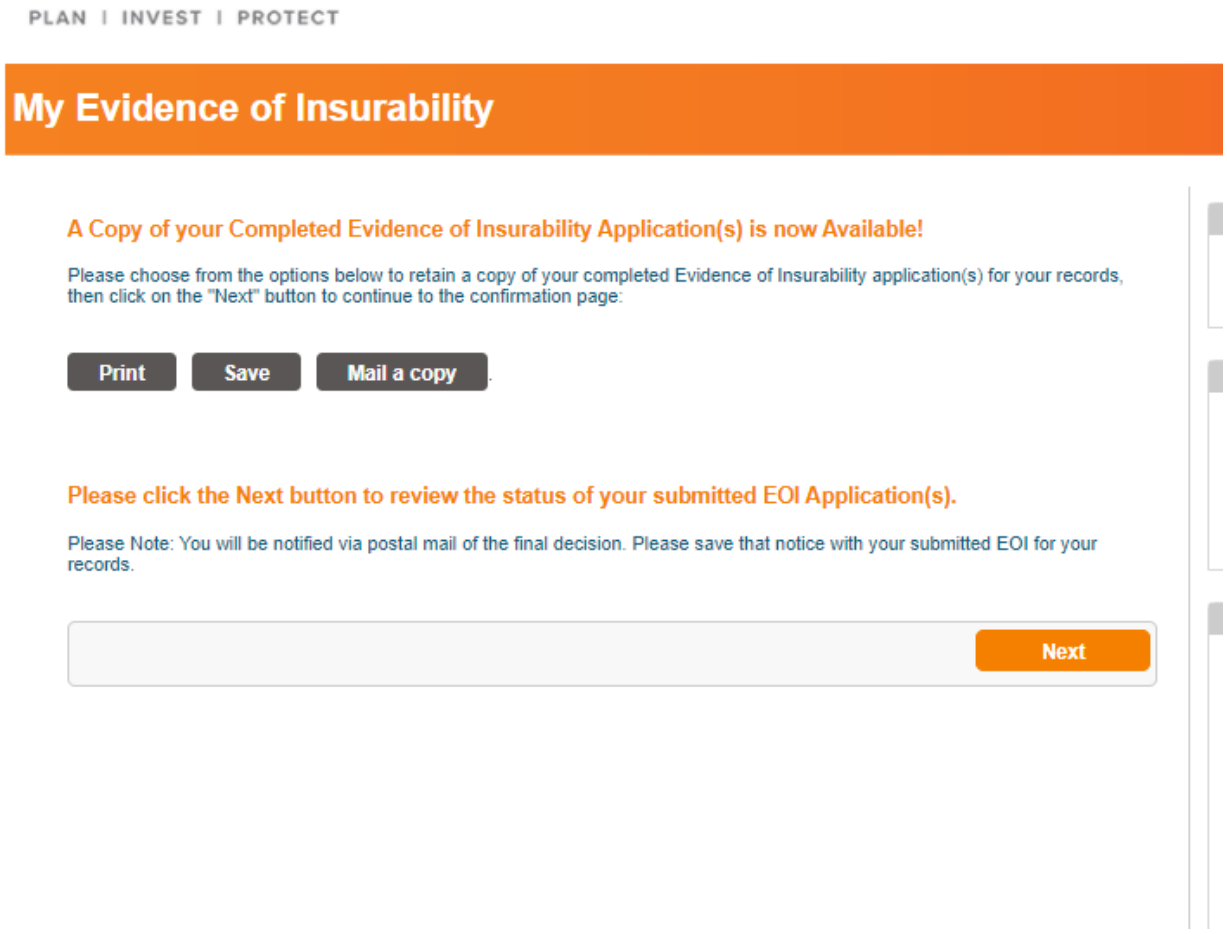


You will then click on the "I Accept" box.

