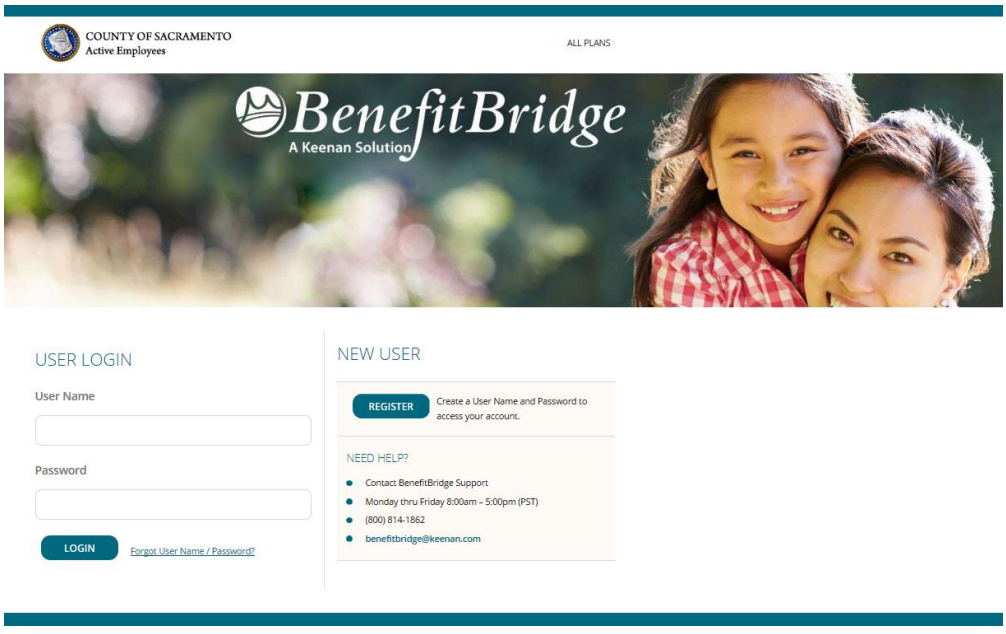
SACRAMENTO COUNTY

# LIFE EVENT INSTRUCTIONS

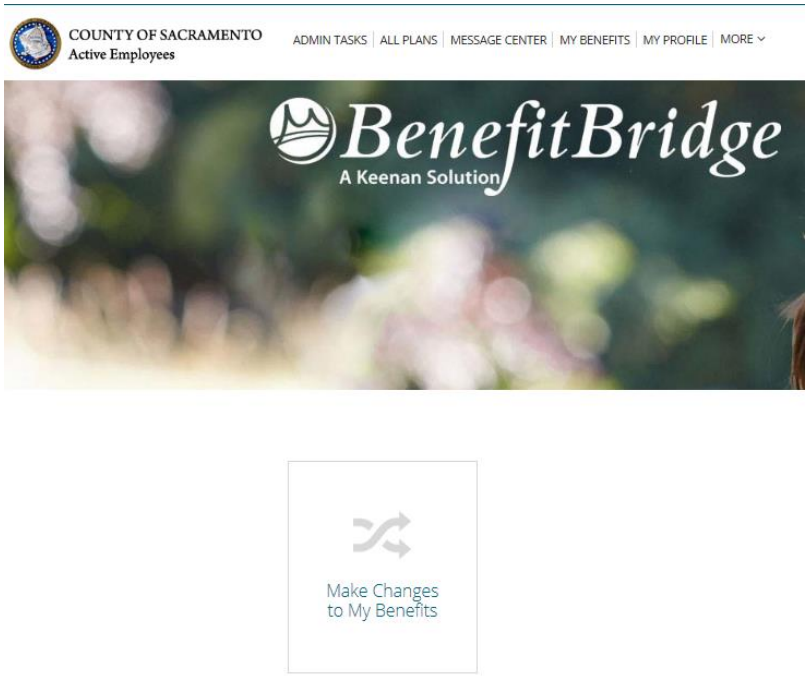
These instructions will help you navigate through BenefitBridge in making your elections for qualifying life events



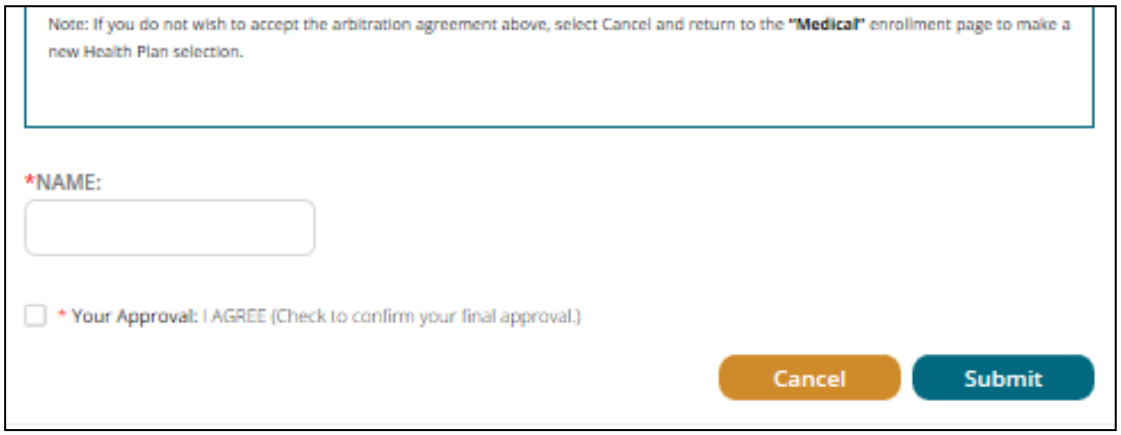
Start by navigating to the website at **www.benefitbridge.com/saccounty**

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.

