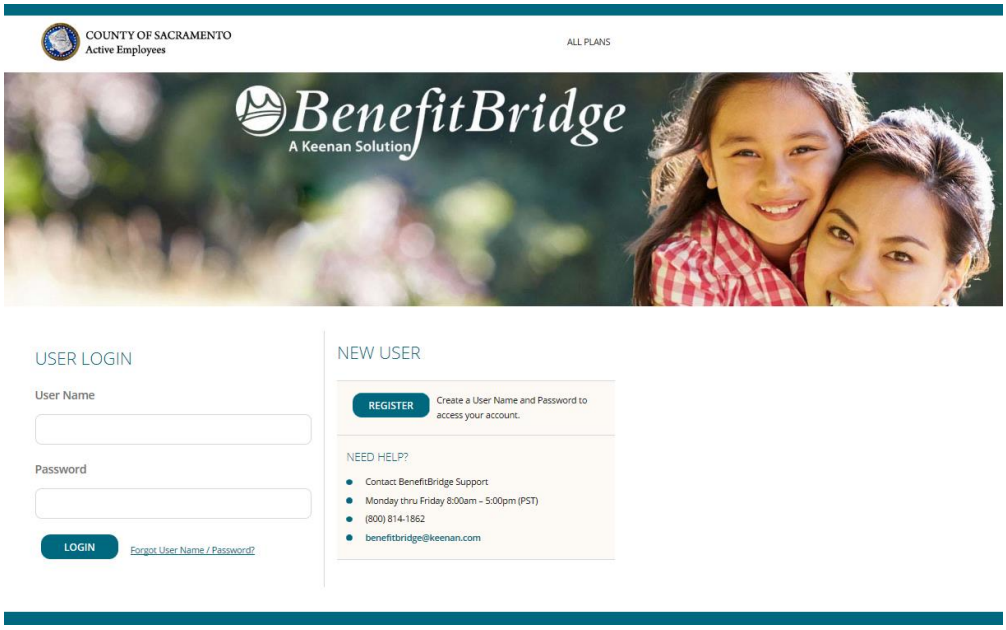
SACRAMENTO COUNTY

# Making Changes to your Life Insurance

These instructions will help you navigate through BenefitBridge in making your changes to your Life Insurance or Critical Illness coverage.



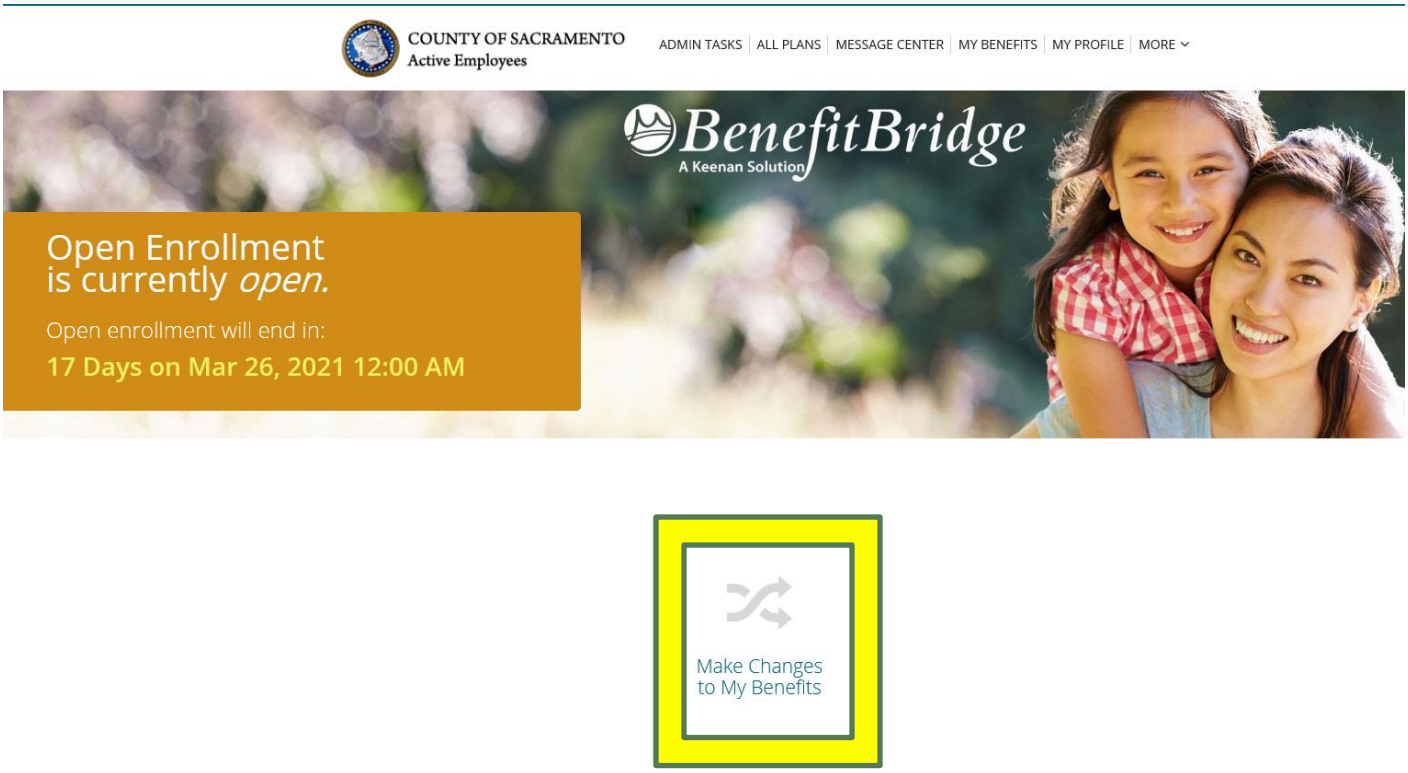

For coverage effective in

## April 2021

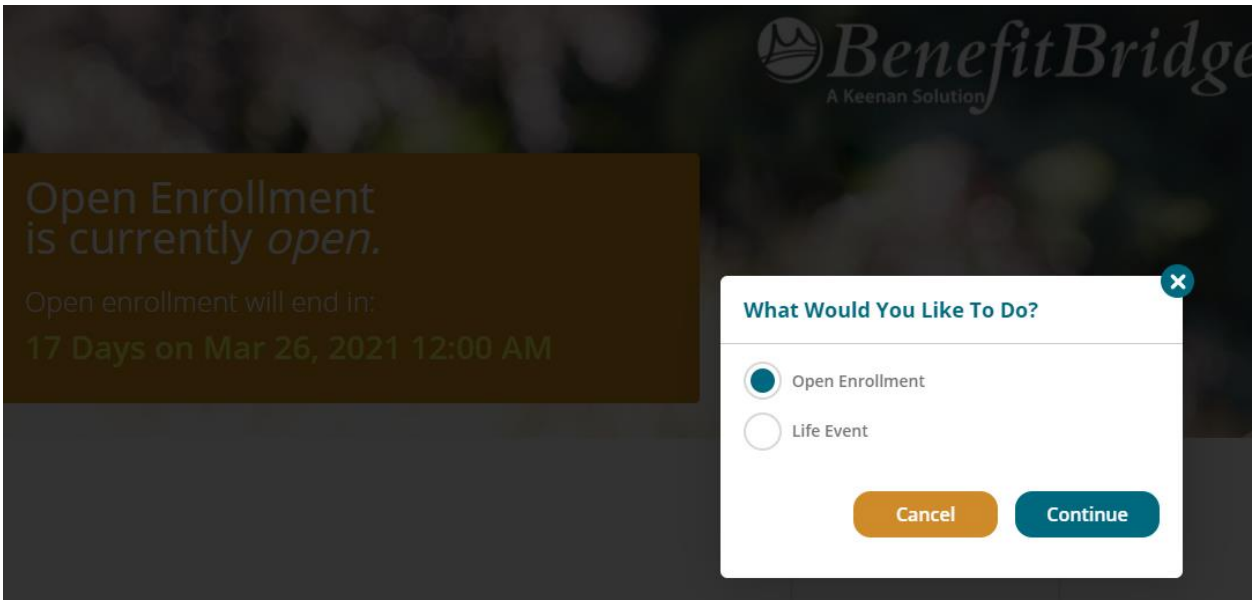
Start by navigating to the website at www.benefitbridge.com/saccounty

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

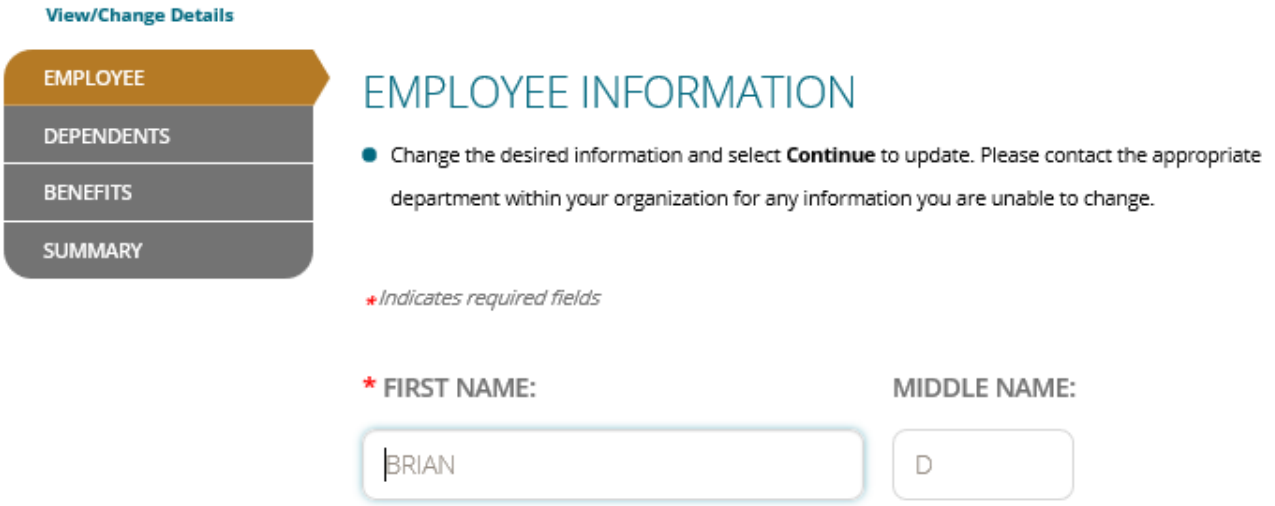

Once you have logged on, close the pop up window by clicking on the "X" in the top corner. You then will click Make Changes to My Benefits , highlighted below, to make changes.