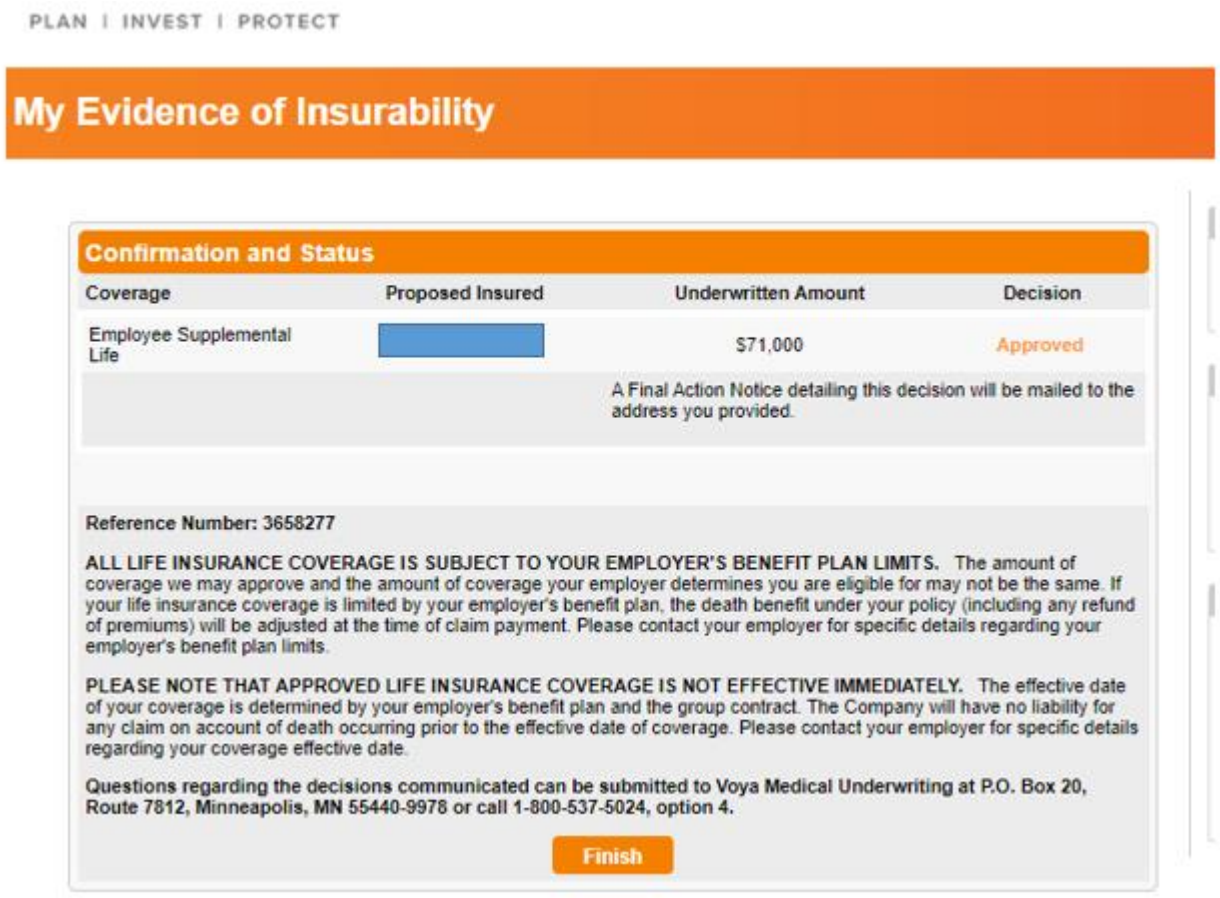


Once you've done that, you'll have the option to submit your questionnaire. Hit "Submit"

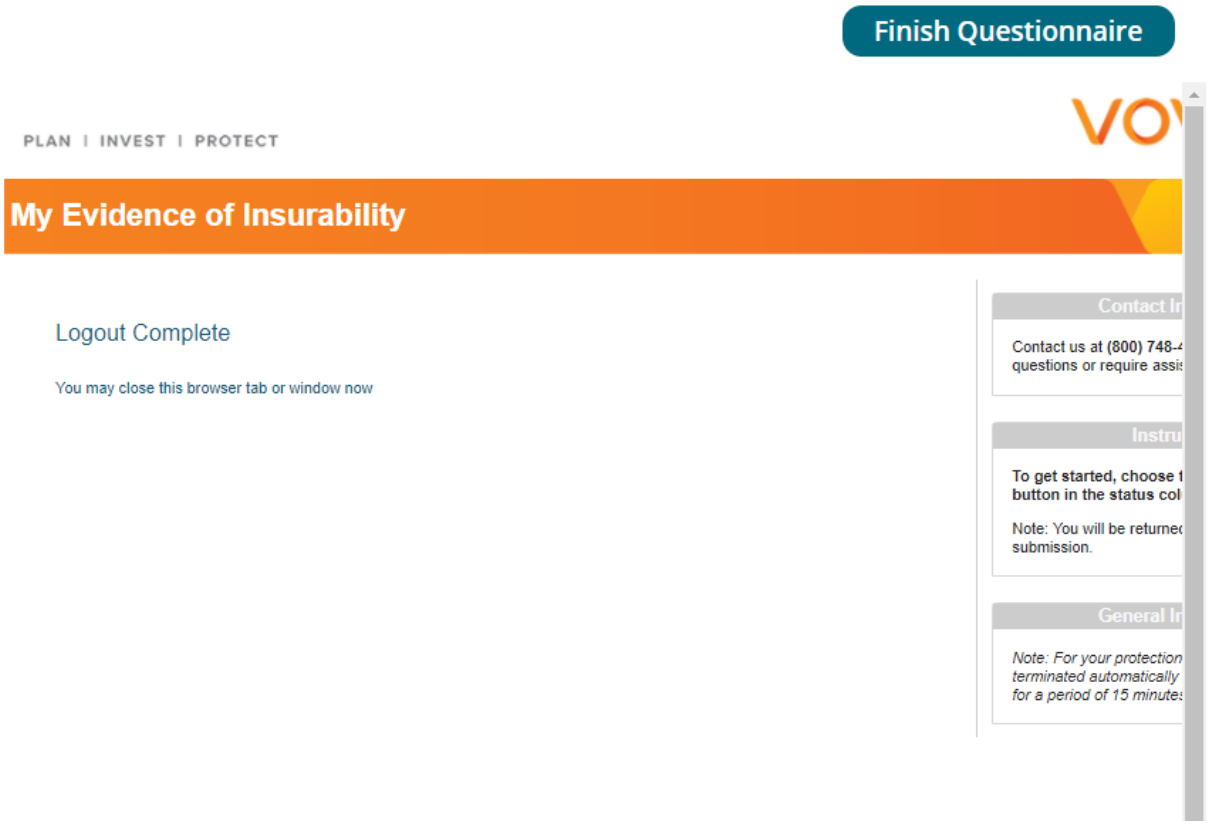
You will be taken to a screen where you can get a copy of the questionnaire you just filled out. Once you've gotten a copy (if you want one), hit "Next".



