

INSTRUCTIONS FOR RENEWING YOUR MEDICAL COVERAGE WAIVER ON BENEFITBRIDGE

1. Go to www.benefitbridge.com/egusd
2. Click on "Register"
3. Enter your first and last name as they appear on your paystub and click "Continue"
4. Click on "Make Changes to My Benefits"
5. Verify the information on the Employee Information screen and click "Continue"

EMPLOYEE INFORMATION

● Please contact the Human Resources Department if you need to make any changes to your demographic data below. Select **Continue** to move to the next tab.

** Indicates required fields*

*FIRST NAME:

MIDDLE NAME:

*LAST NAME:

*DATE OF BIRTH:

*GENDER:

*ADDRESS 1:

ADDRESS 2:

*CITY:

*STATE:

*ZIP:

PHONE NUMBER:

EMAIL:

Cancel

Continue

6. If you are a non-EGEA or non-ATU member, you will see the following screen in Step 7 (if you are an EGEA or ATU member, please skip to Step 8)

7. Select the Standard Dental & Vision option and click “Continue”

SELECT A PACKAGE

- To begin your enrollment, select the button to the right of your benefit options. Then select **Continue** to move to the next screen.

ENROLLMENT PACKAGE	DESCRIPTION	SELECT
2017 Classified Mgt w Standard Dental & Vision		<input type="radio"/>
2017 Classified Mgt w Voluntary Dental & Vision		<input type="radio"/>

[Cancel](#) [Continue](#)

8. Verify your dependents and click on “Add Documents” to add your proof of alternative medical coverage **NOTE: This is the only screen on which proof of medical coverage can be added and has no effect on your dependents.**
9. Upload the proof of alternative medical coverage (copy of medical ID card), click on “Add Document,” then click “Continue”

DEPENDENTS

- REQUIRED DOCUMENTATION:** A marriage license/birth certificate/state registration must be submitted to the appropriate department within your organization before coverage for your dependent will be approved.

Show More ▾

[Add Dependent](#)

DEPENDENT	SSN	RELATION	AGE	OPTIONS
				Select ▾

[Add Documents](#)

Please provide the description of the document

Medical ID card

Please select the document to upload ?

[Upload Document](#) DOC101416.pdf,

[Add Document](#)

[Cancel](#) [Continue](#)




10. Click on “Review and Select Plans”

OPEN ENROLLMENT

Here is a summary of what's new for your employer group benefits this year

Plans with price changes

You can keep the same plans as last year, but new prices apply.

PLAN	Last Year YOUR COST PER PAY PERIOD	Next Year YOUR COST PER PAY PERIOD	Net Change YOUR COST PER PAY PERIOD
Dental  Delta Dental - Active	\$0.00	\$0.00	\$0.00
Vision  VSP - Active	\$0.00	\$0.00	\$0.00
Group Term Life  Hartford Life & AD&D	\$0.00	\$0.00	\$0.00
Cash in Lieu Medical Waive \$65	\$0.00	\$0.00	\$0.00

<input type="radio"/> No Changes to Family or Benefits	I want to keep the same coverage as last year.
<input type="radio"/> Review and Select Plans	I want to review all options before deciding on what change to make.

11. On the MEDICAL tab, click "Continue" without selecting any plans

Open Enrollment

EMPLOYEE ✓
ENROLLMENT PACKAGE ✓
DEPENDENTS ✓
MEDICAL
DENTAL ✓
VISION ✓
GROUP TERM LIFE ✓
CASH IN LIEU ✓
SUMMARY

* Required Enrollment
✓ Selection Completed

Plans Selected
(4 of 5)
Sub Total:
\$0.00 / PAY PERIOD




Dental & Vision

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.
- 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:
 SPOUSE:

PLAN	COST PER PAY PERIOD
<input type="checkbox"/> Compare  Kaiser HMO \$30	Select
<input type="checkbox"/> Compare  Sutter HMO \$30	Select
<input type="checkbox"/> Compare Forfeit / No Cash-Back	Select
<input type="checkbox"/> Compare  WHA HMO \$30	Select

Cancel Continue

12. On the DENTAL tab, make any changes if necessary and click "Continue"

Open Enrollment

- EMPLOYEE ✓
- ENROLLMENT PACKAGE ✓
- DEPENDENTS ✓
- MEDICAL
- DENTAL** ✓
- VISION ✓
- GROUP TERM LIFE ✓
- CASH IN LIEU ✓
- SUMMARY

* Required Enrollment
✓ Selection Completed

Plans Selected (4 of 5)
Sub Total: **\$0.00** / PAY PERIOD

Dental & Vision

Last Year You Chose

PLAN	COST PER PAY PERIOD
<input type="checkbox"/> Compare DELTA DENTAL Delta Dental - Active	\$0.00 (12 deductions per year)