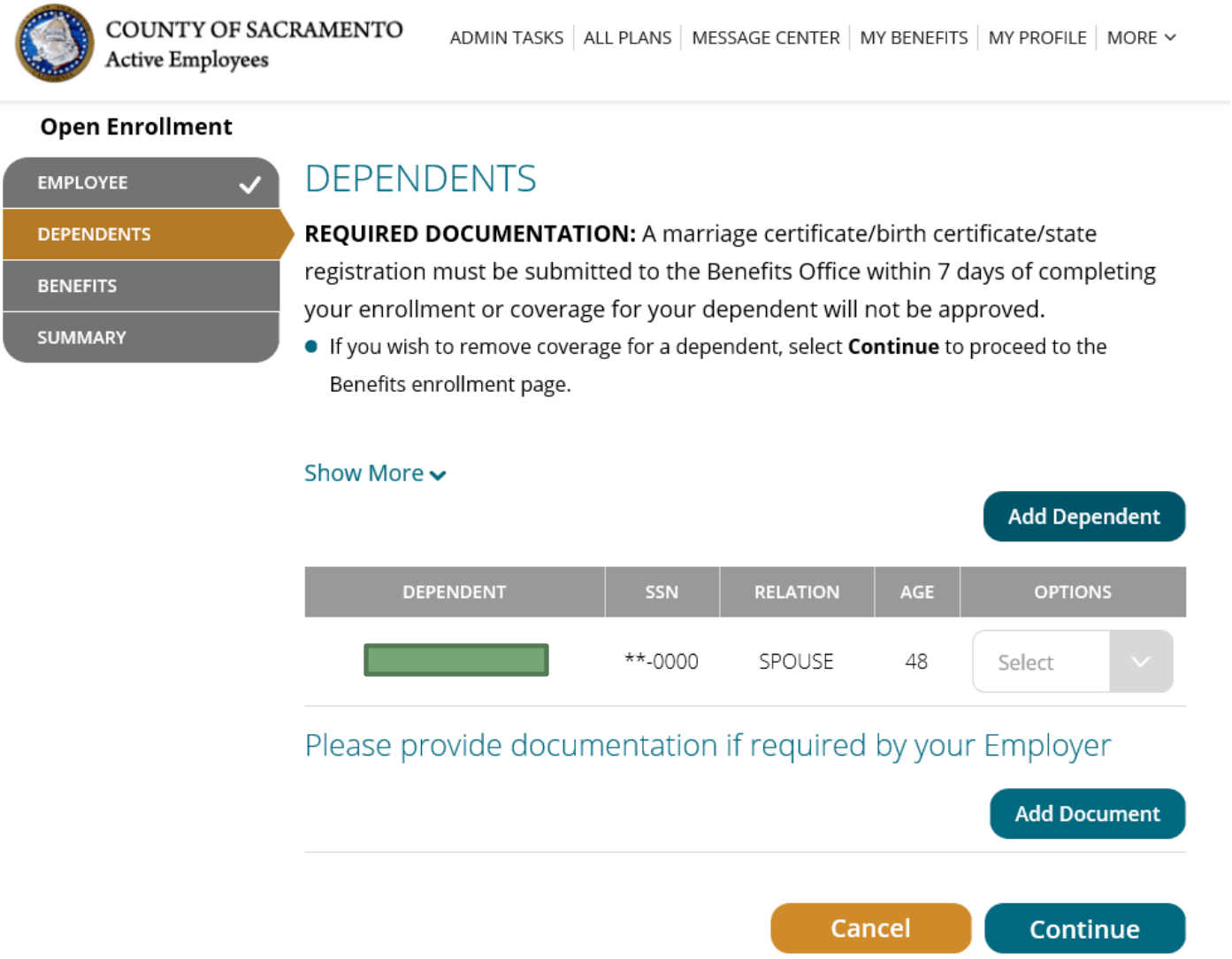
**Then, select OPEN ENROLLMENT in the pop up window. Then, hit continue.**




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



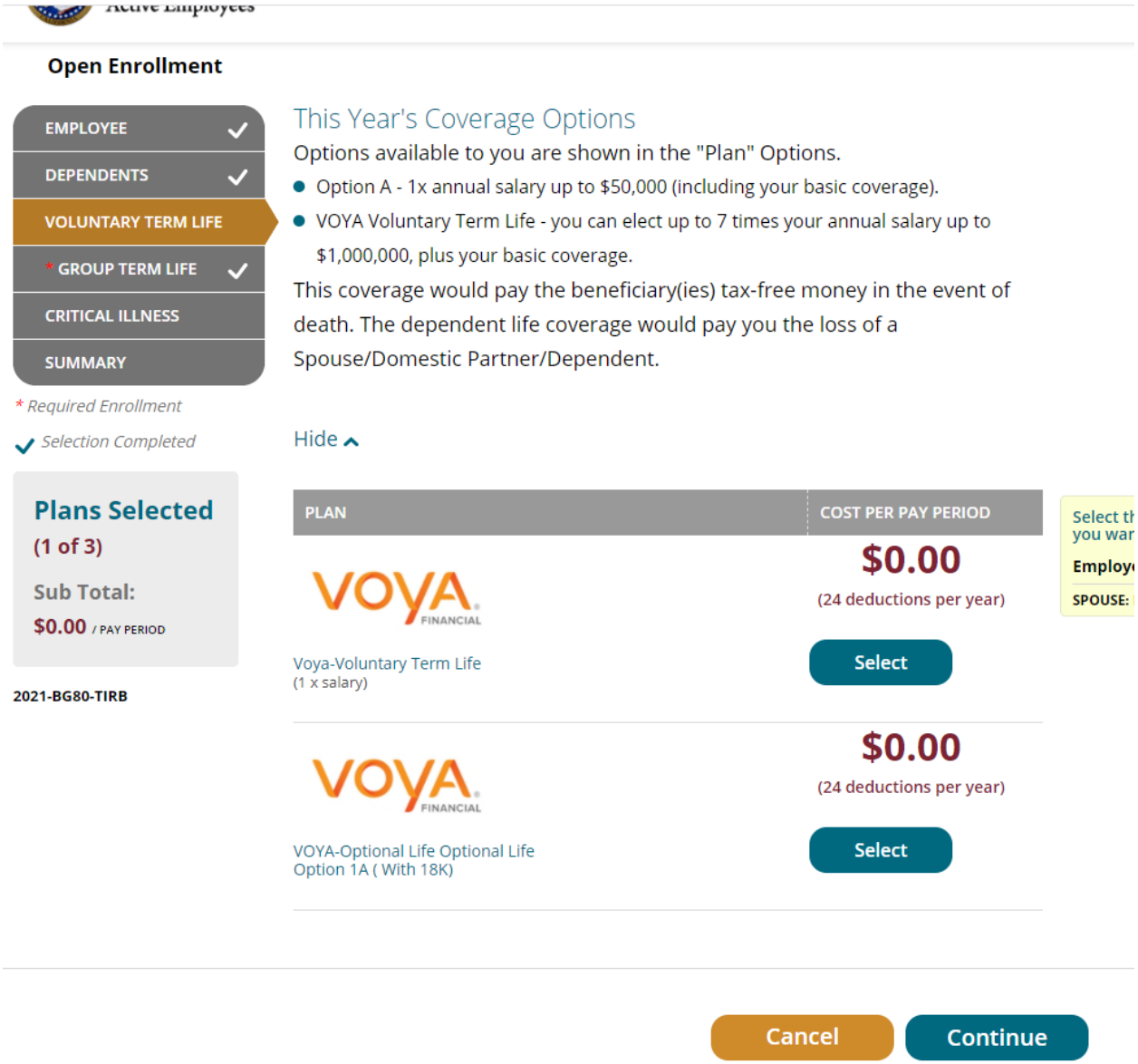

**At the bottom of the screen is a "Continue" button. Please hit continue, and you will be taken to the DEPENDENTS page.**



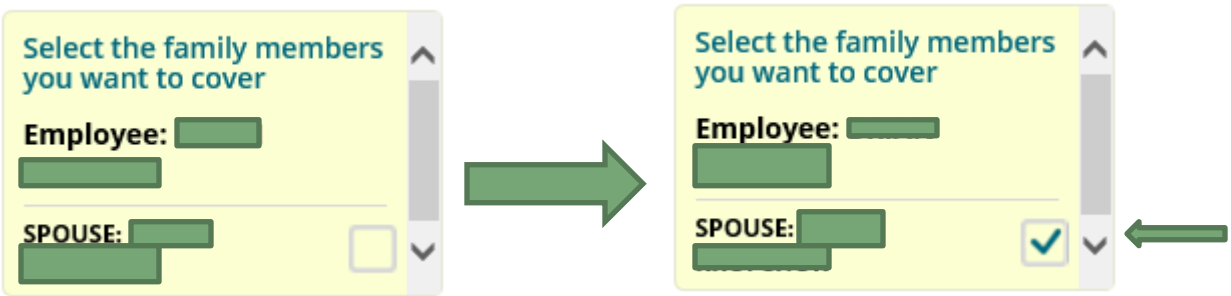

**NOTE: You must add a spouse/domestic partner or children here in order to be able to enroll them. If they are not listed here, you will not be able to add coverage to them. You do need to provide documentation to complete enrollment or coverage. You do *not* need to provide documentation if only listing them as a beneficiary.**

**Once you are done, hit continue**.

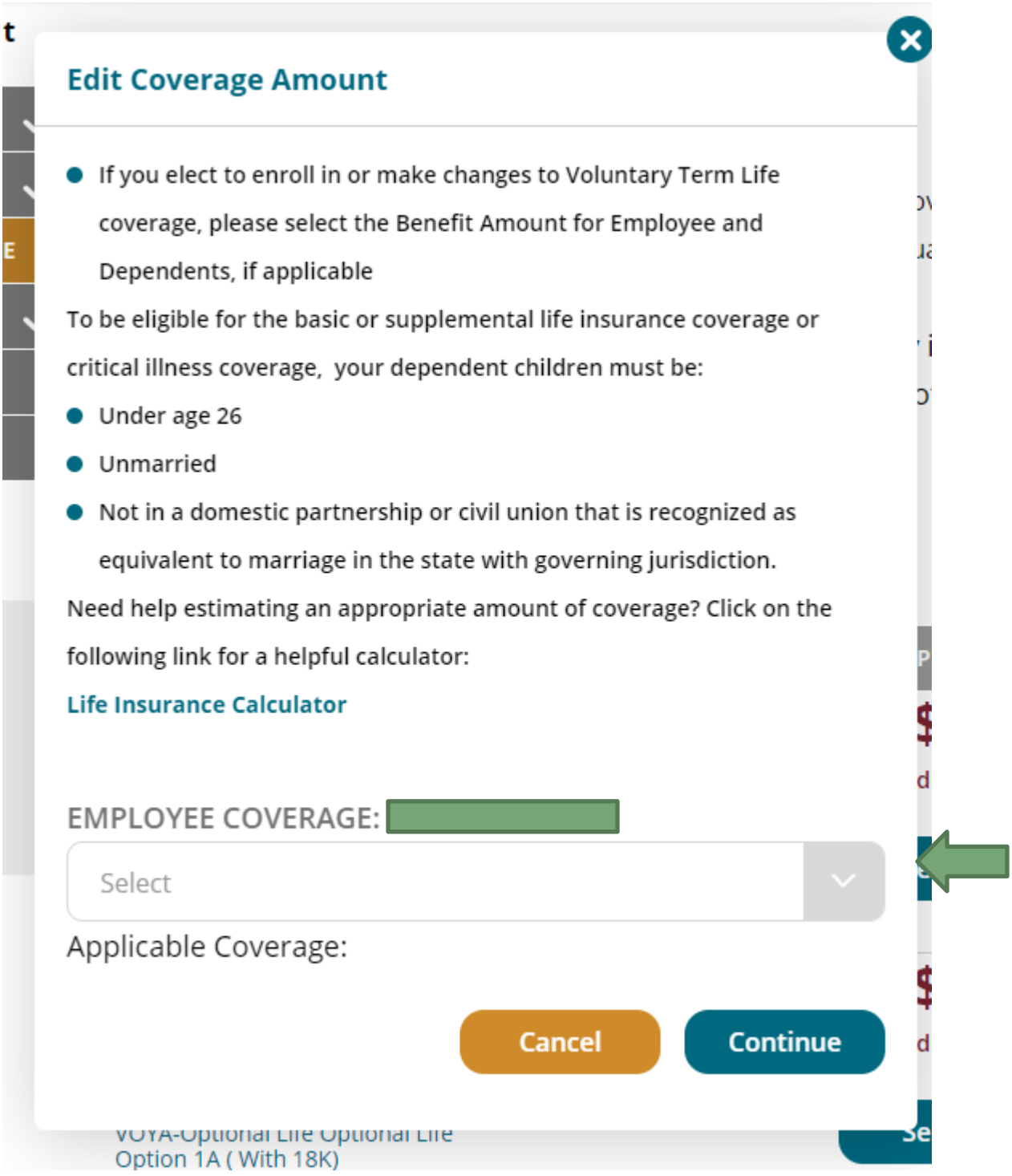
You will then be brought to the Voluntary Term Life page.