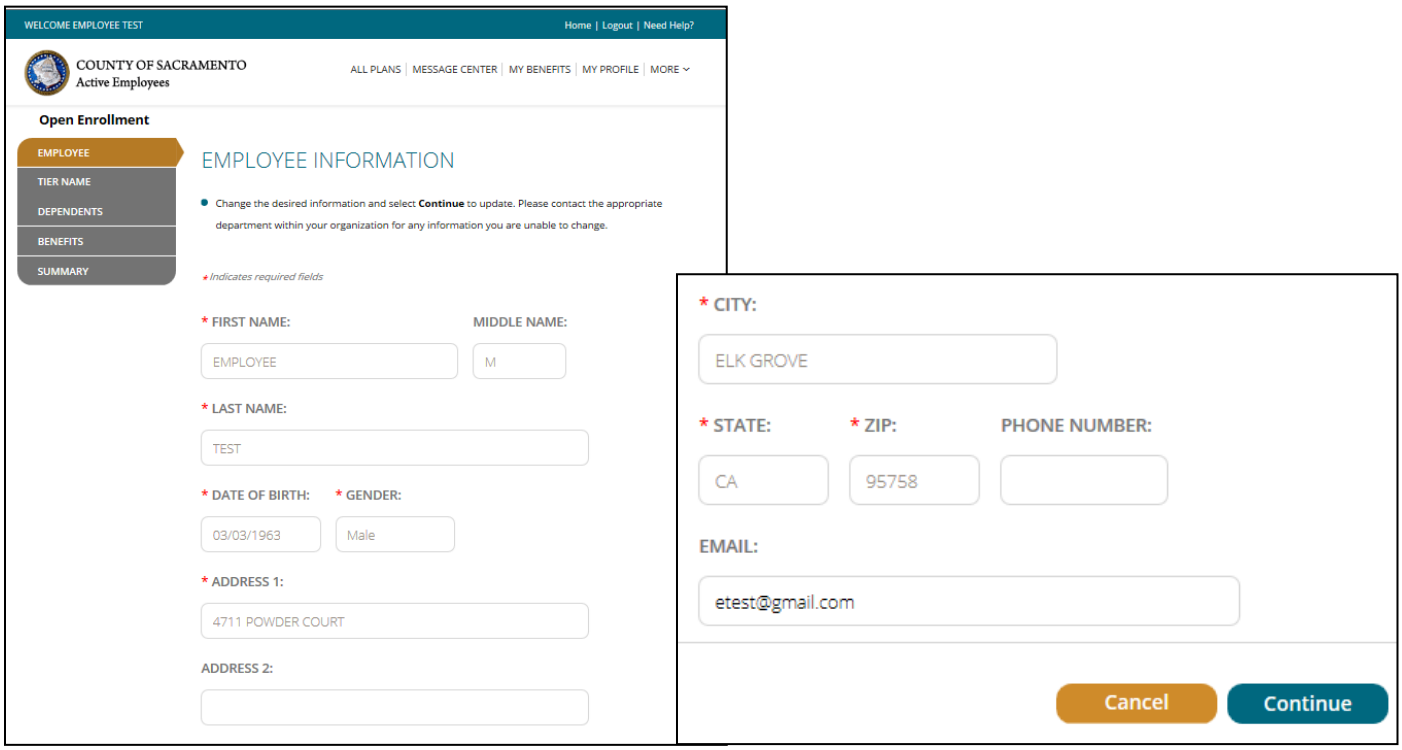



**Important Reminder: no matter where you stop in your life event steps, your enrollment request is not complete until you get to the Summary tab at the end of your enrollment, check the "Your Approval: I agree" box and click the "SUBMIT" button to complete your life event request.**



# EMPLOYEE INFORMATION

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



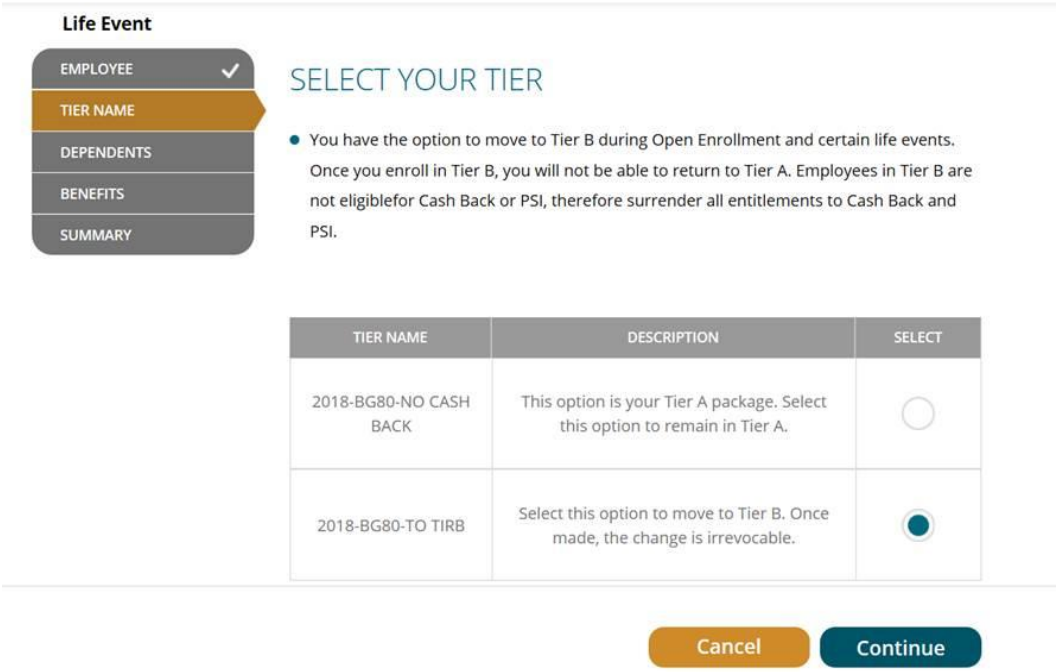

If you need to make changes to your phone number or email address, make the changes and click "CONTINUE". Your email address is used to send you a response about your life event request after it has been reviewed and processed by the Employee Benefits Office

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.

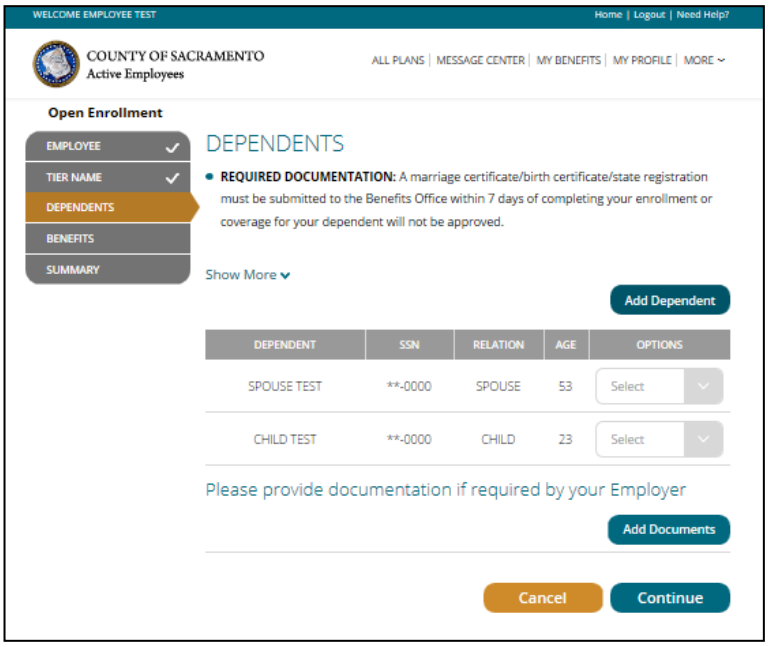
# TIER

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”.



# 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", 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)

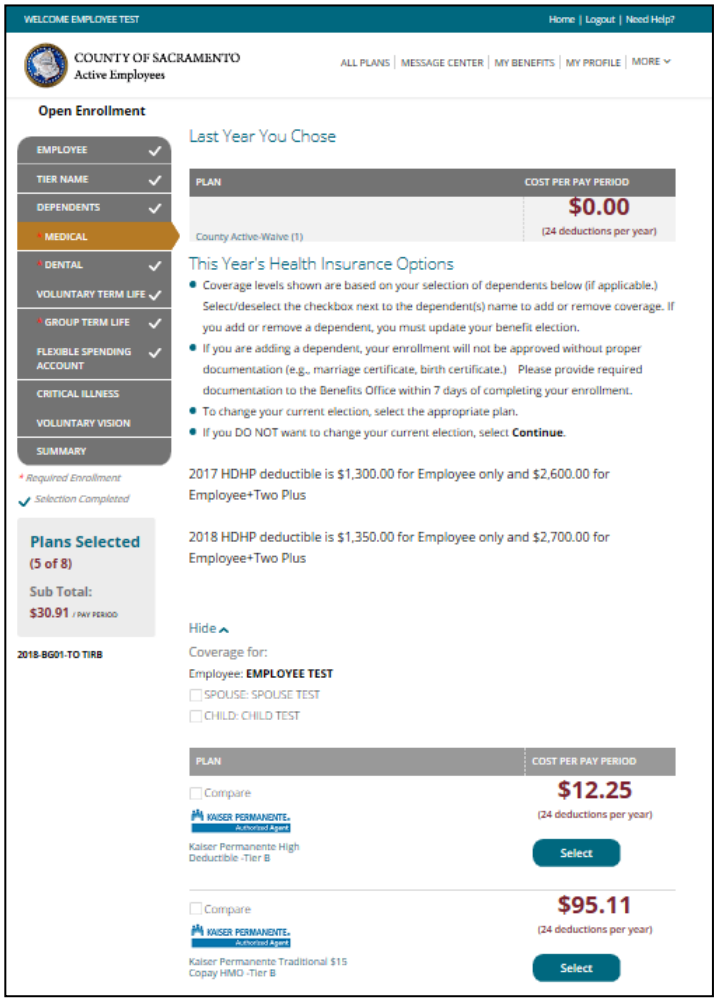
This is where you change coverage, and enroll or remove dependents.

