

FHDA – PY 2024 ENROLLMENT GUIDE

Click here to add dependents

CURRENT COVERAGE					
Plan Year 2024		Plan Year 2023			
MEDICAL AND PHARMACY BENEFIT PLAN		START DATE	END DATE	COST	COVERED
Blue Shield Access+ HMO -Employee+Family		Jan 01 2024		\$ 430.00	Employee Sam Sample Sam Sample
DENTAL BENEFIT PLAN		START DATE	END DATE	COST	COVERED
Delta Dental PPO -Employee+Family		Jan 01 2024		\$ 0.00	Employee Sam Sample Sam Sample
SHOW MORE					

QUICK LINKS

- ENROLL NOW ▶
- Add A Life Event ▶
- Upload Supporting Docs ▶
- View & Print Confirmations ▶
- Update Beneficiaries ▶
- FHDA Online Enrollment Guide

Click here to enroll

- Alerts:**
- Task 1 Your EOI for the 'Supplemental Life and AD&D' is awaiting Approval for the sum of \$50,000.00 for the 'Plan Year 2024'. [Click Here](#) to complete EOI.
 - Task 2 Your EOI for the 'Supplemental Life Insurance for Spouse' is awaiting Approval for the sum of \$50,000.00 for the 'Plan Year 2024'. [Click Here](#) to complete EOI.
 - Task 3 Your EOI for the 'LTD Buy-Up - 66 2/3% of Salary' is awaiting Approval for the sum of \$6,055.86 for the 'Plan Year 2024'. [Click Here](#) to complete EOI.

DISCLAIMER

I hereby declare under penalty of perjury under the laws of the State of California that I have no other access to medical insurance, excluding Medicare, where all or part of the premium is paid through some other source and that the information, I have provided to the District in this online Attestation is true and correct. Effective January 1, 2024, the Paid Benefits Program has three load thresholds, each with a respective District contribution to the premium cost as described below:

- a. PTF with loads of 0.400 – 0.499: The District is responsible for sixty percent (60%) of the Kaiser HMO monthly plan premium or the dollar equivalent under the other plan options. The employee shall contribute 40% of the Kaiser premium plus any buy-up amount toward the selected plan and each tier.
- b. PTF with loads of 0.500 – 0.599: The District is responsible for seventy percent (70%) of the Kaiser HMO monthly plan premium or the dollar equivalent under the other plan options. The employee shall contribute 30% of the Kaiser premium plus any buy-up amount toward the selected plan and each tier.
- c. PTF with loads of 0.600 – 0.670: The District is responsible for eighty percent (80%) of the Kaiser HMO monthly plan premium or the dollar equivalent under the other plan options. The employee shall contribute 20% of the Kaiser premium plus any buy-up amount toward the selected plan and each tier.

IMPORTANT: By enrolling online, you are affirming that you have no other access to medical insurance, as a primary insured or a dependent, where all or part of the premium or cash in lieu of participation is paid through some other source. Exceptions are Medicare-eligible enrollees; other California Community college district employer coverage shall be excluded from the definition of medical insurance where the employee cost of participation is higher than the employee cost of participation for a comparable district plan. In no case shall a part-time faculty employee have dual coverage with another plan or employer.

I ACCEPT

I DECLINE

Click on I Accept to start enrollment



Welcome, Shomald Vieira On Behalf Of SAMPLE SAMPLE

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IHISTORYREPORTS

ENROLLMENT - BENEFITSWALK

SELECT YOUR BENEFITS COVERAGE BENEFITSWALK (PLAN YEAR 2024)



→ ABOUT YOU

Employee

MY QUESTION

DEPENDENT QUESTION

✓ CORE BENEFITS

✓ FLEXIBLE SPENDING ACCOUNT

✓ VOLUNTARY BENEFITS

✓ BENEFICIARY INFORMATION

✓ ELECTION SUMMARY

Interactive Questions (enter the following)

Emergency contact name:

Relationship:

Phone number:

Email address:

Your benefit election is administratively joined to the other spouse/domestic partner's medical plan due to elimination of dual coverage (HR use only)

Save & Continue

Please answer the interactive questions and click on Save & Continue



RUNNING TOTAL Per Pay Period Deduction



Welcome,
Shornald Veyra On Behalf Of
SAMPLE SAMPLE

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ENROLLMENT - BENEFITWALK

SELECT YOUR BENEFITS COVERAGE BENEFITWALK (PLAN YEAR 2024)