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.



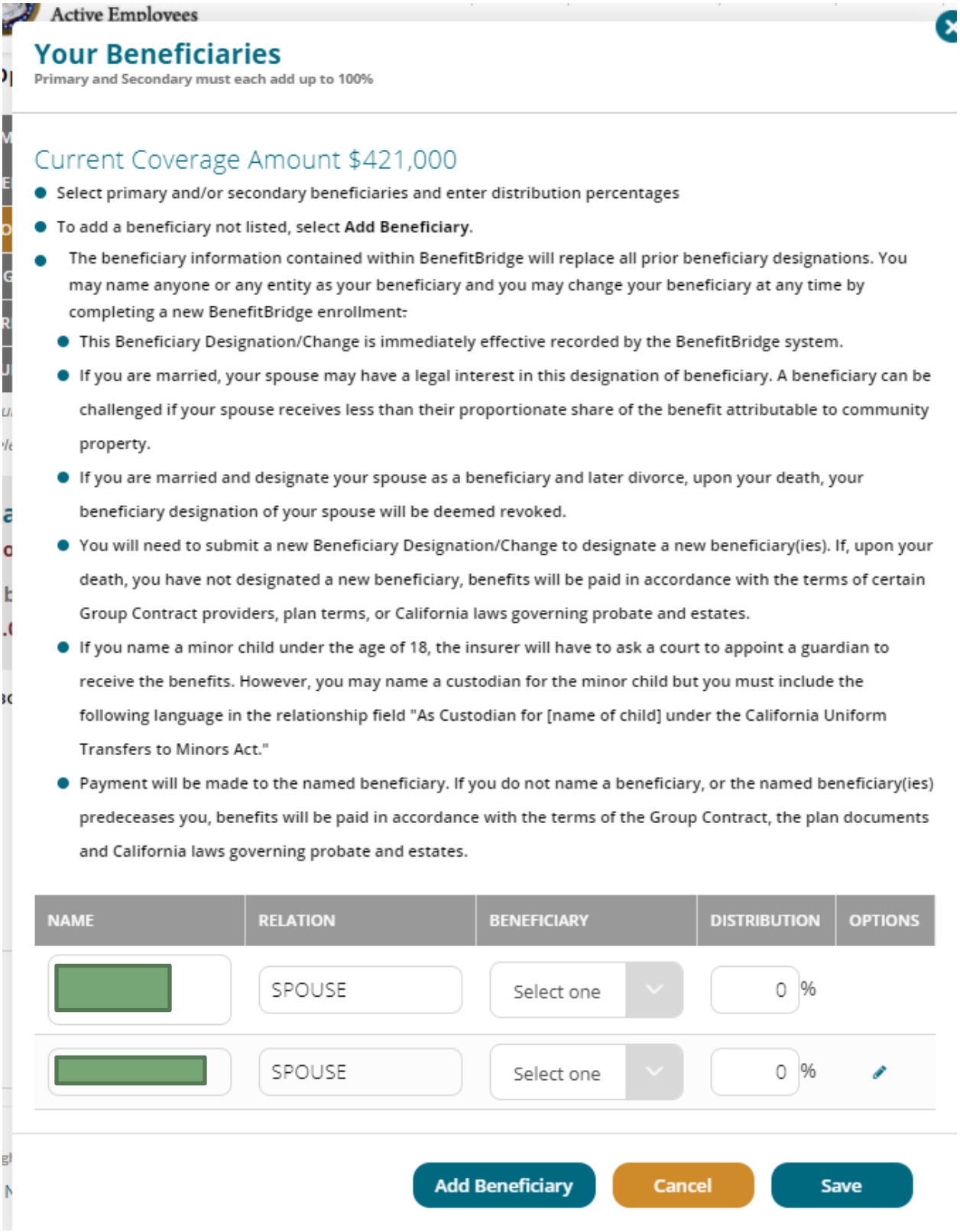
For more information on the different options, please refer to the Voya website *https://presents.voya.com/EBRC/saccounty* or contact the Employee Benefits Office. Once you hit "select", a new window will pop up for you to make changes.




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.

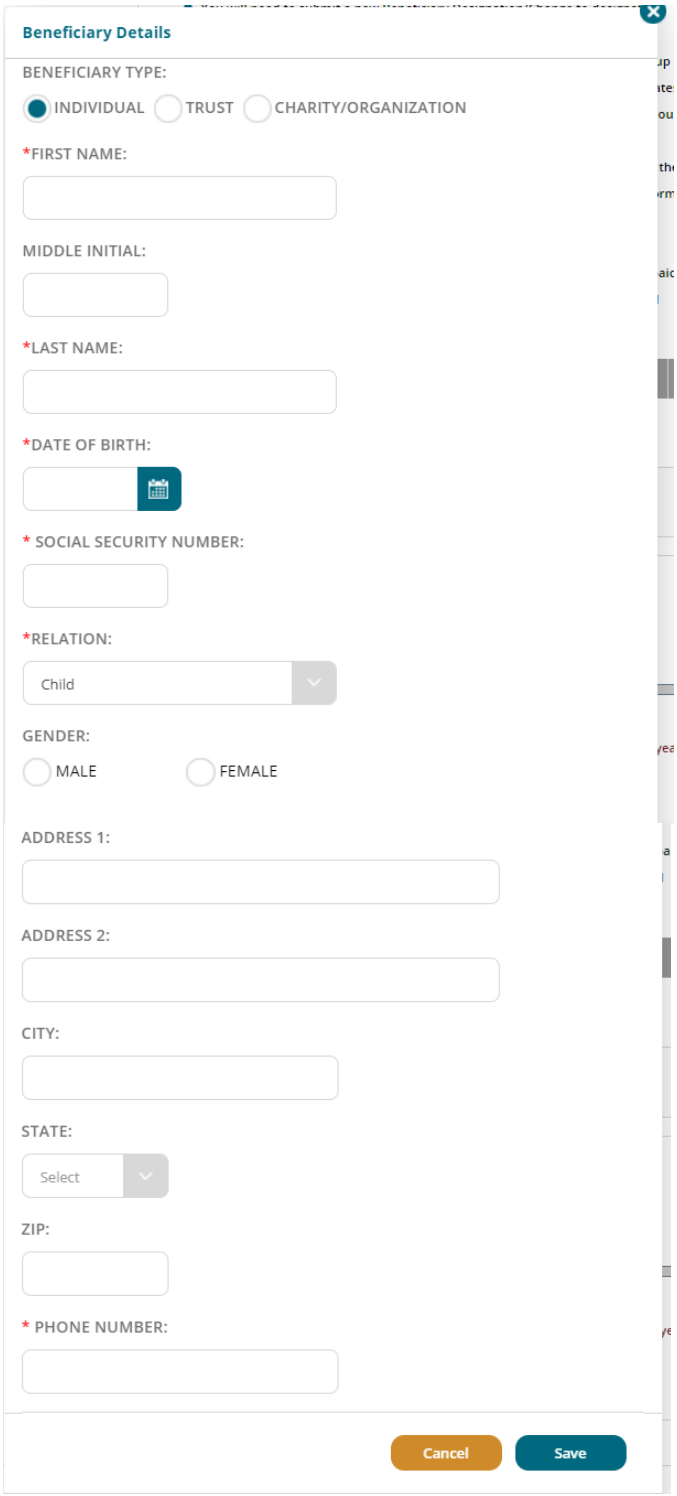
Once you are done, hit continue.

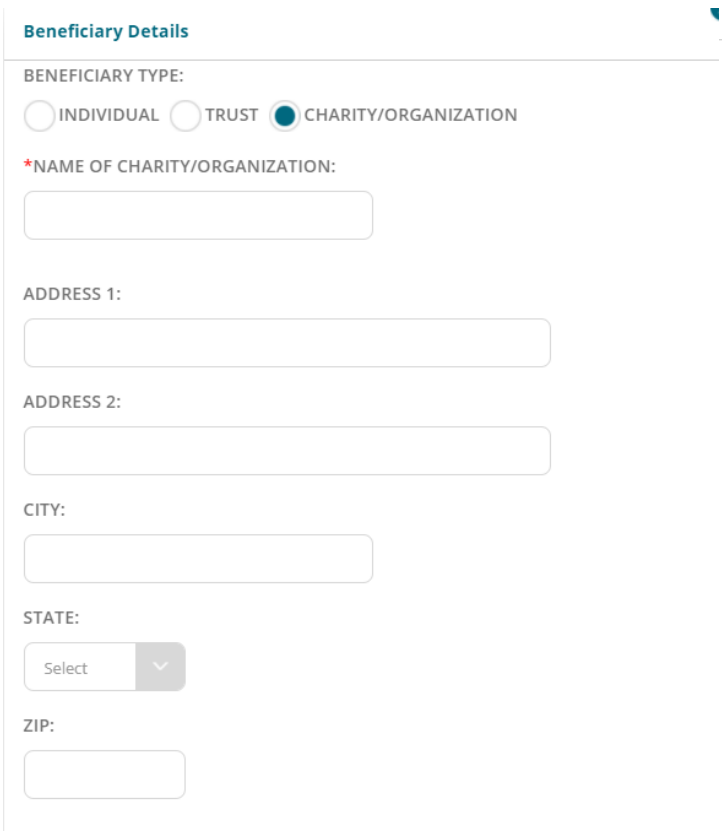
You will then be asked to designate your beneficiaries. You may see beneficiaries listed that are no longer valid. While you can't delete them, just set them to "0" in the distribution and they will not be considered a beneficiary.