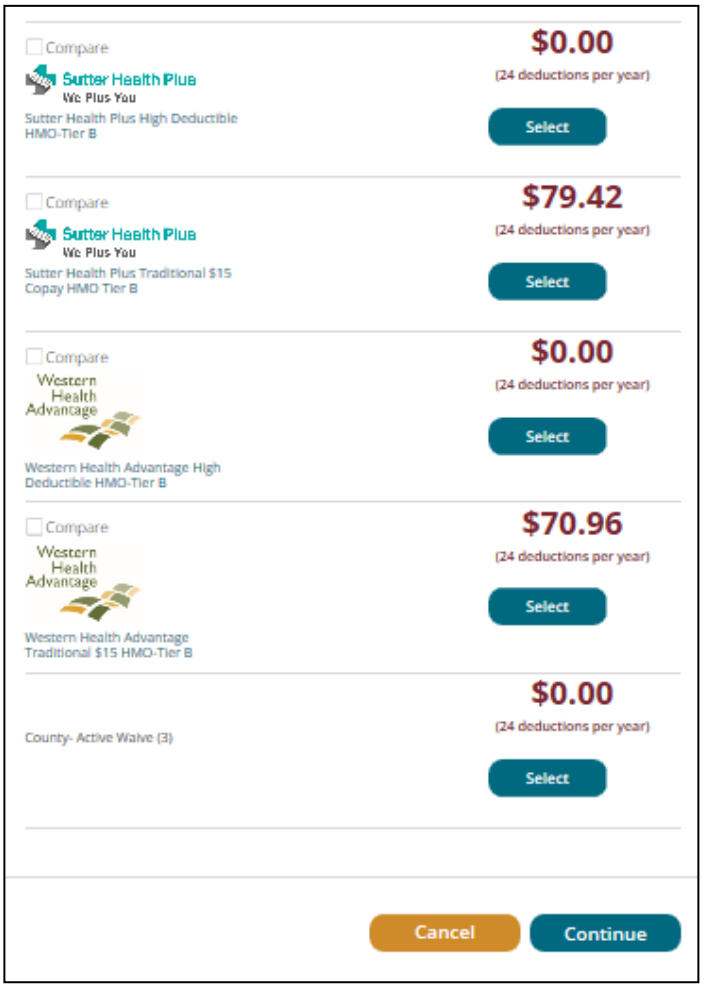
If you only want to change one benefit, you can step directly to the benefit type you want to make changes to by clicking on the benefit type on the left side grid.

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**.**

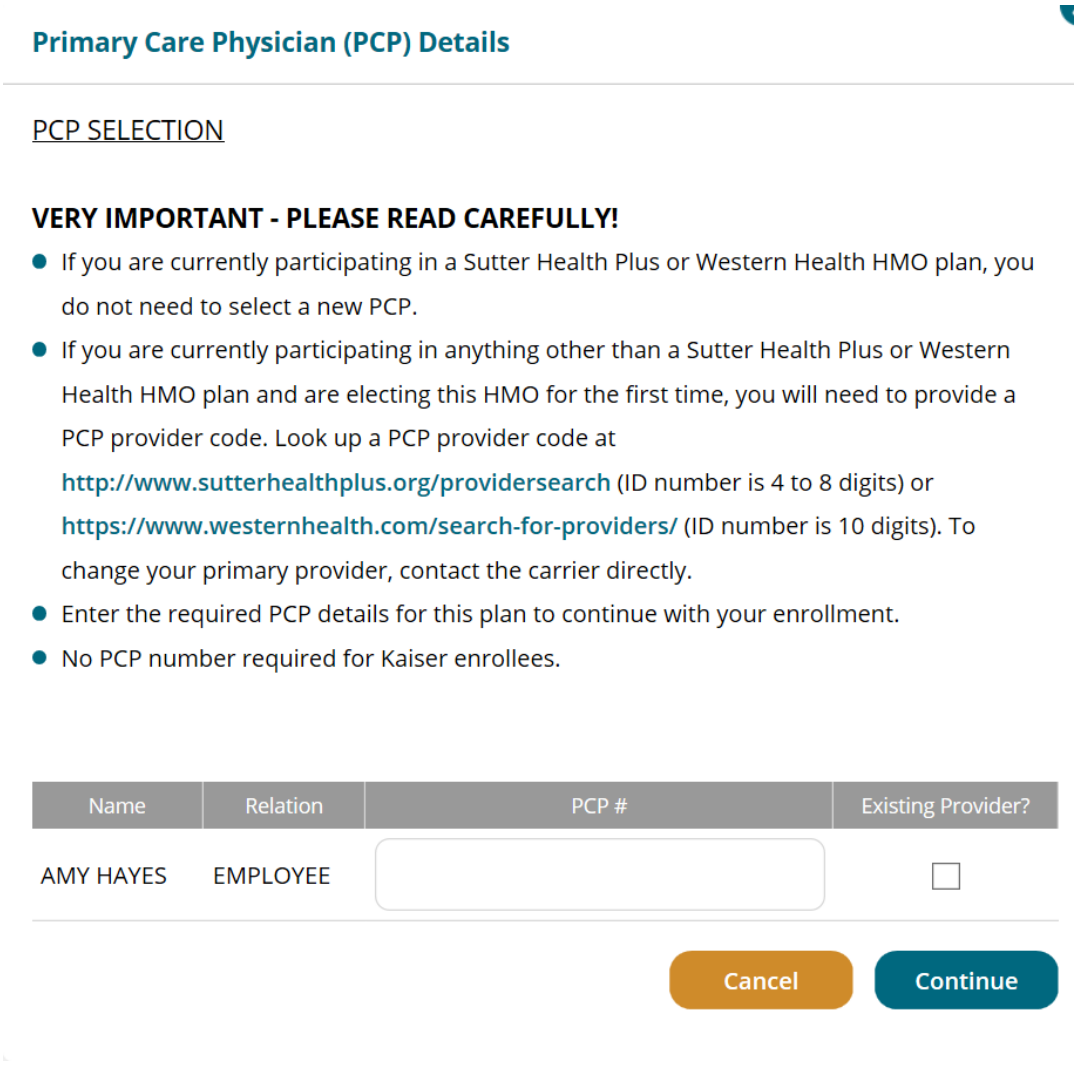
For medical, check the box next to the dependents that should be enrolled, then choose the medical plan you wish to enroll in.