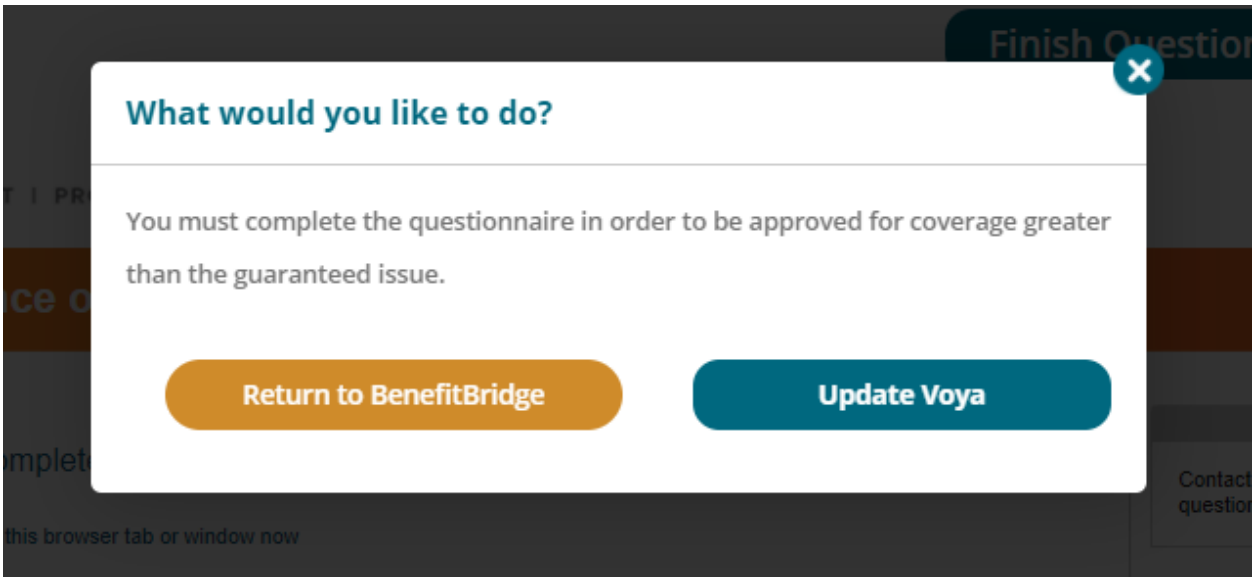
The last screen will let you know if you are approved, or if more information is needed. Once you have reviewed this screen, hit "Finish".



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



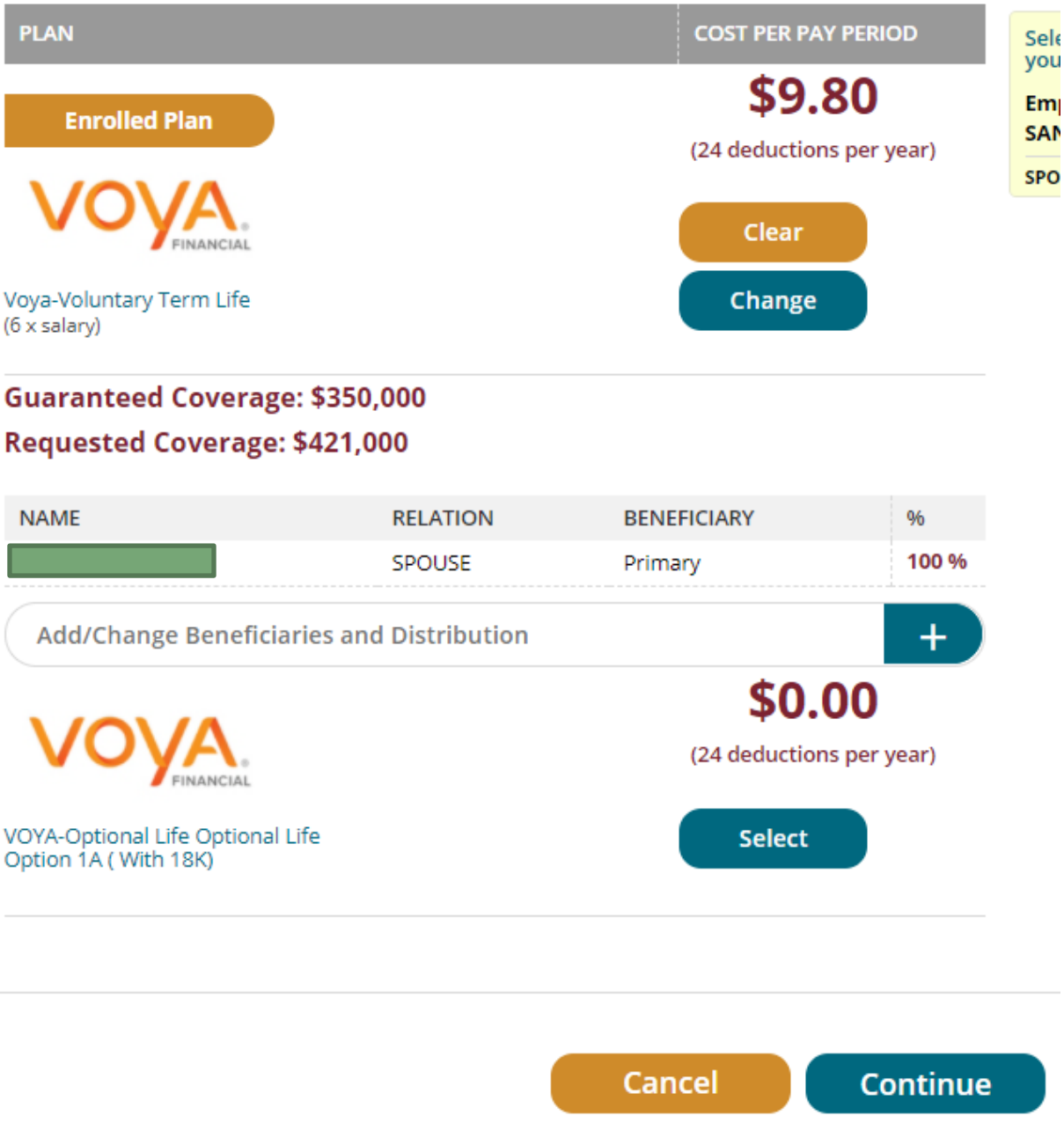
A pop up window will ask if you want to return to BenefitBridge. Select this option.