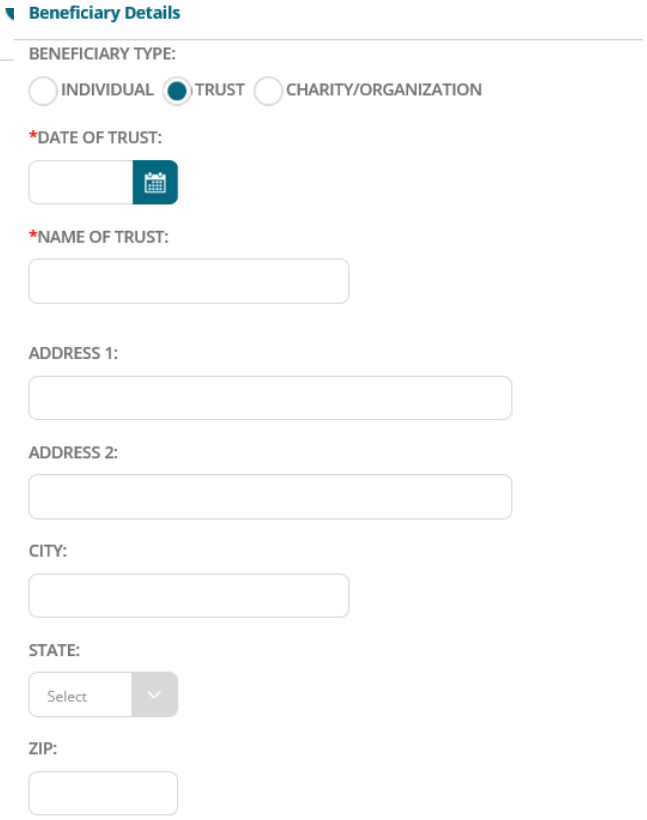


If they are already listed, just change the "beneficiary" drop down to "Primary" and enter 100 into the "distribution" column. If you have more than one person as a beneficiary, you will mark them as Primary and then enter the percentage you want them to receive. All primary beneficiaries must 100% between them.

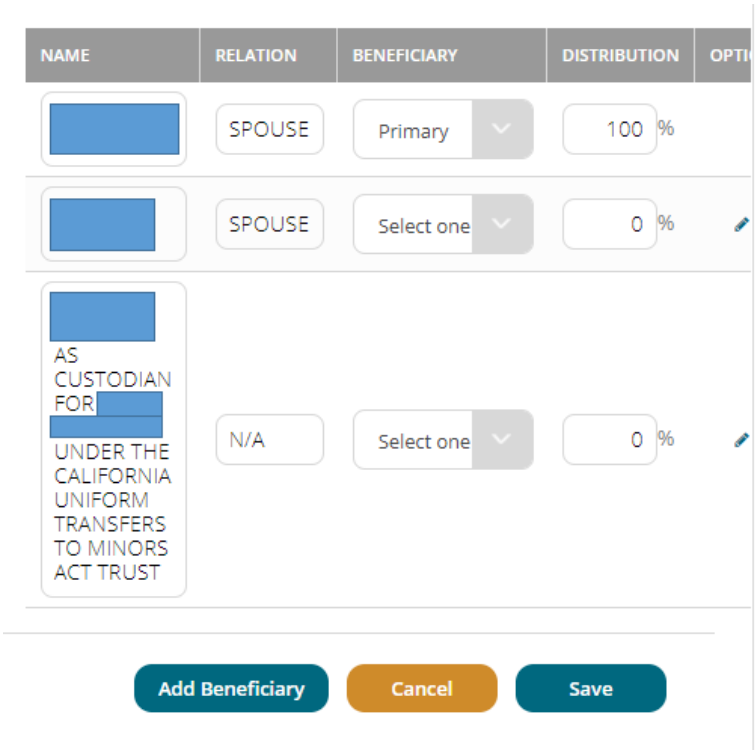
If you need to add them, just select the "Add Beneficiary" button. You can have an individual, a trust, or a charity as a beneficiary. You will then need to enter the information for them:






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.**

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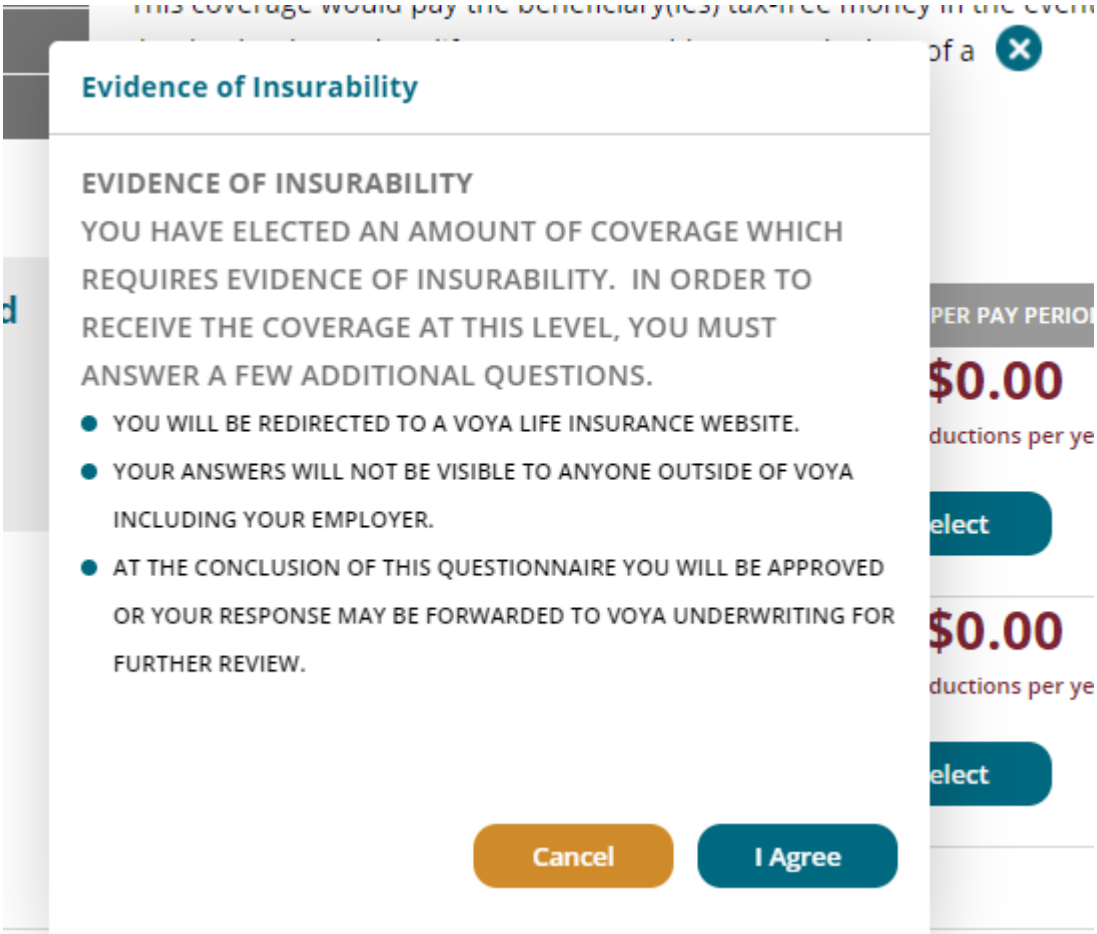
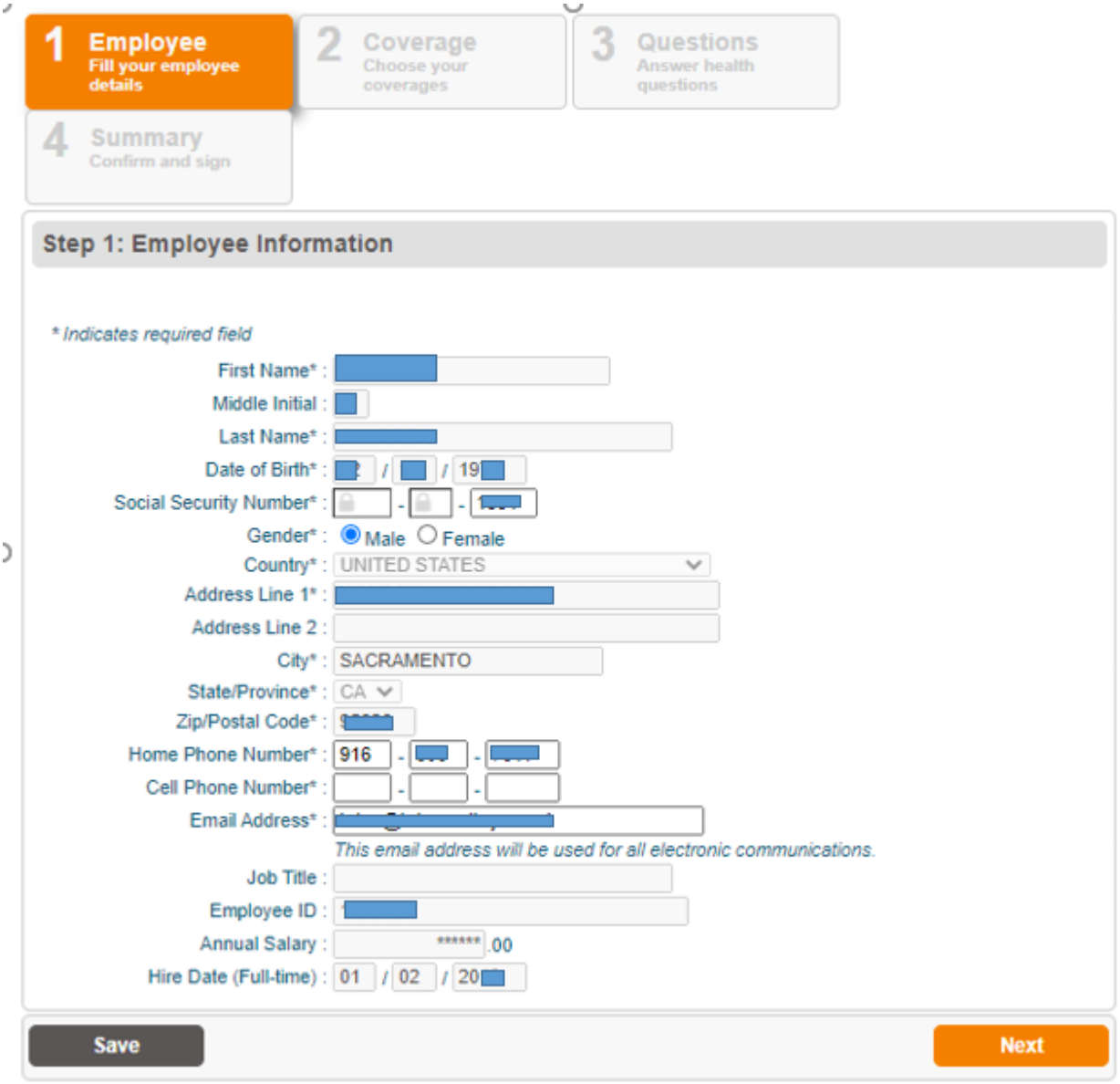
**When you have entered all of the information and selected your primary beneficiary(s), hit "Save"**