# 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!**

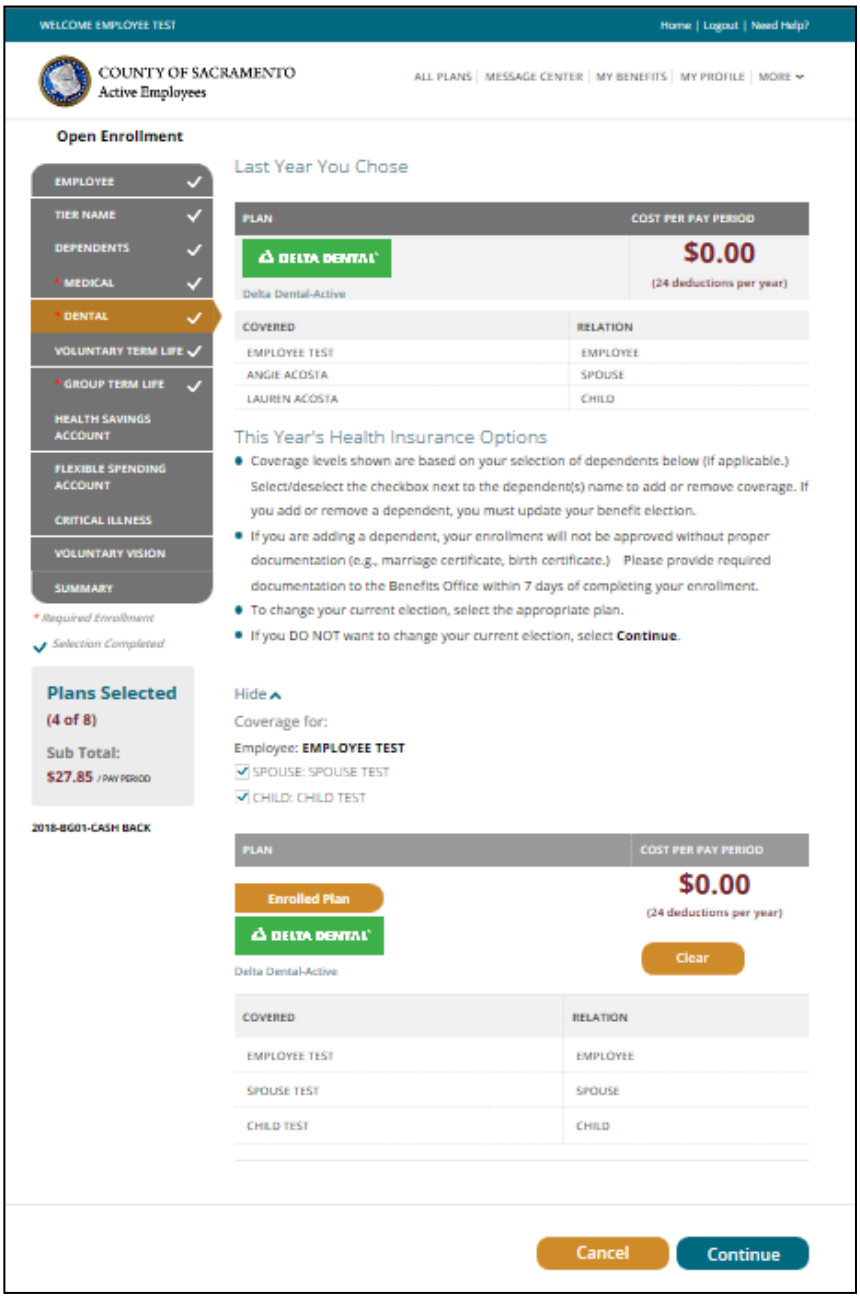
- If you are currently participating in a Sutter Health Plus or Western Health HMO plan, you do not need to select a new PCP.
- If you are currently participating in anything other than a Sutter Health Plus or Western Health HMO plan and are electing this HMO for the first time, you will need to provide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

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.



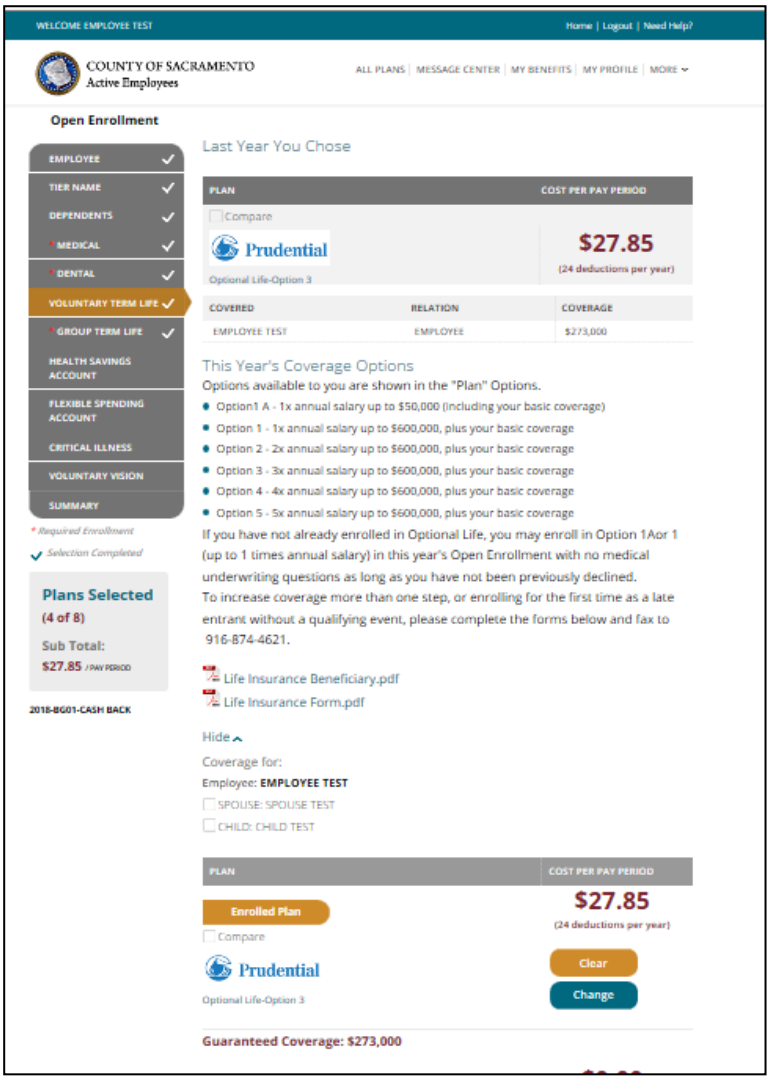

Once you have all family members selected, click "**CONTINUE**".

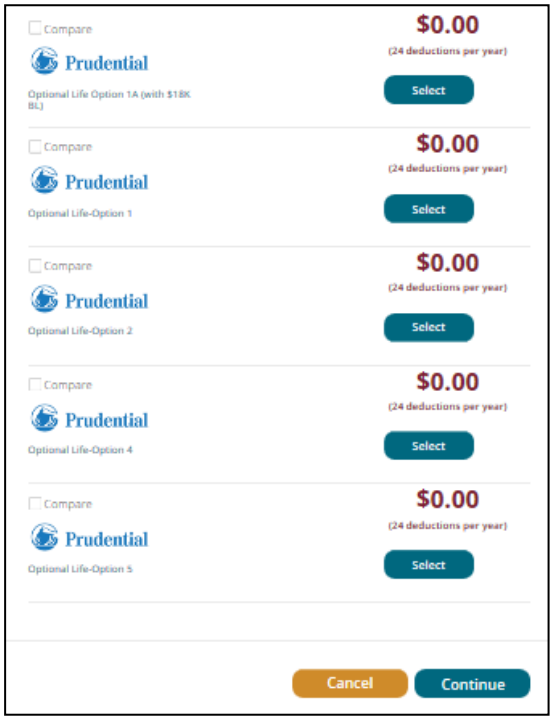
# BENEFITS (Optional Life Insurance)

You will again be brought back to the BENEFITS page.