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

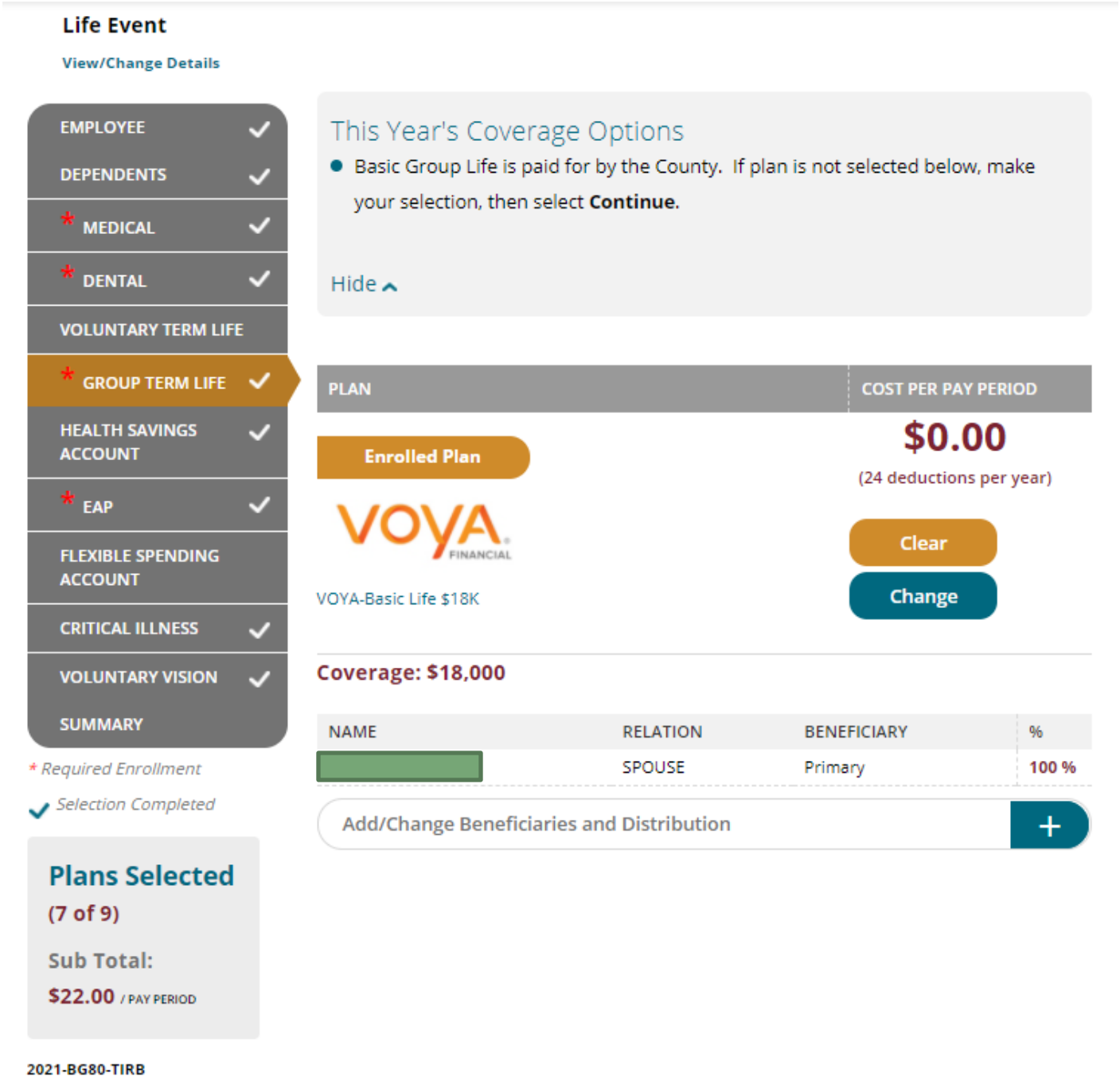
NOTE: If you are insuring a Spouse/Domestic Partner for more than the guaranteed amount, they will have to fill out their own Evidence of Insurability (EOI) questionnaire. Once you have submitted your request for coverage, a separate email will be sent to you containing the link to the Spouse EOI. You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



Hit continue.

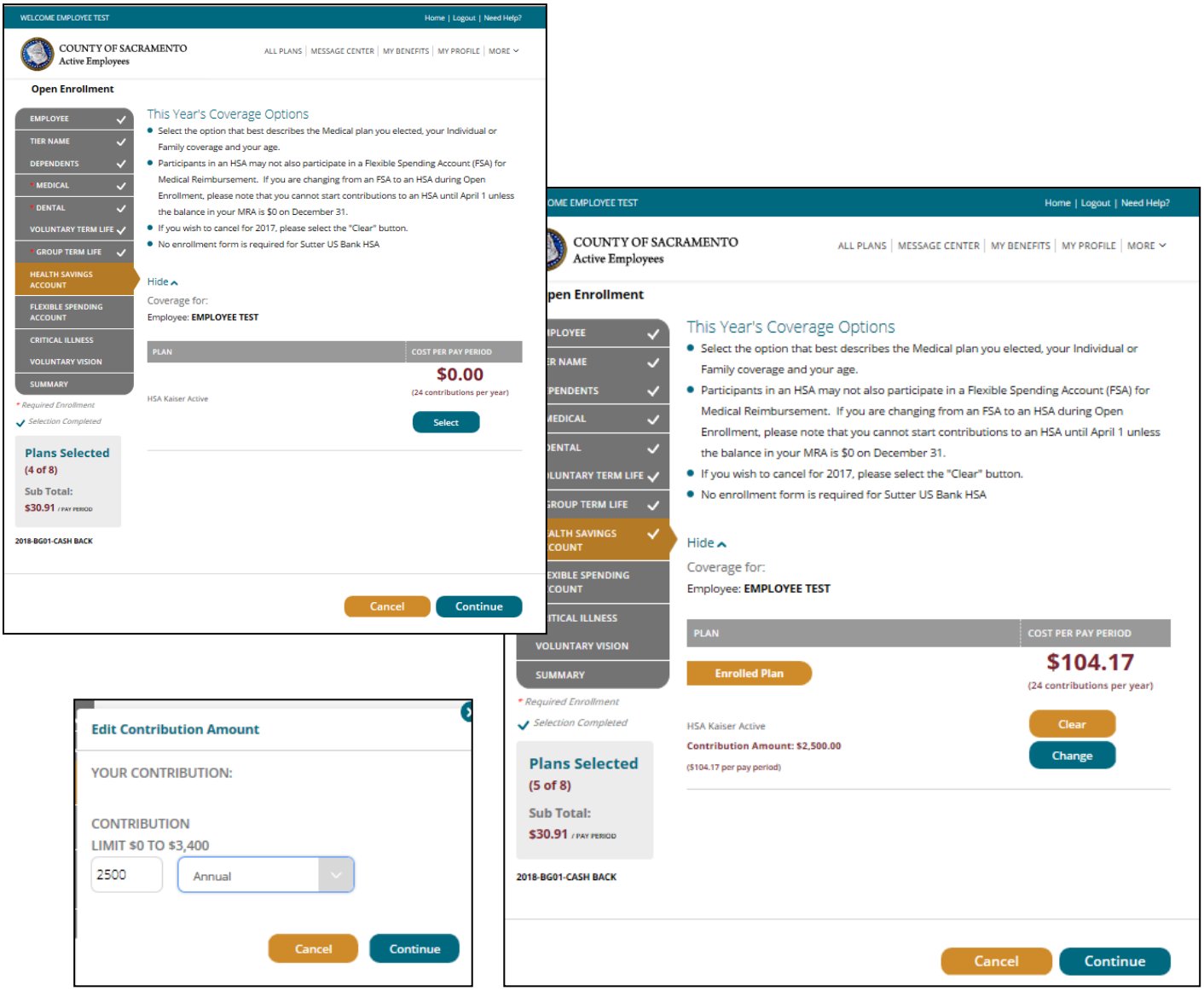
The next screen is your basic life insurance that is provided to you by the County. Just select continue down at the bottom, as you cannot make changes to this.