**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:**

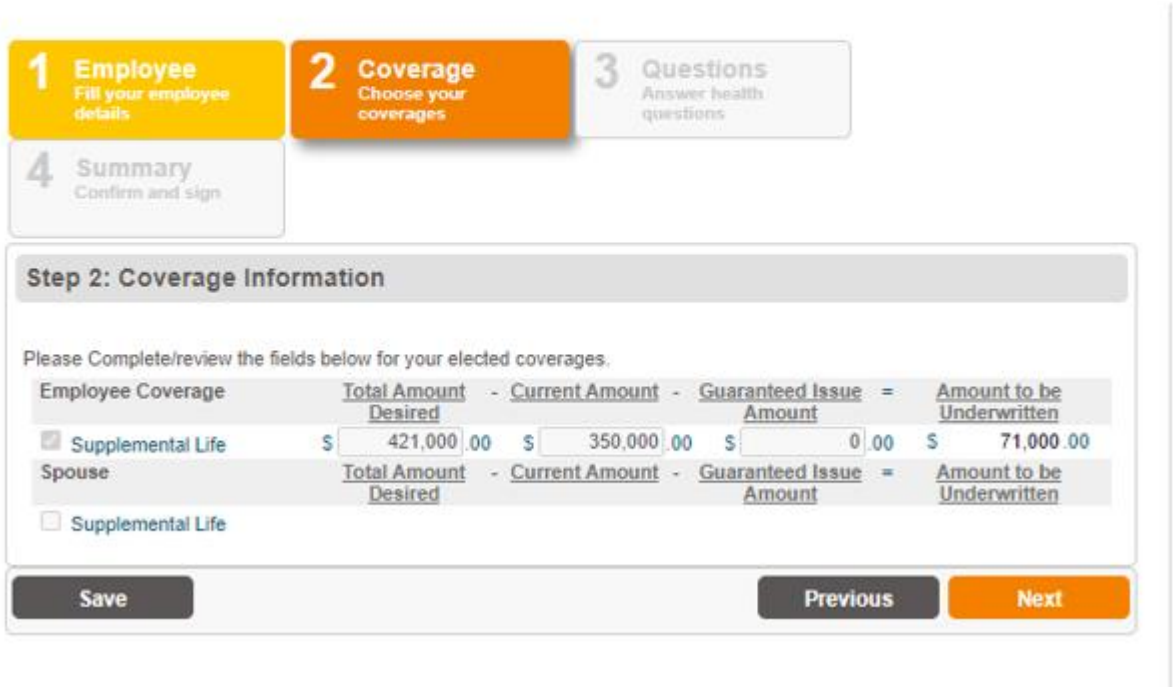



**It will be pre-populated with your information. Just verify the information and then hit the "next" button.**

**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] | | | | | | ☐ |

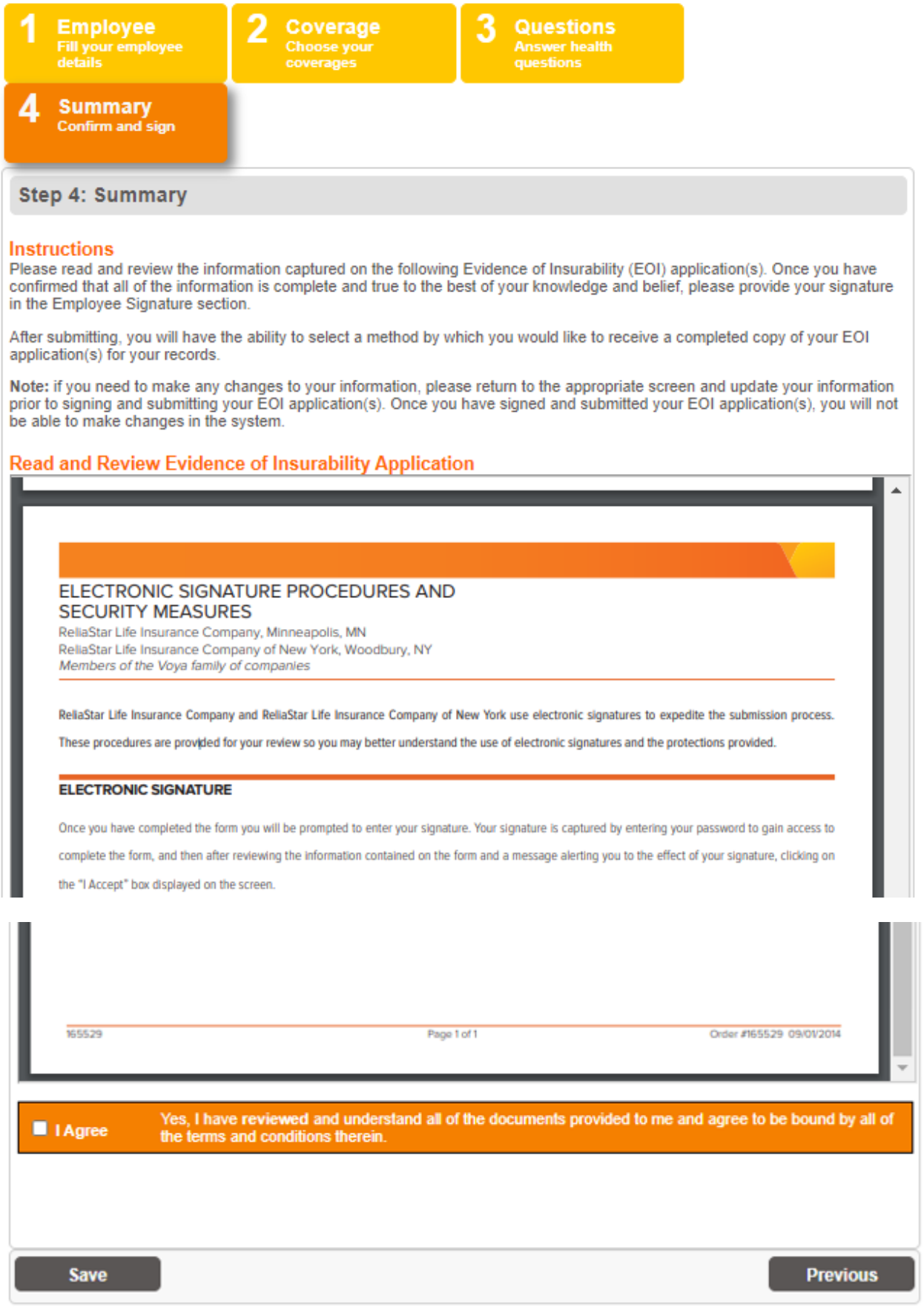
EMPLOYEE HEALTH QUESTIONS — Employee (EE)

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

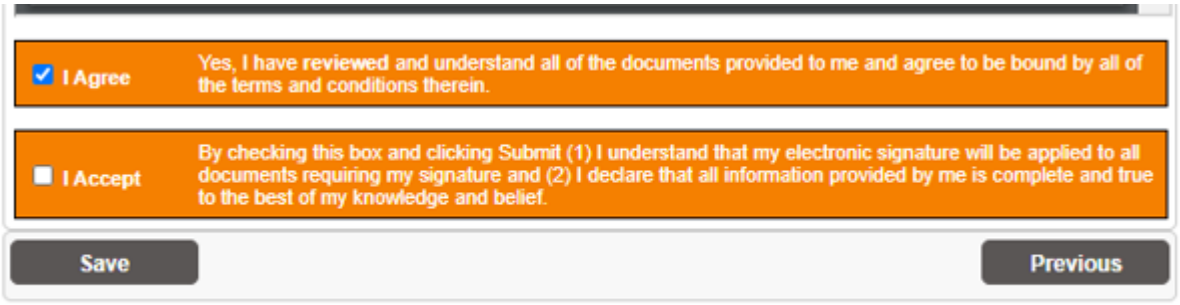
1. Within the last 5 years have you been treated for or been diagnosed by a member of the medical profession or health practitioner as having AIDS (Acquired Immunodeficiency Syndrome)? ○ Yes ○ No
2. Within the last 5 years have you been treated for, any of the following: Insulin dependent diabetes, heart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

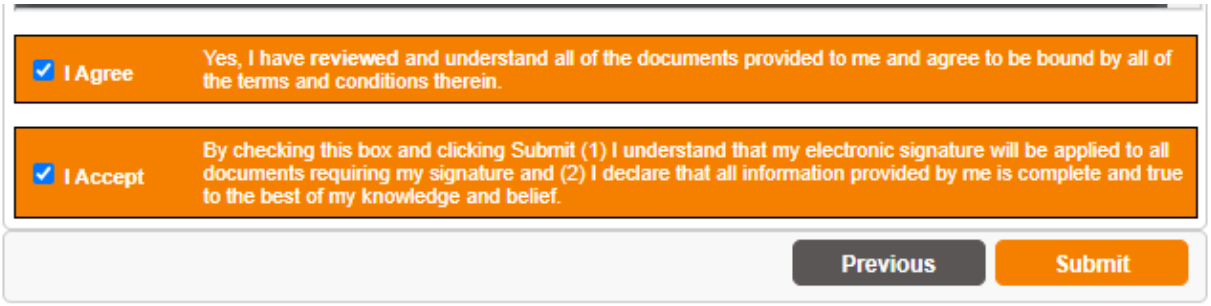
**Answer the questions and then hit the "next" button. You will then be taken to the summary page, and you will need to scroll down.**