→ ABOUT YOU

MY QUESTION
DEPENDENT QUESTION

- ✓ CORE BENEFITS
- ✓ FLEXIBLE SPENDING ACCOUNT
- ✓ VOLUNTARY BENEFITS
- ✓ BENEFICIARY INFORMATION
- ✓ ELECTION SUMMARY

Dependent

Interactive Questions (enter the following)

Newly added Dependent

All dependents Show

Sam Sample (Spouse)

Marriage/Partnership Union Date: 07/15/2020

Save & Continue



RUNNING TOTAL Per Pay
Period Deduction

SECOVA

Please complete dependent Interactive Questions if adding Spouse and click on Save & Continue

ENROLLMENT - BENEFITSWALK

SELECT YOUR BENEFITS COVERAGE BENEFITSWALK (PLAN YEAR 2024)



✓ ABOUT YOU

→ CORE BENEFITS

→ Medical and Pharmacy Benefit Plan

✓ Dental Benefit Plan

✓ Vision Benefit Plan

○ Dental Benefit Plan

○ Vision Benefit Plan

✓ Employee Assistance Program

✓ Basic Life Insurance

✓ Basic Life Insurance For Your Spouse or Domestic Partner

✓ Basic Life Insurance For Your Dependent Child(ren)

✓ Basic AD&D Insurance For Employee

✓ Basic Long Term Disability

✓ FLEXIBLE SPENDING ACCOUNT

Medical and Pharmacy Benefit Plan

CURRENT COVERAGE

Blue Shield Access+ HMO

Employee+Family

Employee Cost (Per Pay Period) :

Pre Tax: \$430.00

Post Tax: \$0.00

Employer Cost:

\$2,369.78

Total:

\$2,799.78

I WANT TO WAIVE MEDICAL AND PHARMACY BENEFIT PLAN

OR

Add Dependents

ANTHEM EPO DEL NORTE

View Benefit Information

Employee + 1 Child

\$404.00

Employee Only

\$207.00

Employee + Spouse

\$404.00

Employee+Family

\$523.00

ANTHEM HMO SELECT

View Benefit Information

Employee + 1 Child

\$352.00

Employee Only

\$181.00

Please select the Medical Plan & Tier level of your choice, Scroll Down & Click on Save & Continue



RUNNING TOTAL Per Pay Period Deduction \$1408.57

ENROLLMENT - BENEFITSWALK

SELECT YOUR BENEFITS COVERAGE BENEFITSWALK (PLAN YEAR 2024)



✓ ABOUT YOU

→ CORE BENEFITS

- ✓ Medical and Pharmacy Benefit Plan
- Dental Benefit Plan
- ✓ Vision Benefit Plan
- Dental Benefit Plan
- Vision Benefit Plan
- ✓ Employee Assistance Program
- ✓ Basic Life Insurance
- ✓ Basic Life Insurance For Your Spouse or Domestic Partner
- ✓ Basic Life Insurance For Your Dependent Child(ren)
- ✓ Basic AD&D Insurance For Employee
- ✓ Basic Long Term Disability

Dental Benefit Plan

This selection may be linked to other coverage options. Please review carefully before you proceed.

CURRENT COVERAGE	
Delta Dental PPO	Employee+Family
Employee Cost (Per Pay Period):	
Pre Tax: \$0.00	Employer Cost: \$189.32
Post Tax: \$0.00	Total: \$189.32

I WANT TO WAIVE DENTAL BENEFIT PLAN

OR

DELTA DENTAL PPO [?]

[*View Benefit Information](#)

- Employee + 1 Child
- Employee Only
- Employee + Spouse
- Employee+Family

- \$0.00
- \$0.00
- \$0.00
- \$0.00

Employee Cost: \$0.00
Employer Cost: \$189.32



PER PAY PERIOD DEDUCTION FOR THIS PLAN
\$0.00

↓ Select Dependents

Add Dependents



RUNNING TOTAL Per Pay
Period Deduction
\$1408.57

Please select the Tier level of your choice for Dental, Scroll down and Click on Save & Continue

ENROLLMENT - BENEFITWALK

SELECT YOUR BENEFITS COVERAGE BENEFITWALK (PLAN YEAR 2024)



✓ ABOUT YOU

→ CORE BENEFITS

- ✓ Medical and Pharmacy Benefit Plan
- ✓ Dental Benefit Plan
- Vision Benefit Plan
- Dental Benefit Plan
- Vision Benefit Plan
- ✓ Employee Assistance Program
- ✓ Basic Life Insurance
- ✓ Basic Life Insurance For Your Spouse or Domestic Partner
- ✓ Basic Life Insurance For Your Dependent Child(ren)

Vision Benefit Plan

This selection may be linked to other coverage options. Please review carefully before you proceed.