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**



The HSA annual limits for 2024 are listed below:

Under age 55	Over age 55
Single: $4,150 ($172.91/pay period)	Single: $5,150 ($214.58/pay period)
Family: $8,300 ($345.83/pay period)	Family: $9,300 ($387.50/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".**

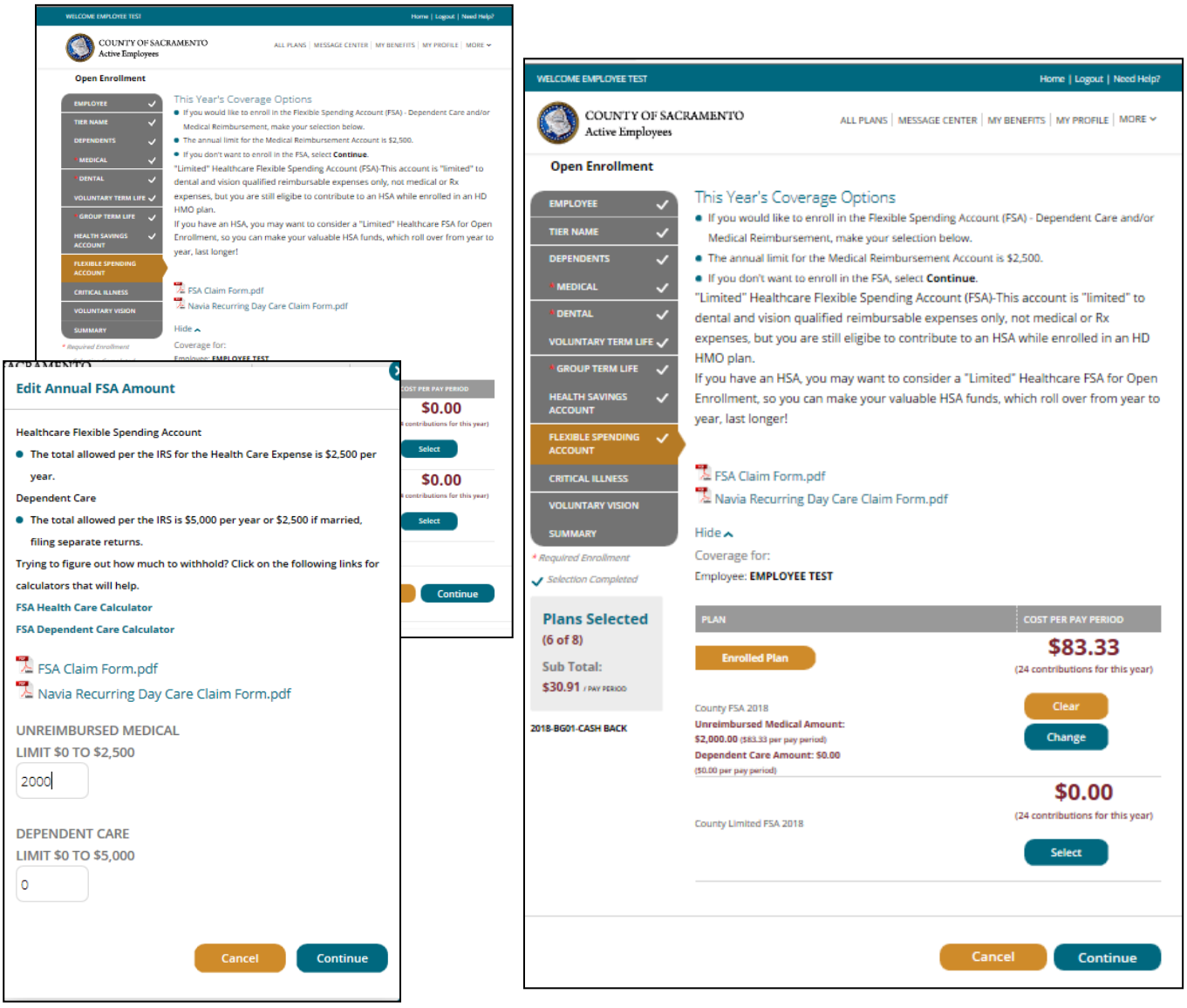
OPTIONAL (FSA)

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 2024**", 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). FSA limit for **2024** is **$3,050.**