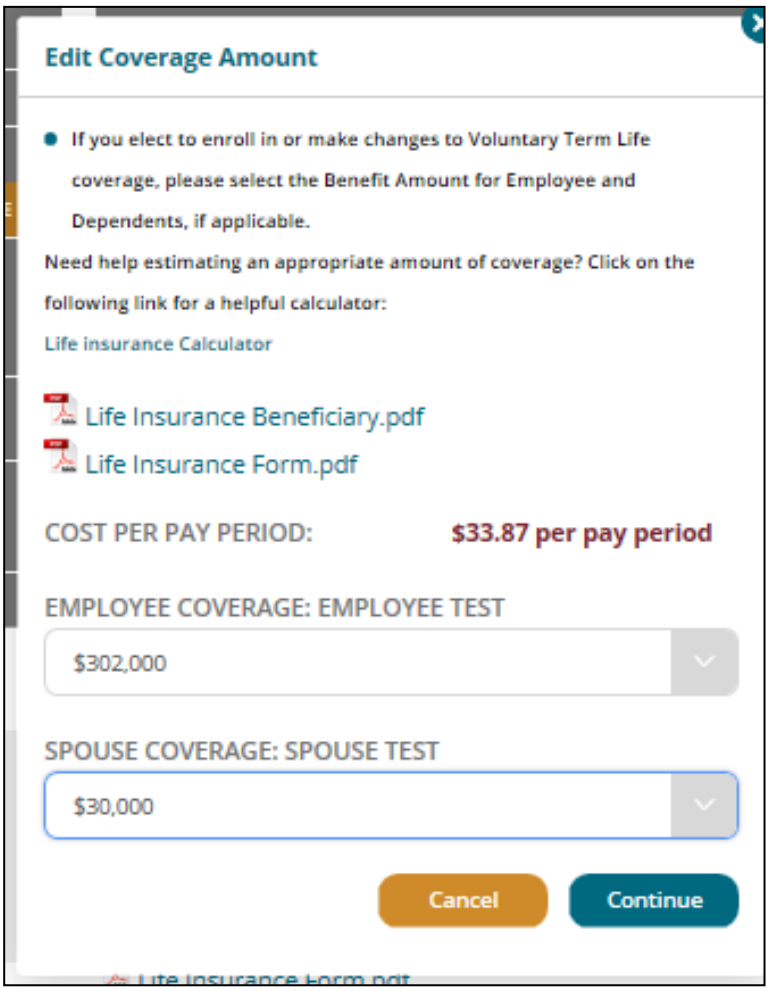
Changes to life insurance can be made at any time and are not limited to life events. Decreases should be made online and are automatically approved. Be sure the box is checked for any dependent you want covered by the Optional Life plan.

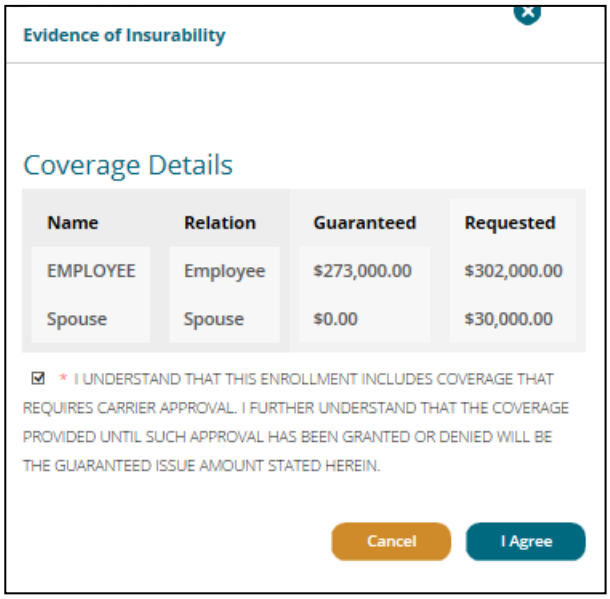
If you are waiving voluntary term life insurance coverage, select **CLEAR**.



# BENEFITS (Optional Life Insurance)




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.

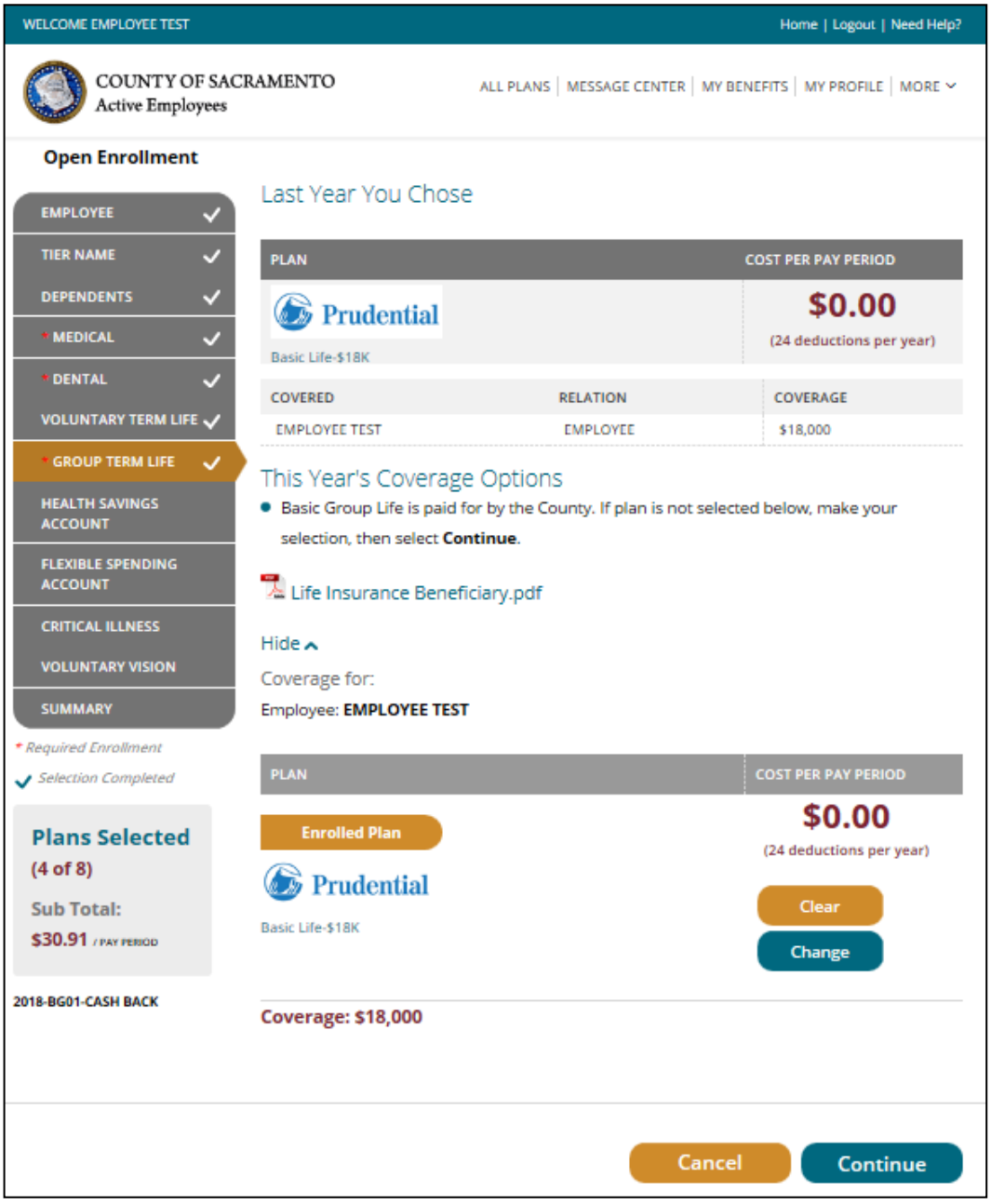
Once you are satisfied with your voluntary life options click "**Continue**".