**Click on the "I Agree" check box.**

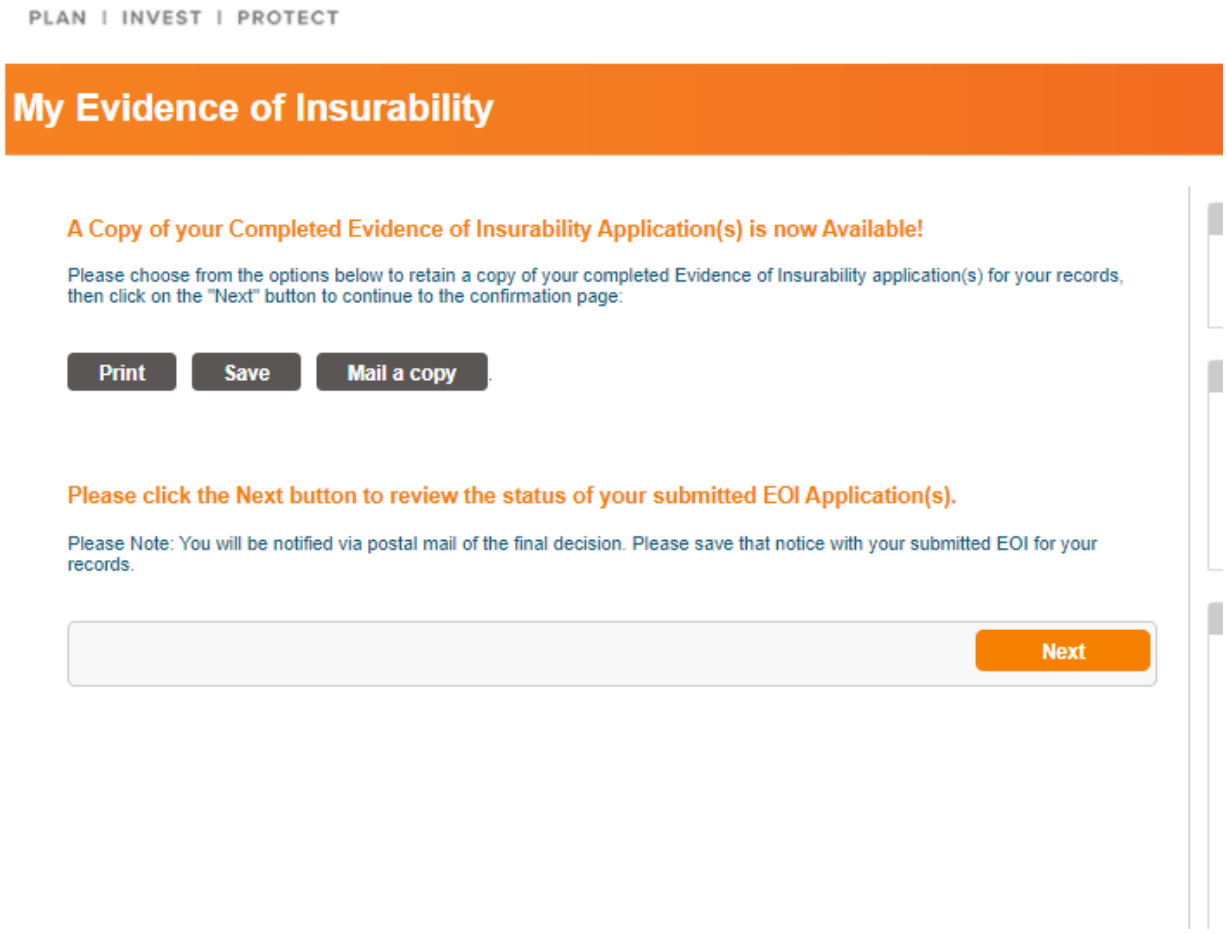



**You will then click on the "I Accept" box.**

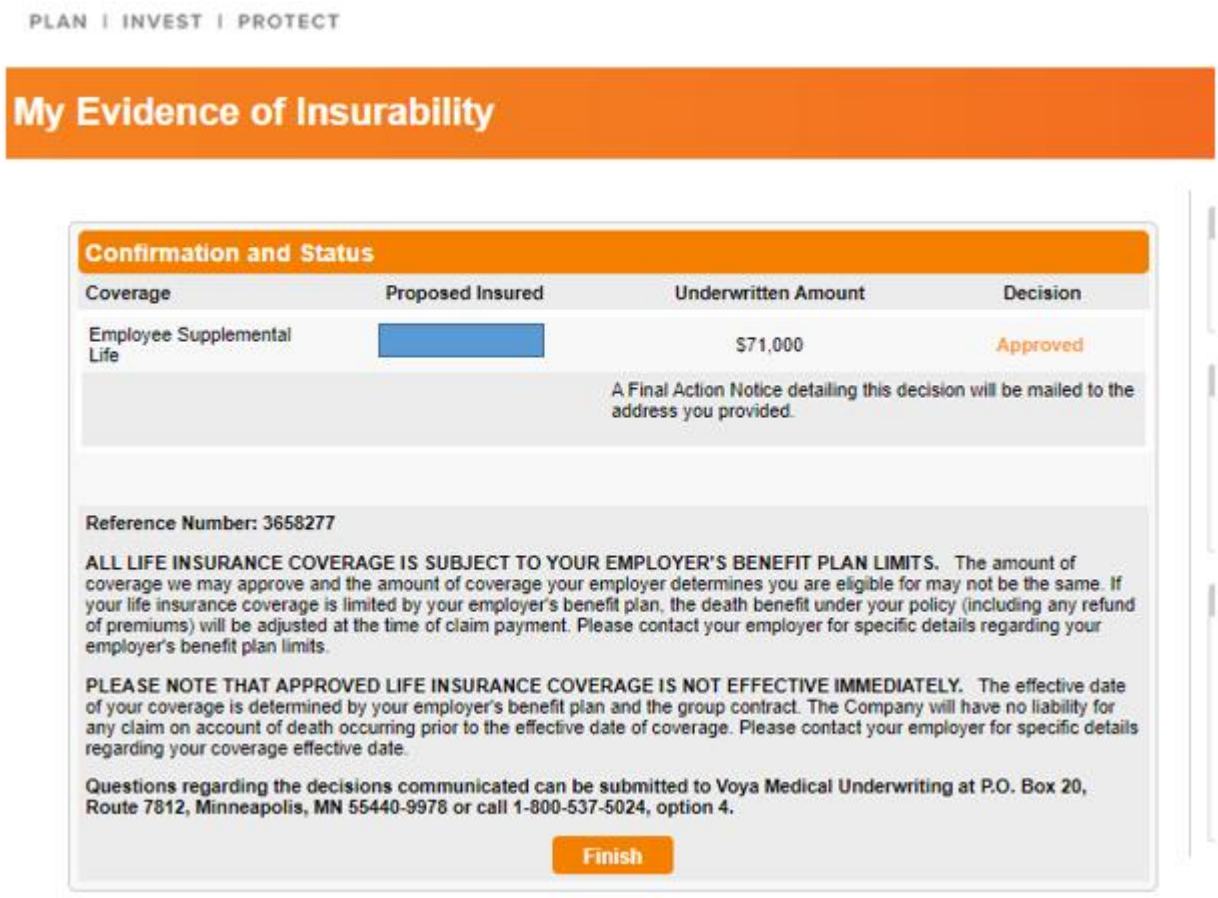



**Once you've done that, you'll have the option to submit your questionnaire. Hit "Submit"**

**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".**

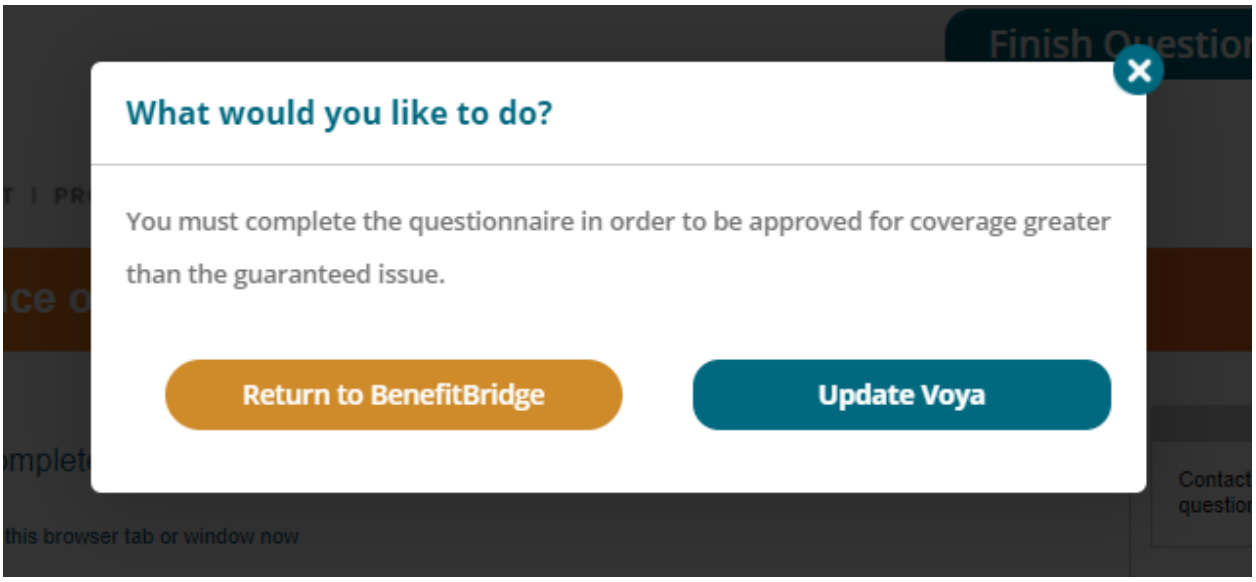



**The last screen will let you know if you are approved, or if more information is needed. Once you have reviewed this screen, hit "Finish".**




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

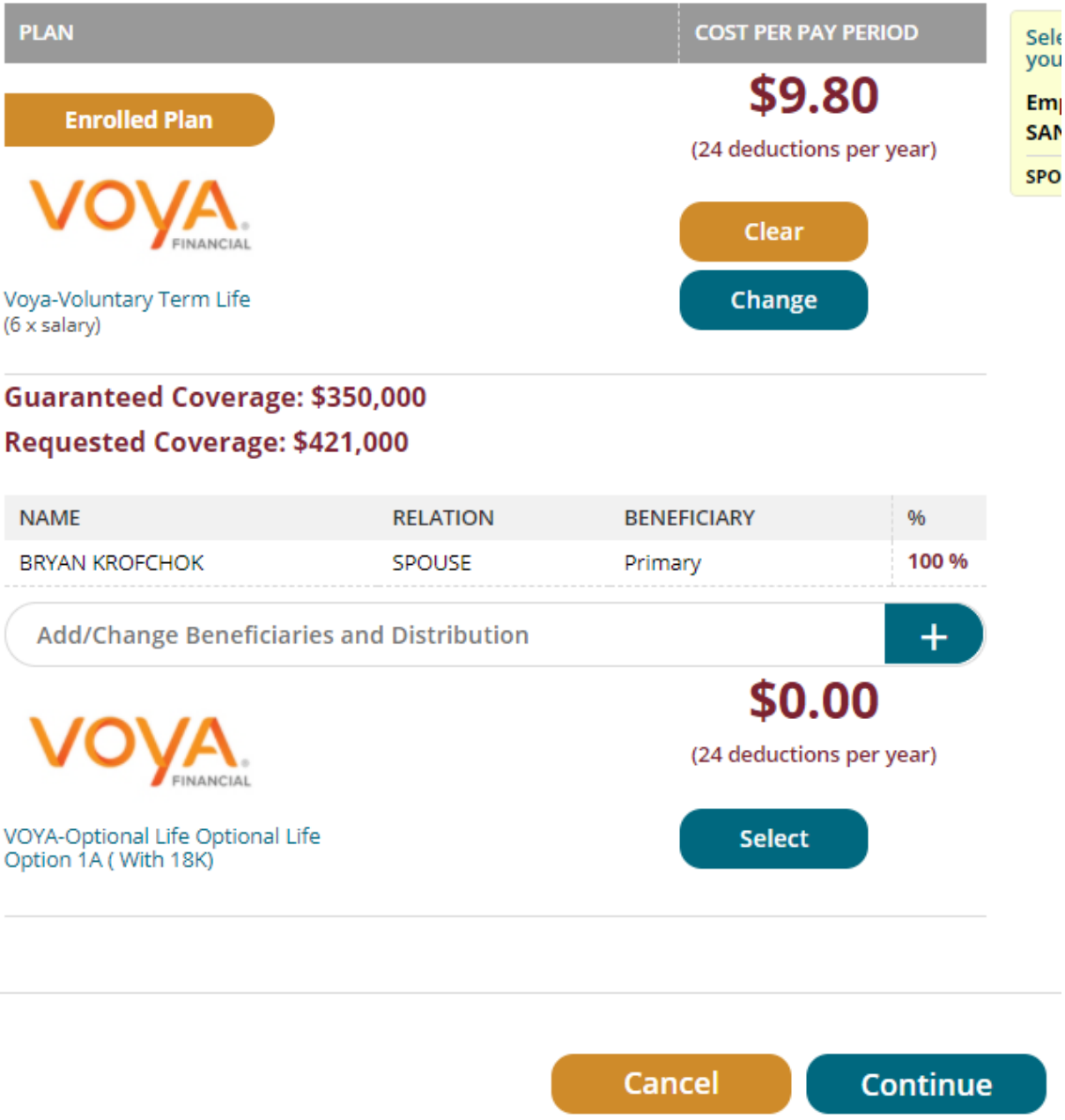
**A pop up window will ask if you want to return to BenefitBridge. Select this option.**