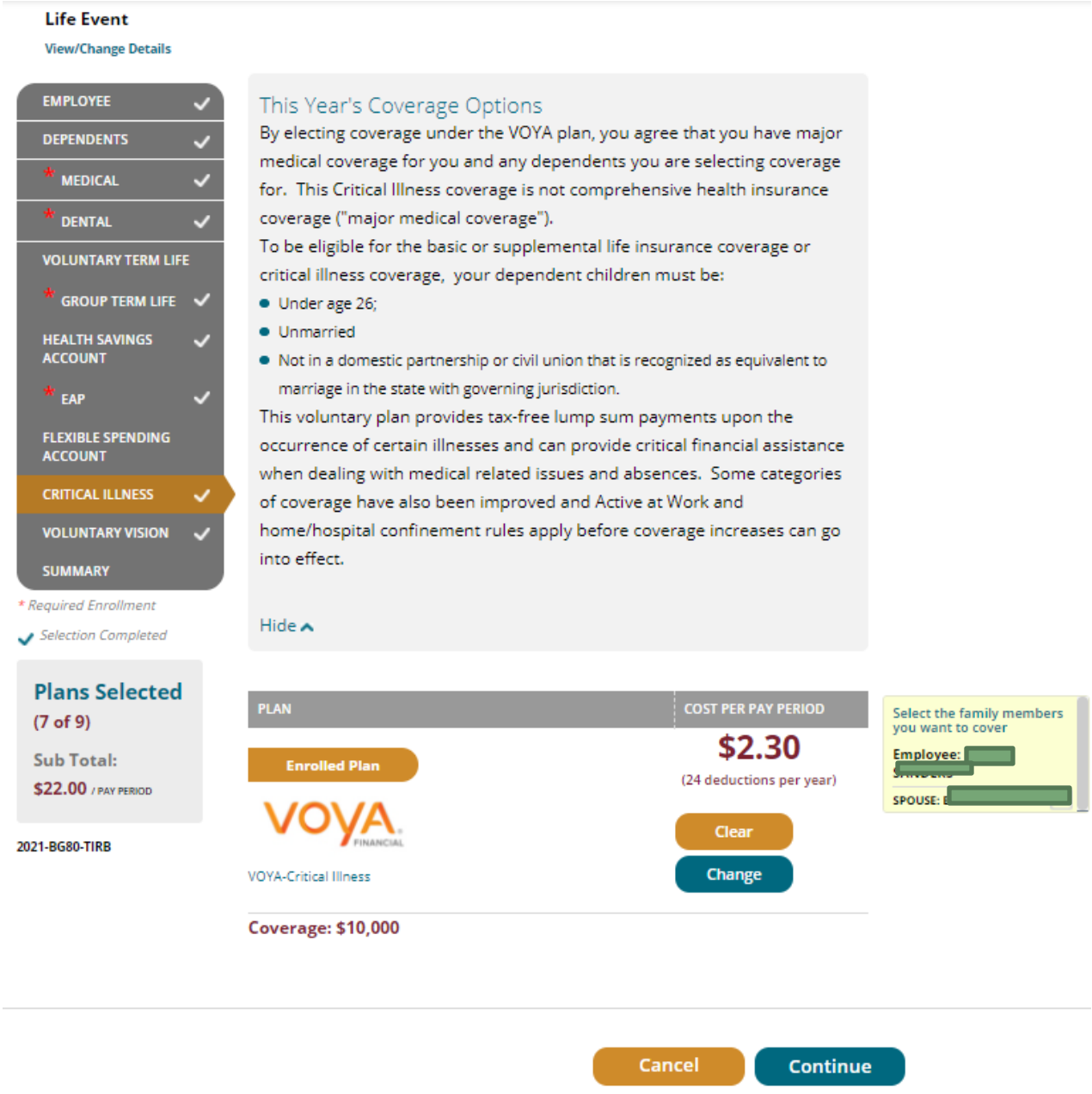
To enroll in the Dependent Care Account or General Purpose Medical Reimbursement Account, select "**County FSA 2024**", then click "Continue". Follow the same steps as above.



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".



Once you have made your selection, please hit "Continue"

OPTIONAL (Voluntary Vision)

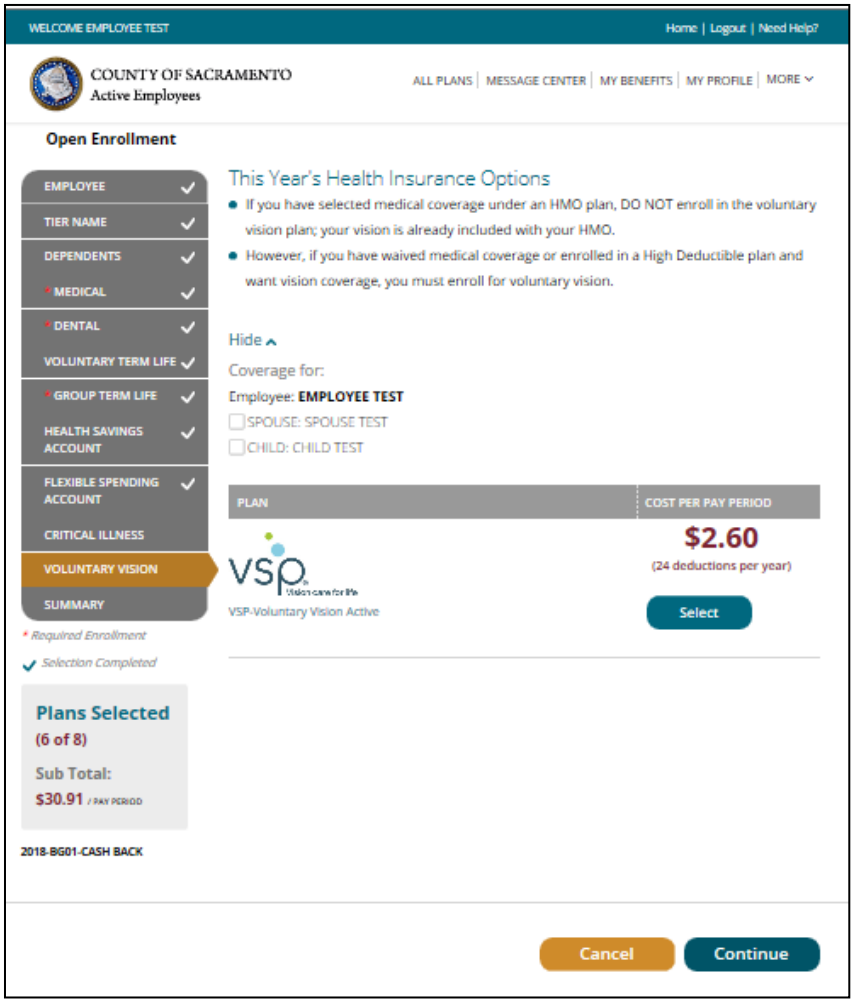
If you're enrolled in Sutter or WHA HMO, the cost and coverage for vision benefits are bundled with your HMO selection.