# BENEFITS (Basic Life Insurance)

Please complete and submit the Life Insurance Beneficiary Form to update your beneficiary.

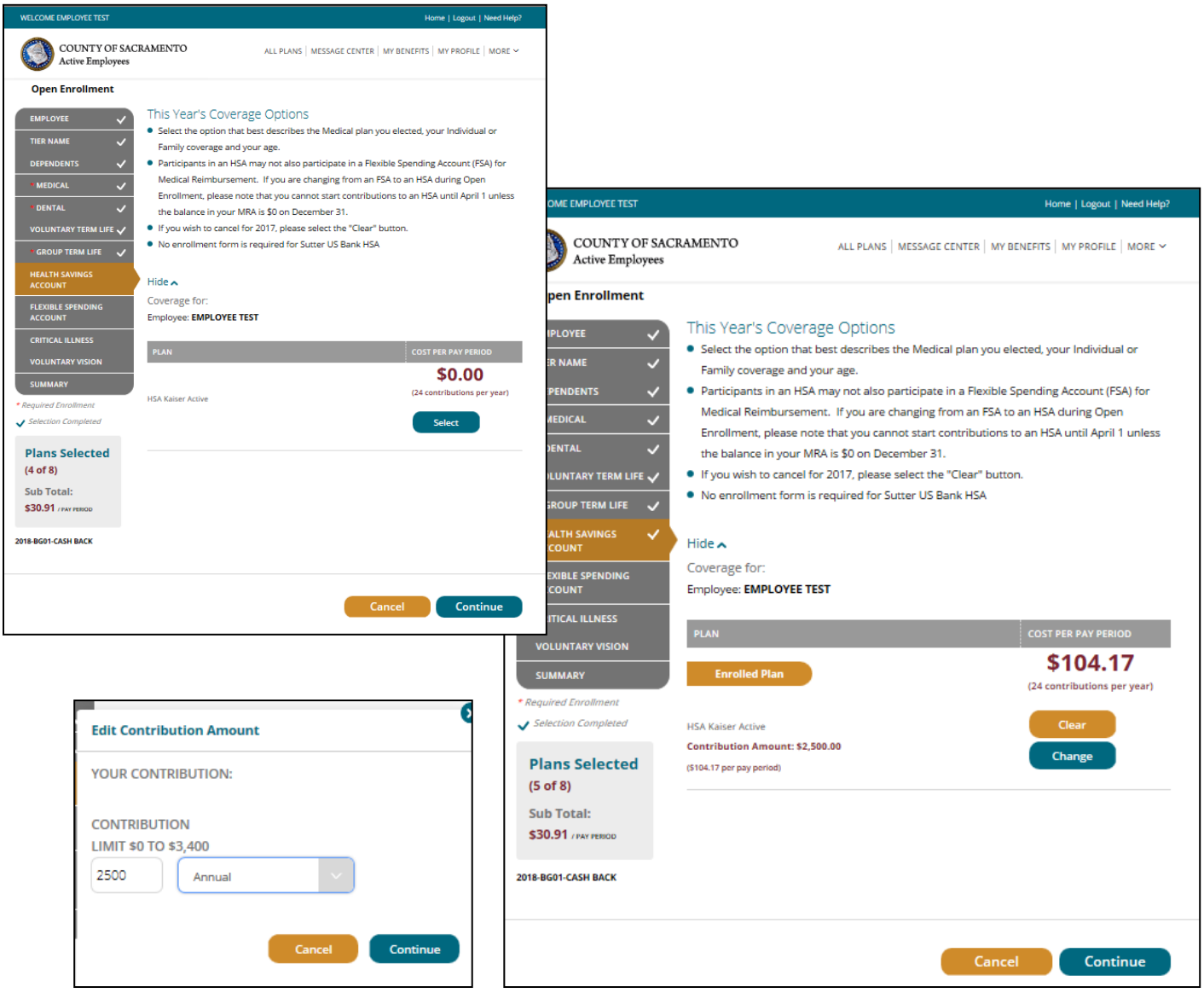
Beneficiary forms are accepted year round and should be updated as your life circumstances change!

Submit this completed form by fax or email to the Benefits Office anytime. Click "**Continue**".



# 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**.




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".**

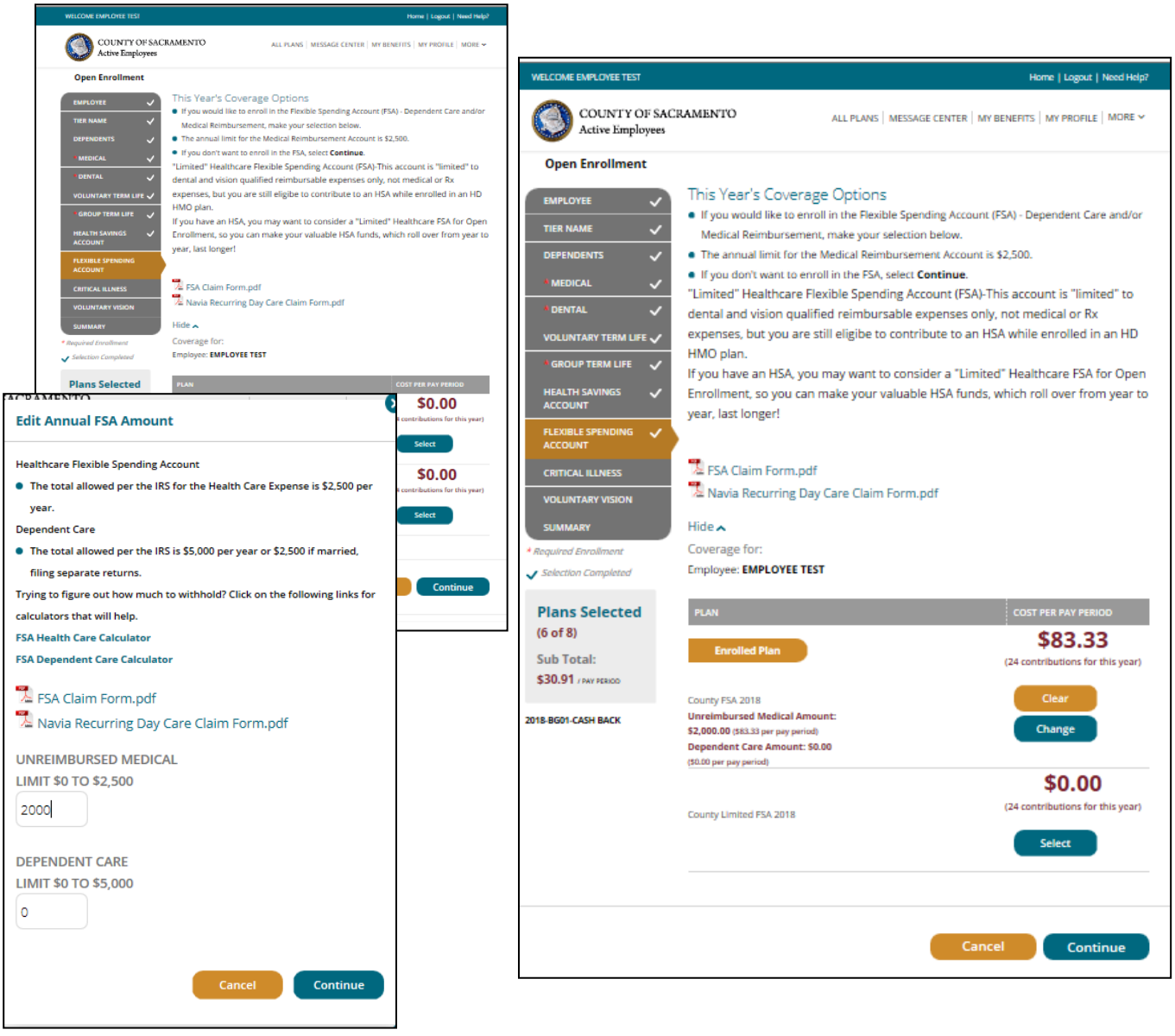
# OPTIONAL (FSA)

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.