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

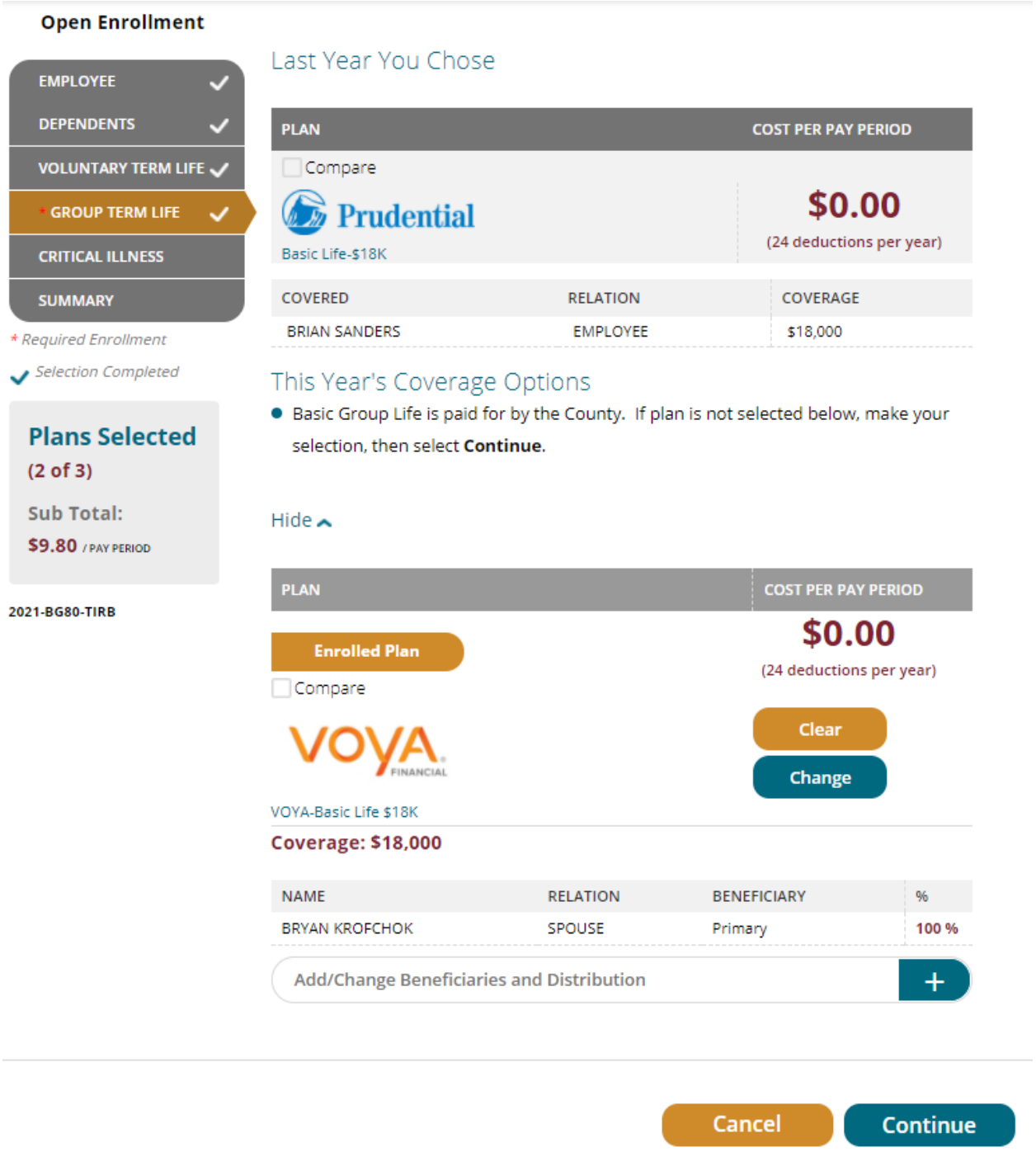
**NOTE: If you are insuring a Spouse/Domestic Partner for more than the guaranteed amount, they will have to fill out their own Evidence of Insurability (EOI) questionnaire. Once you have submitted your request for coverage, a separate email will be sent to you containing the link to the Spouse EOI.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

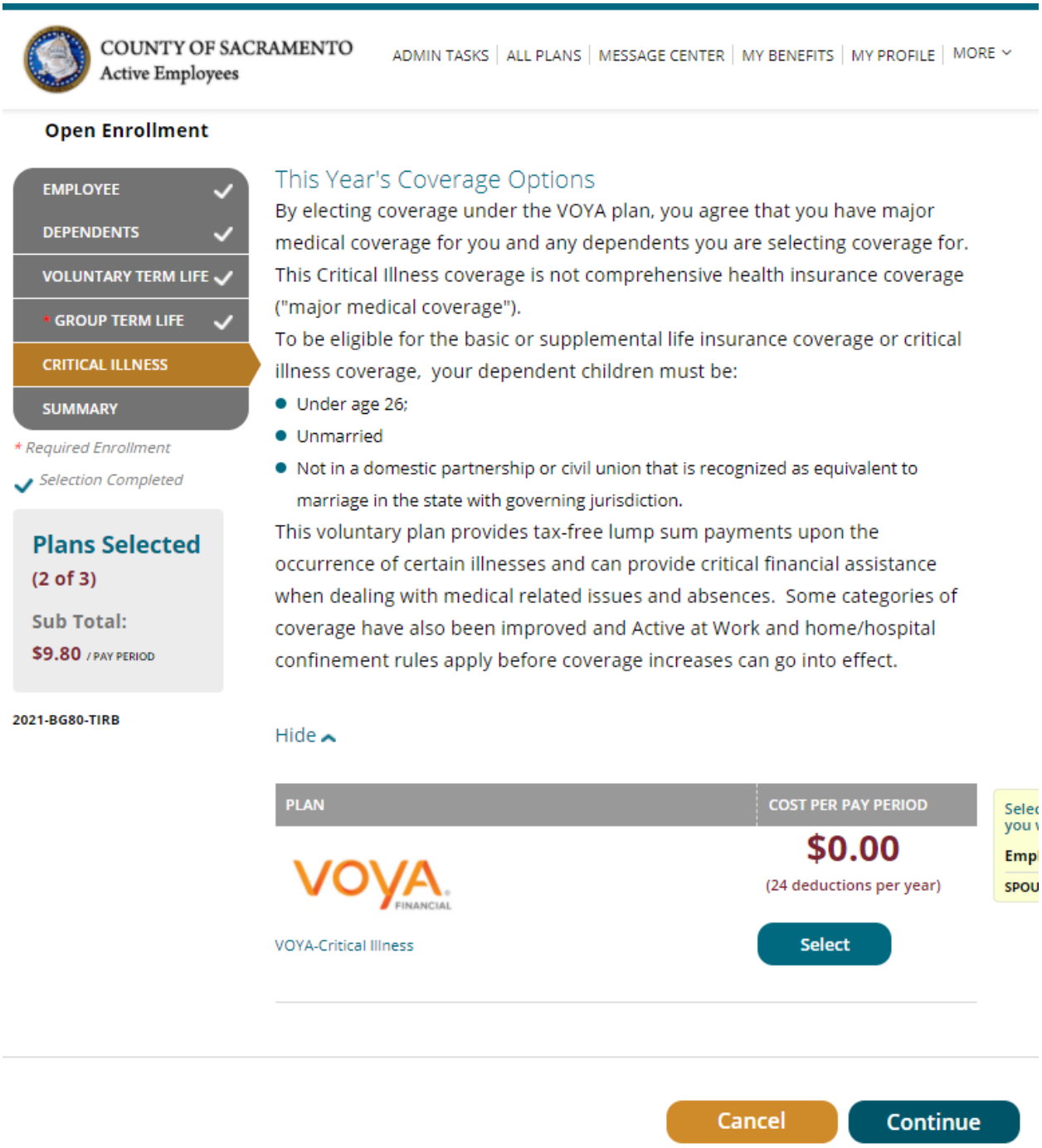



**Hit continue.**

**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 Critical Illness, and you can make any changes you want your election changes.**