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

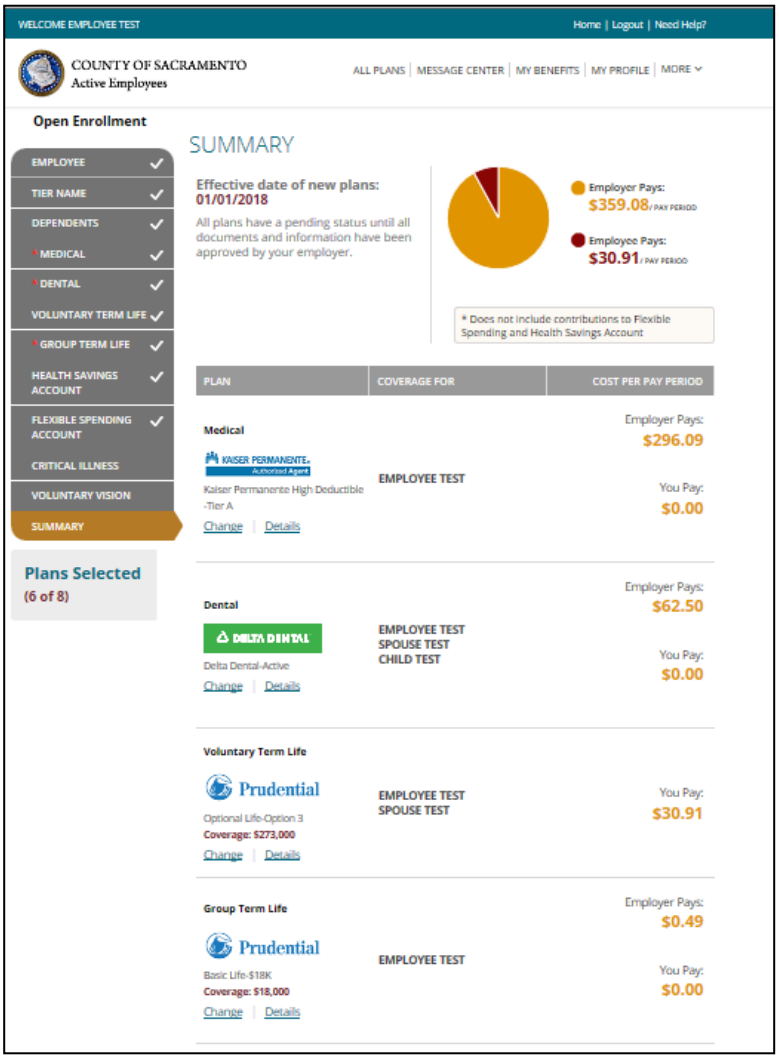
For **2024**, you now have the option to enroll in VSP standard or enhanced coverage.

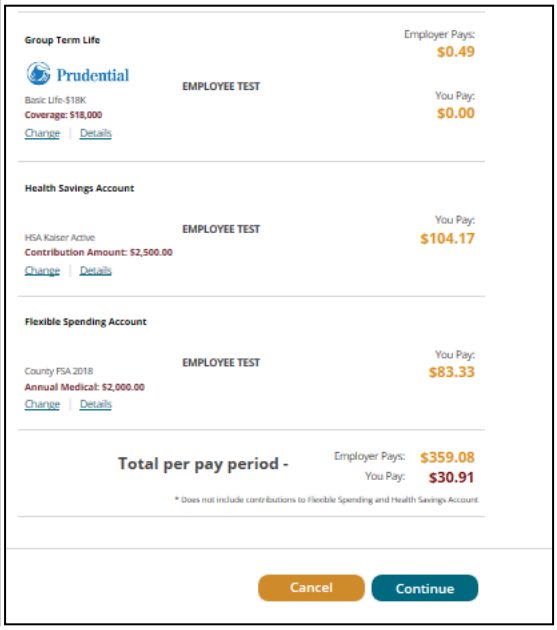
Click **Select** under the Voluntary Vision to enroll. Be sure the box is checked for any dependent you want covered by the Voluntary Vision plan. Click "Continue".



REVIEW & FINAL APPROVAL

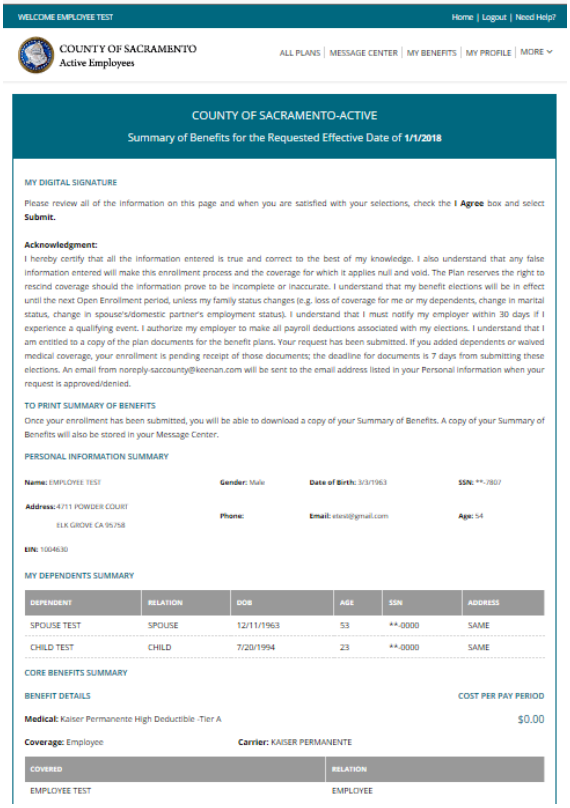
You are almost finished! Scroll through and review the Acknowledgement provisions.