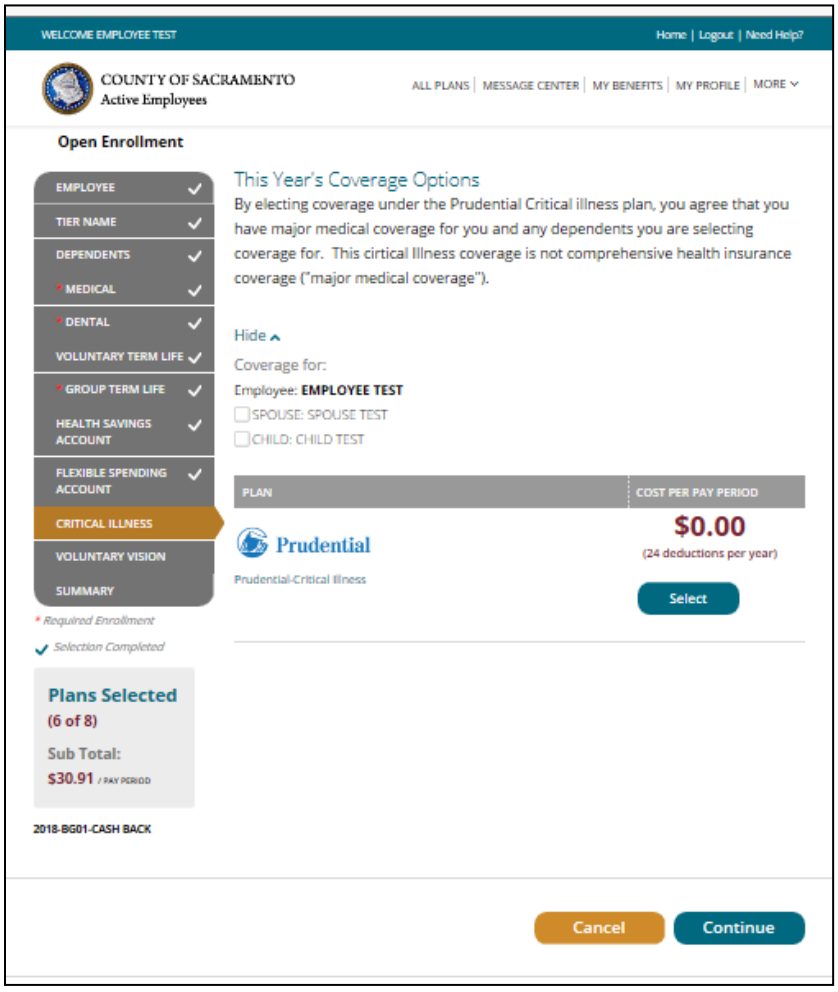
Enter your annual election in the box provided. Your pay check deduction amount will be based on your annual election, deductions are generally taken twice each month (24 pay periods).

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.