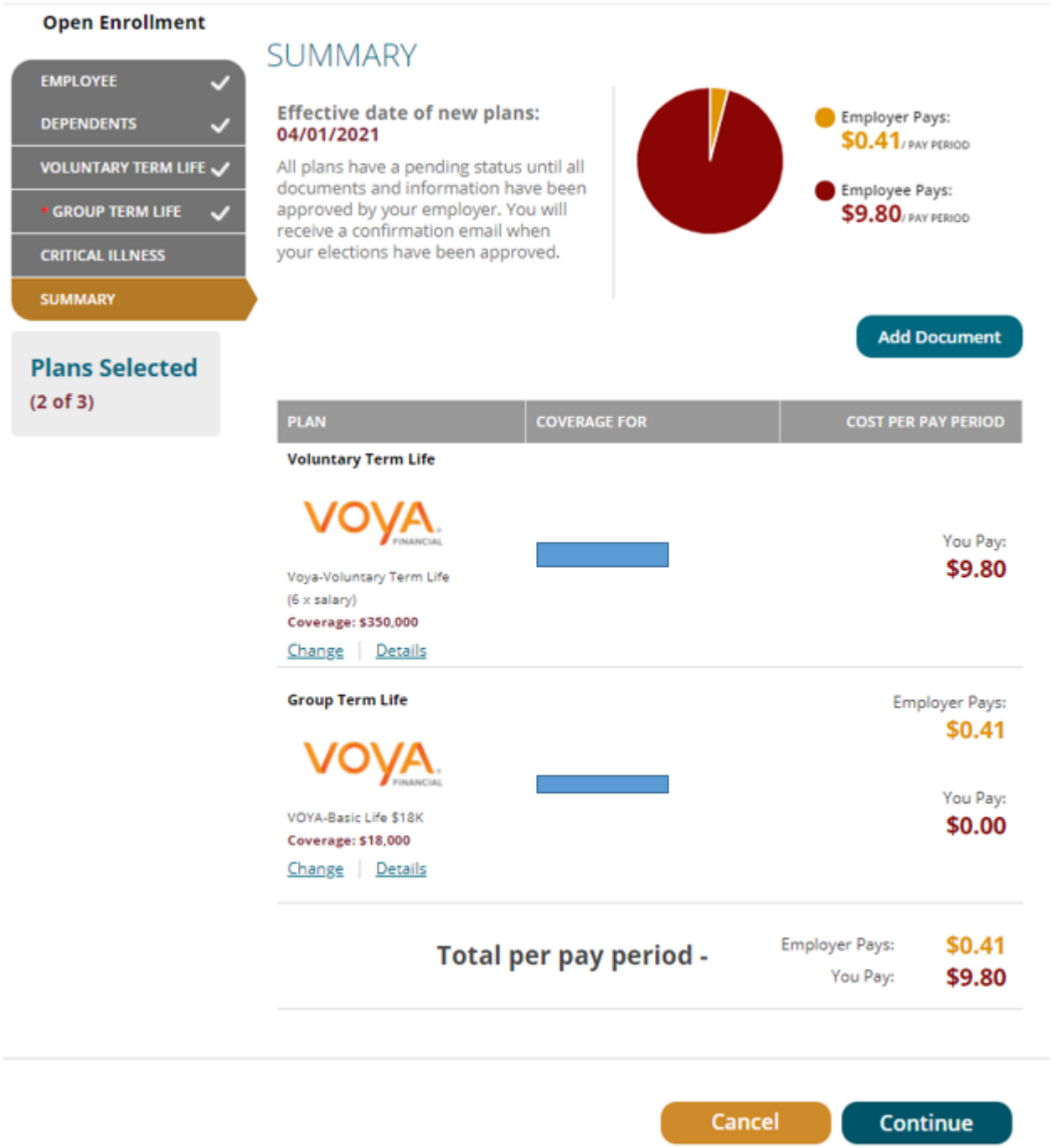



**The process will be the same as with the Voluntary Life Insurance.**

**Once you are all done, hit continue.**

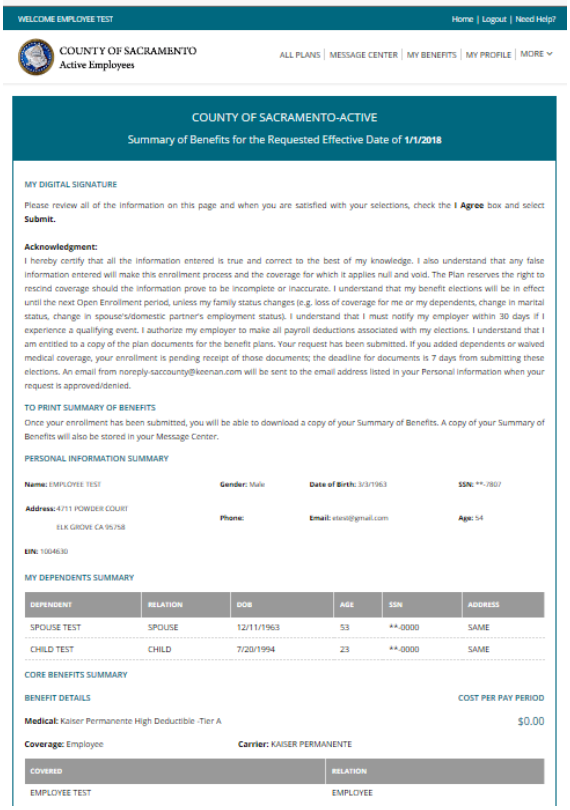
**You're almost finished. You will now see a summary page of the changes and the costs for your life insurance.**

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




**Once you have had a chance to review everything and it is correct, hit the "Continue" button.**

**You will then be taken to the final summary page. If the selections reflect the coverage you want, type in your name, check the "Your Approval: I AGREE" box, and then click "Submit".**



WELCOME EMPLOYEE TEST — Home | Logout | Need Help?

COUNTY OF SACRAMENTO
Active Employees

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

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

MY DIGITAL SIGNATURE

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

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

TO PRINT SUMMARY OF BENEFITS

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

PERSONAL INFORMATION SUMMARY

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

MY DEPENDENTS SUMMARY

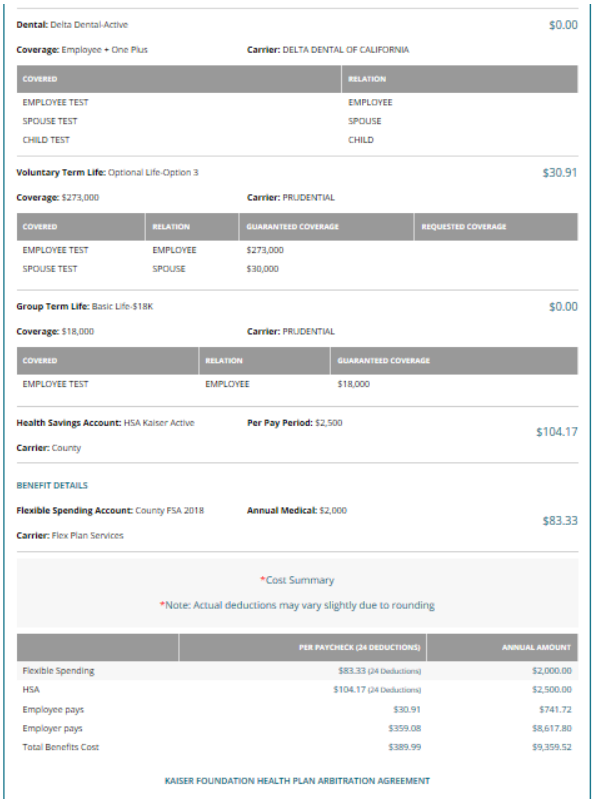
| DEPENDENT | RELATION | DOB | AGE | SSN | ADDRESS |
|---|---|---|---|---|---|
| SPOUSE TEST | SPOUSE | 12/11/1963 | 53 | **-0000 | SAME |
| CHILD TEST | CHILD | 7/20/1994 | 23 | **-0000 | SAME |

CORE BENEFITS SUMMARY

BENEFIT DETAILS — COST PER PAY PERIOD

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

| COVERED | RELATION |
|---|---|
| EMPLOYEE TEST | EMPLOYEE |



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

| COVERED | RELATION |
|---|---|
| EMPLOYEE TEST | EMPLOYEE |
| SPOUSE TEST | SPOUSE |
| CHILD TEST | CHILD |

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

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

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

| COVERED | RELATION | GUARANTEED COVERAGE |
|---|---|---|
| EMPLOYEE TEST | EMPLOYEE | $18,000 |

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

BENEFIT DETAILS

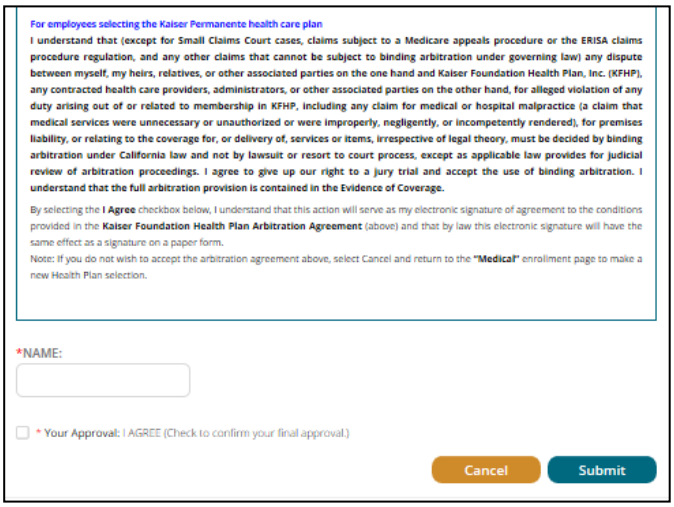
**Flexible Spending Account:** County FSA 2018 **Annual Medical:** $2,000 — $83.33
**Carrier:** Flex Plan Services

*Cost Summary

*Note: Actual deductions may vary slightly due to rounding

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

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT



For employees selecting the Kaiser Permanente health care plan

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

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

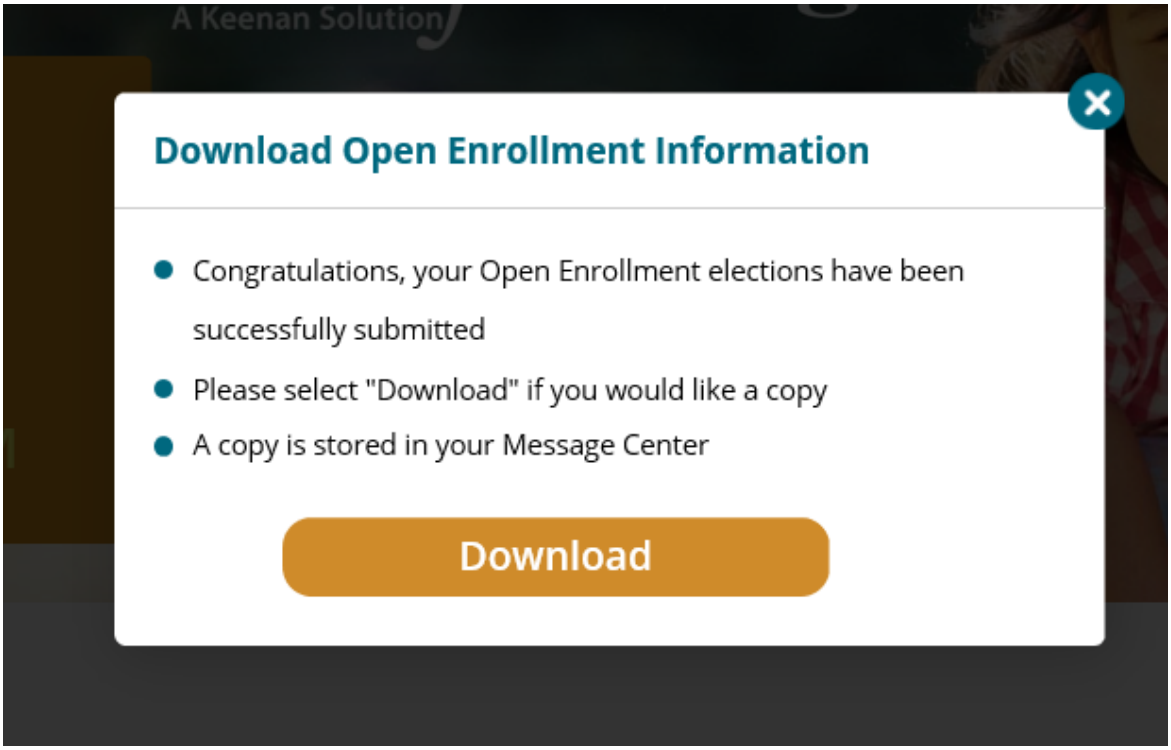
*NAME:

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

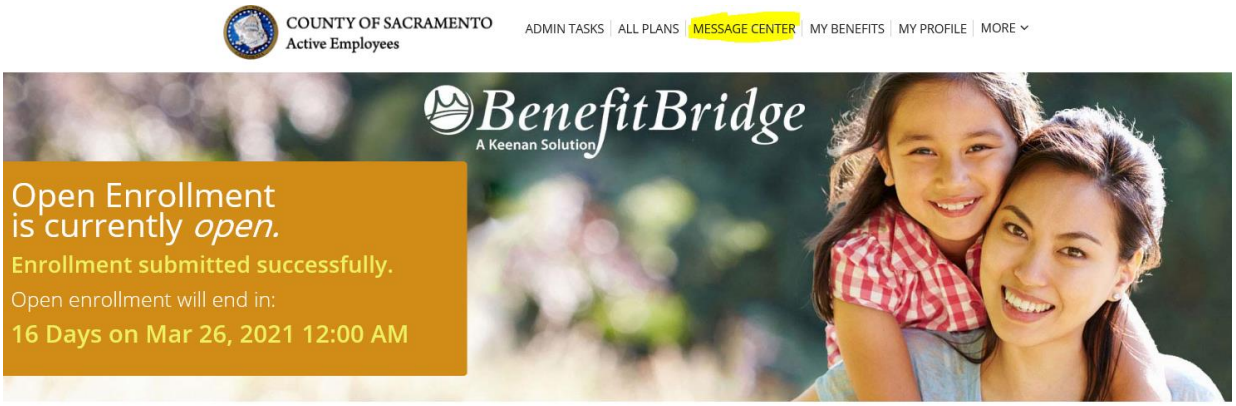
Cancel Submit

**Important Reminder: Your enrollment request is not complete until you get to the Summary tab at the end of your enrollment, check the "Your Approval: I agree" box and click the "SUBMIT" button to complete your Open Enrollment request. All Changes are irrevocable will take effect the 1st of April, 2021.**

Note:  You will receive a below pop-up screen if you wish to download your submission to your beneficiary or CI/ Life changes you submitted.  If you select download  a copy of your submission of your changes, it will be stored in the Message Center and you now have record of your submission and can review to ensure you made all your changes for open enrollment  to be effective 4/1/2021:




You can always log on later and select Message Center to review a record stored to your changes.



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