COVERED	RELATION
	EMPLOYEE
	SPOUSE

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.
- 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:
 SPOUSE:

PLAN	COST PER PAY PERIOD
Enrolled Plan <input type="checkbox"/> Compare DELTA DENTAL Delta Dental - Active	\$0.00 (12 deductions per year) Clear

COVERED	RELATION
	EMPLOYEE
	SPOUSE

Cancel **Continue**

13. On the VISION tab, make any necessary changes and click "Continue"

Open Enrollment


EMPLOYEE ✓
ENROLLMENT PACKAGE ✓
DEPENDENTS ✓
MEDICAL ✓
DENTAL ✓
VISION ✓
GROUP TERM LIFE ✓
CASH IN LIEU ✓
SUMMARY

* Required Enrollment
✓ Selection Completed

Plans Selected
(4 of 5)
Sub Total:
\$0.00 / PAY PERIOD

Dental & Vision

Last Year You Chose

PLAN	COST PER PAY PERIOD
<input type="checkbox"/> Compare  VSP - Active	\$0.00 (12 deductions per year)
COVERED	RELATION
	EMPLOYEE
	SPOUSE

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.
- 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:

SPOUSE:

PLAN	COST PER PAY PERIOD
Enrolled Plan <input type="checkbox"/> Compare  VSP - Active	\$0.00 (12 deductions per year) Clear
COVERED	RELATION
	EMPLOYEE
	SPOUSE

Cancel **Continue**

14. On the GROUP TERM LIFE tab, click "Continue"

Open Enrollment

- EMPLOYEE ✓
- ENROLLMENT PACKAGE ✓
- DEPENDENTS ✓
- MEDICAL
- DENTAL ✓
- VISION ✓
- GROUP TERM LIFE ✓**
- CASH IN LIEU ✓
- SUMMARY


** Required Enrollment*
✓ Selection Completed

Plans Selected
(4 of 5)

Sub Total:
\$0.00 / PAY PERIOD

Dental & Vision


Last Year You Chose

PLAN	COST PER PAY PERIOD
<input type="checkbox"/> Compare  Hartford Life & AD&D	\$0.00 (12 deductions per year)

COVERED	RELATION	COVERAGE
	EMPLOYEE	


This Year's Coverage Options

- Make your selection for Group Term Life below, if applicable.
- If your spouse is not your beneficiary, please complete a paper beneficiary change form (below), which requires a spouse's signature as indicated in the form.

 [Elk Grove USD Beneficiary Designation Form.pdf](#)

Hide ▲

Coverage for:
Employee:

PLAN	COST PER PAY PERIOD
Enrolled Plan <input type="checkbox"/> Compare  Hartford Life & AD&D	\$0.00 (12 deductions per year) Clear Change

Coverage:

Cancel **Continue**

15. On the CASH IN LIEU tab, click "Continue" to renew your waiver

Open Enrollment

EMPLOYEE ✓
ENROLLMENT PACKAGE ✓
DEPENDENTS ✓
MEDICAL
* DENTAL ✓
* VISION ✓
* GROUP TERM LIFE ✓
CASH IN LIEU ✓
SUMMARY

** Required Enrollment*
✓ *Selection Completed*

Plans Selected
(4 of 5)

Sub Total:
\$0.00 / PAY PERIOD

Last Year You Chose

PLAN	COST PER PAY PERIOD
Medical Waive \$65	\$0.00 (12 deductions per year)

This Year's Coverage Options

● If you would like to enroll in the Cash in Lieu plan, make your selection below.

Hide ^

Coverage for:
Employee:
 SPOUSE:

PLAN	COST PER PAY PERIOD
Enrolled Plan	\$0.00 (12 deductions per year)
Medical Waive \$65	Clear

Dental & Vision

Cancel **Continue**

16. On the SUMMARY screen, verify that your elections for 2017 are correct and click "Continue"

Open Enrollment

- EMPLOYEE ✓
- ENROLLMENT PACKAGE ✓
- DEPENDENTS ✓
- MEDICAL ✓
- DENTAL ✓
- VISION ✓
- GROUP TERM LIFE ✓
- CASH IN LIEU ✓
- SUMMARY**

Plans Selected (4 of 5)

SUMMARY


Effective date of new plans: 1/1/2017

All plans have a pending status until all documents and information have been approved by your employer.