# 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".

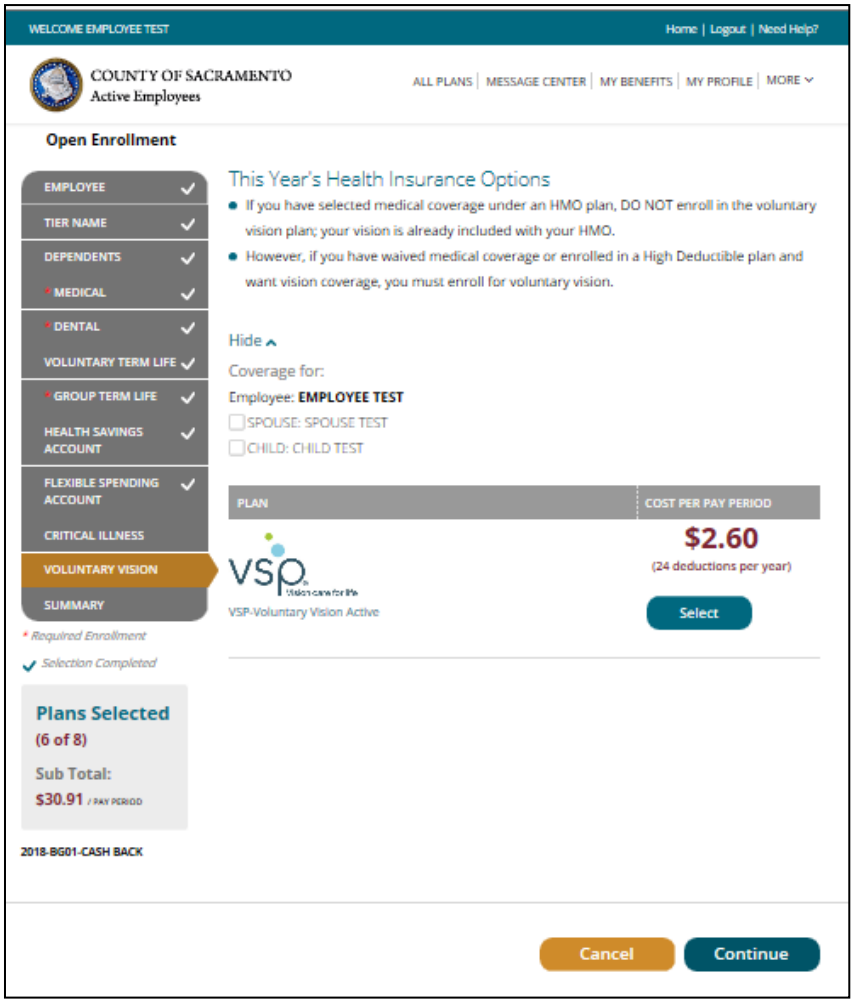


# OPTIONAL (Voluntary Vision)

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

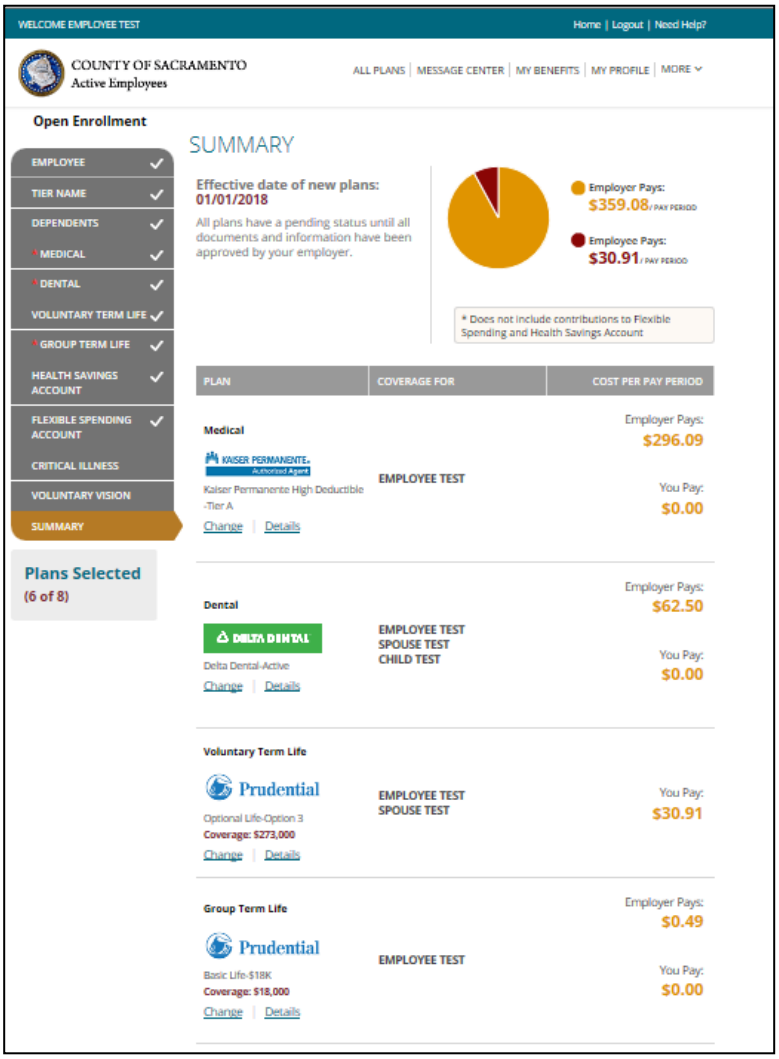
Vision benefits are not included if you enroll in a high deductible plan or you waive medical coverage, so you will need to select Voluntary Vision to have coverage.

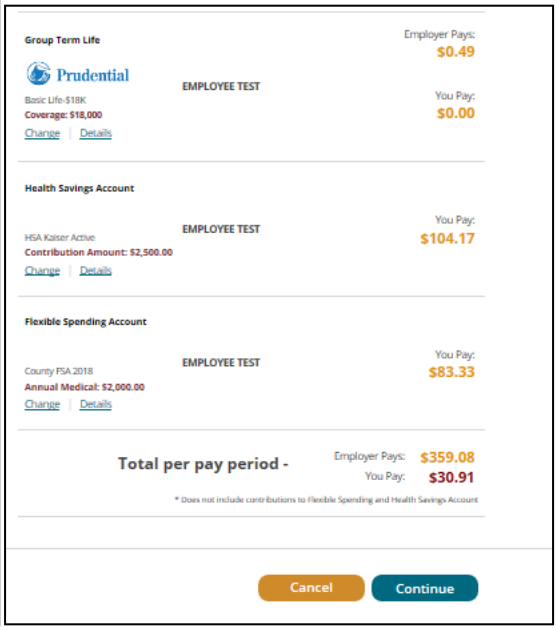
Click **Select** under the Voluntary Vision to enroll. Be sure the box is checked for any dependent you want covered by the Voluntary Vision plan. Click "Continue".



# REVIEW & FINAL APPROVAL

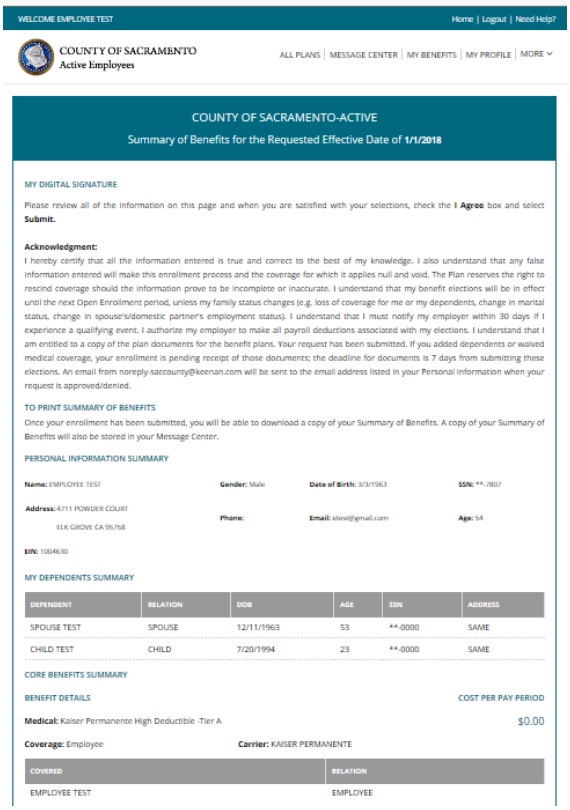
You are almost finished! Scroll through and review the Acknowledgement provisions.




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 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".**


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 |

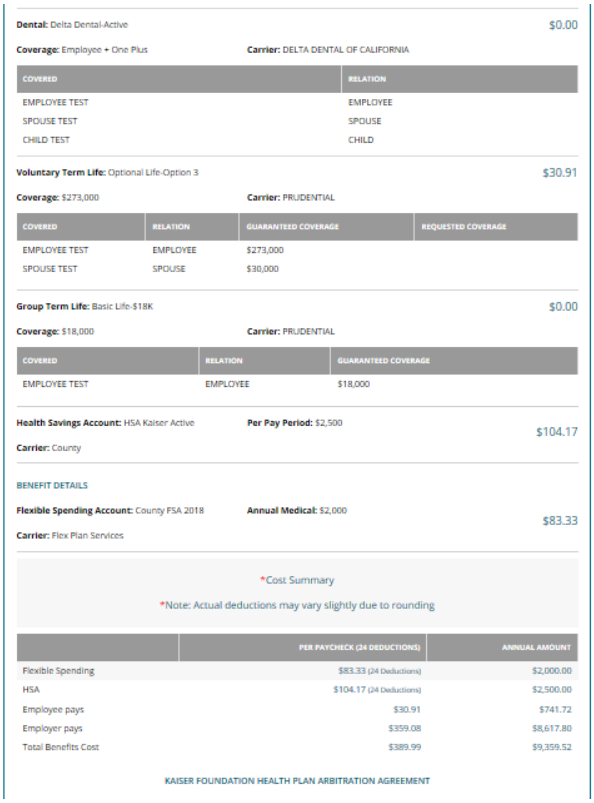
CORE BENEFITS SUMMARY

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

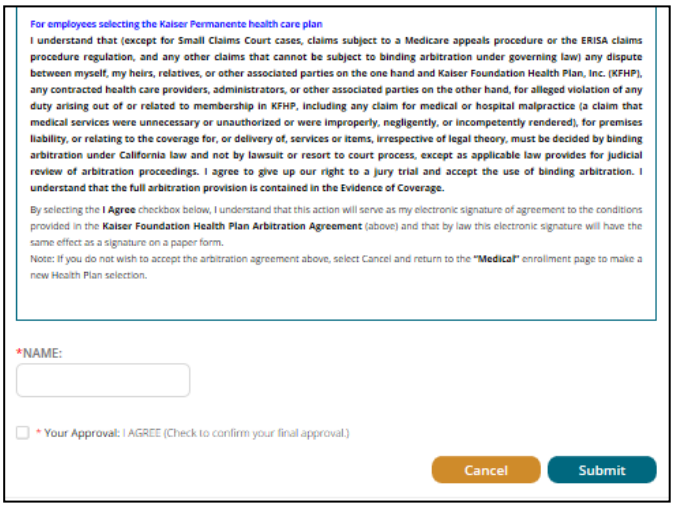
**Carrier:** Flex Plan Services

*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.)* ***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.