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 — Home | Logout | Need Help?

COUNTY OF SACRAMENTO
Active Employees

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

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

MY DIGITAL SIGNATURE

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

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

TO PRINT SUMMARY OF BENEFITS

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

PERSONAL INFORMATION SUMMARY

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

MY DEPENDENTS SUMMARY

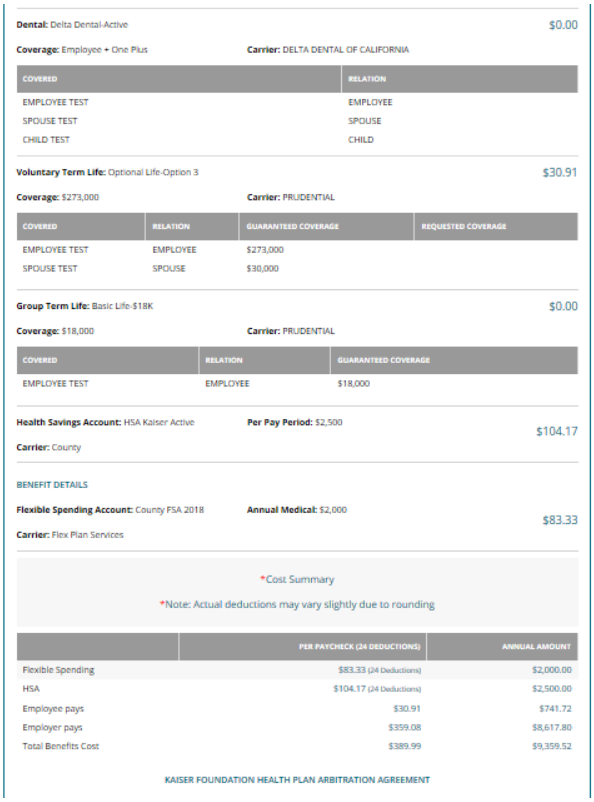
DEPENDENT	RELATION	DOB	AGE	SSN	ADDRESS
SPOUSE TEST	SPOUSE	12/11/1963	53	**-0000	SAME
CHILD TEST	CHILD	7/20/1994	23	**-0000	SAME

CORE BENEFITS SUMMARY

BENEFIT DETAILS — COST PER PAY PERIOD

Medical: Kaiser Permanente High Deductible -Tier A $0.00
Coverage: Employee **Carrier:** KAISER PERMANENTE

COVERED	RELATION
EMPLOYEE TEST	EMPLOYEE



Dental: Delta Dental-Active $0.00
Coverage: Employee + One Plus **Carrier:** DELTA DENTAL OF CALIFORNIA

COVERED	RELATION
EMPLOYEE TEST	EMPLOYEE
SPOUSE TEST	SPOUSE
CHILD TEST	CHILD

Voluntary Term Life: Optional Life-Option 3 $30.91
Coverage: $273,000 **Carrier:** PRUDENTIAL

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

Group Term Life: Basic Life-$18K $0.00
Coverage: $18,000 **Carrier:** PRUDENTIAL

COVERED	RELATION	GUARANTEED COVERAGE
EMPLOYEE TEST	EMPLOYEE	$18,000

Health Savings Account: HSA Kaiser Active **Per Pay Period:** $2,500 $104.17
Carrier: County

BENEFIT DETAILS

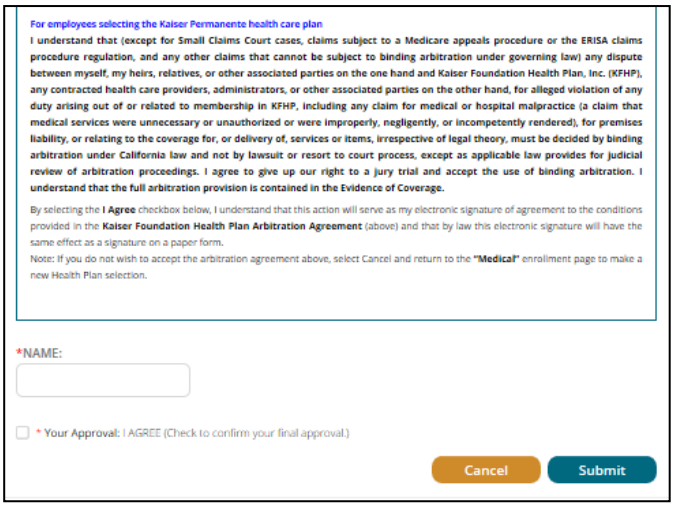
Flexible Spending Account: County FSA 2018 **Annual Medical:** $2,000 $83.33
Carrier: Flex Plan Services

*Cost Summary

*Note: Actual deductions may vary slightly due to rounding

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

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT



For employees selecting the Kaiser Permanente health care plan

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

By selecting the **I Agree** checkbox below, I understand that this action will serve as my electronic signature of agreement to the conditions provided in the **Kaiser Foundation Health Plan Arbitration Agreement** (above) and that by law this electronic signature will have the same effect as a signature on a paper form.
Note: If you do not wish to accept the arbitration agreement above, select Cancel and return to the **"Medical"** enrollment page to make a new Health Plan selection.

*NAME:

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

Cancel Submit

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

NOTE:* If you added dependents or waived medical coverage, <u>your enrollment is not complete until you provide documentation</u>** *(birth certificates for children, marriage certificate, proof of other coverage, etc.)* ***by 5:00 pm on November 3, 2023. *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.**

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 27th**.

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.gov **Fax:** 916-874-4621