PLAN	COVERAGE FOR	COST PER PAY PERIOD
Dental		
	Delta Dental - Active	You Pay: \$0.00
	Change Details	
Vision		
	VSP - Active	You Pay: \$0.00
	Change Details	
Group Term Life		
	Hartford Life & AD&D	You Pay: \$0.00
	Coverage: Change Details	
Cash in Lieu		
	Medical Waive \$65	You Pay: \$0.00
	Coverage: \$780	
	Change Details	
Total per pay period -		Employer Pays: / PAY PERIOD
		You Pay: \$0.00

Cancel Continue

17. On the Summary of Benefits for the Requested Effective Date of 1/1/2017 screen, type in your name at the bottom of the screen as your digital signature, check the "Your Approval: I AGREE" box, and click "Submit"



MY BENEFITS ALL PLANS MESSAGE CENTER RESOURCE CENTER

ELK GROVE USD
Summary of Benefits for the Requested Effective Date of 1/1/2017

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.

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: _____ **Gender:** _____ **Date of Birth:** _____ **SSN:** _____
Address: _____ **Phone:** _____ **Email:** _____ **Age:** _____

MY DEPENDENTS SUMMARY

DEPENDENT	RELATION	DOB	AGE	SSN	ADDRESS

CORE BENEFITS SUMMARY

BENEFIT DETAILS	COST PER PAY PERIOD						
Dental: Delta Dental - Active Coverage: Employee + Spouse Carrier: DELTA DENTAL/CSDC	\$0.00						
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">COVERED</th> <th>RELATION</th> </tr> </thead> <tbody> <tr> <td> </td> <td>EMPLOYEE</td> </tr> <tr> <td> </td> <td>SPOUSE</td> </tr> </tbody> </table>	COVERED	RELATION		EMPLOYEE		SPOUSE	
COVERED	RELATION						
	EMPLOYEE						
	SPOUSE						
Vision: VSP - Active Coverage: Employee + One Carrier: VISION SERVICE PLAN	\$0.00						
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">COVERED</th> <th>RELATION</th> </tr> </thead> <tbody> <tr> <td> </td> <td>EMPLOYEE</td> </tr> <tr> <td> </td> <td>SPOUSE</td> </tr> </tbody> </table>	COVERED	RELATION		EMPLOYEE		SPOUSE	
COVERED	RELATION						
	EMPLOYEE						
	SPOUSE						
Group Term Life: Hartford Life & AD&D Coverage: _____ Carrier: HARTFORD INSURANCE	\$0.00						
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">COVERED</th> <th style="width: 30%;">RELATION</th> <th style="width: 40%;">GUARANTEED COVERAGE</th> </tr> </thead> <tbody> <tr> <td> </td> <td>EMPLOYEE</td> <td> </td> </tr> </tbody> </table>	COVERED	RELATION	GUARANTEED COVERAGE		EMPLOYEE		
COVERED	RELATION	GUARANTEED COVERAGE					
	EMPLOYEE						
Cash in Lieu: Medical Waiver \$0.00 \$65 I certify that I have Cash in Lieu insurance elsewhere and I understand that I will not be able to enroll in this coverage until the next open enrollment or until I have a qualifying event.							

*Cost Summary

*Note: Actual deductions may vary slightly due to rounding

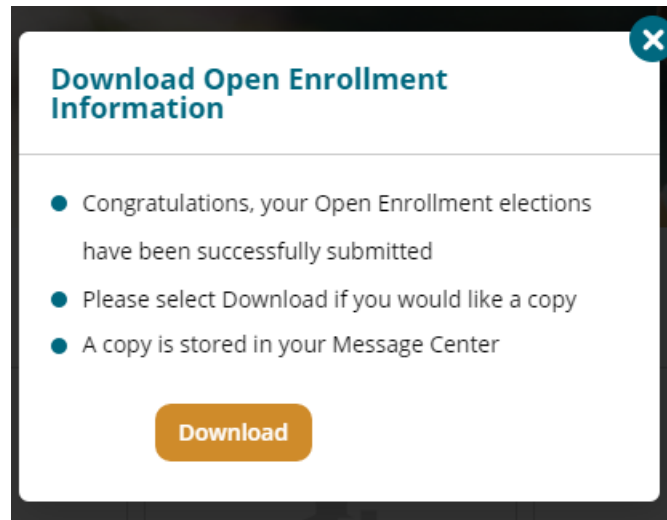
	PER PAYCHECK (12 DEDUCTIONS)	ANNUAL AMOUNT
Employee pays	\$0.00	\$0.00
Employer pays		

*NAME:

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

Cancel
Submit

18. You may download a copy of your Open Enrollment information so that you will have record of your elections for 2017



19. An email confirmation will be sent to you once your elections have been approved by Compensation and Benefits