CURRENT COVERAGE

Vision Benefit Plan

Employee+Family

Employee Cost (Per Pay Period):

Pre Tax: \$0.00

Post Tax: \$0.00

Employer Cost:

\$19.18

Total:

\$19.18

VISION BENEFIT PLAN ¹

[View Benefit Information](#)

Employee + 1 Child

\$0.00

Employee Cost: \$0.00

Employee Only

\$0.00

Employer Cost: \$19.18

Employee + Spouse

\$0.00

Employee+Family

\$0.00



PER PAY PERIOD DEDUCTION FOR THIS PLAN

\$0.00



**RUNNING TOTAL Per Pay
Period Deduction
\$1408.57**

Dental plan and Vision plan are bundled, the Tier level of Vision plan is aligned with dental plan.

SELECT YOUR BENEFITS COVERAGE BENEFITSWALK (PLAN YEAR 2024)



✓ ABOUT YOU

→ CORE BENEFITS

- ✓ Medical and Pharmacy Benefit Plan
- ✓ Dental Benefit Plan
- ✓ Vision Benefit Plan
- Dental Benefit Plan
- Vision Benefit Plan
- Employee Assistance Program
- ✓ Basic Life Insurance
- ✓ Basic Life Insurance For Your Spouse or Domestic Partner
- ✓ Basic Life Insurance For Your Dependent Child(ren)
- ✓ Basic AD&D Insurance For Employee
- ✓ Basic Long Term Disability

✓ FLEXIBLE SPENDING ACCOUNT

✓ VOLUNTARY BENEFITS

Employee Assistance Program

CURRENT COVERAGE

Coverage: EAP - OptumHealth	Coverage Date: 01/01/2024
Employee Cost (Per Pay Period) :	Employer Cost:
Pre Tax: \$0.00	\$3.23
Post Tax: \$0.00	Total: \$3.23

● EAP - OptumHealth

Employee Cost
\$0.00

Employer Cost
\$ 3.23



Employee Cost: \$0.00
Employer Cost: \$3.23

PER PAY PERIOD DEDUCTION FOR THIS PLAN
\$0.00



**RUNNING TOTAL Per Pay
Period Deduction
\$1408.57**

**EAP is employer provided plan.
Just Click on Save & Continue**

ENROLLMENT - BENEFITSWALK

SELECT YOUR BENEFITS COVERAGE BENEFITSWALK (PLAN YEAR 2024)



✓ ABOUT YOU

→ CORE BENEFITS

- ✓ Medical and Pharmacy Benefit Plan
- ✓ Dental Benefit Plan
- ✓ Vision Benefit Plan
- Dental Benefit Plan
- Vision Benefit Plan
- ✓ Employee Assistance Program
- Basic Life Insurance
- ✓ Basic Life Insurance For Your Spouse or Domestic Partner
- ✓ Basic Life Insurance For Your Dependent Child(ren)
- ✓ Basic AD&D Insurance For Employee
- ✓ Basic Long Term Disability

✓ FLEXIBLE SPENDING ACCOUNT

Basic Life Insurance

CURRENT COVERAGE	
Coverage: Basic Life Insurance Actual Coverage Amount : \$50,000.00	Coverage Date: 01/01/2024
Employee Cost (Per Pay Period) : Pre Tax: \$0.00 Post Tax: \$0.00	Employer Cost: \$9.00 Total: \$9.00

● BASIC LIFE INSURANCE

\$50,000.00

Requested Coverage Amount: \$50,000.00
Actual Coverage Amount: \$50,000.00

Employee Cost: \$0.00
Employer Cost: \$9.00

RUNNING TOTAL Per Pay Period Deduction \$1408.57

Basic Life Insurance is Employer Provided Just Click on Save & Continue

ENROLLMENT - BENEFITSWALK

SELECT YOUR BENEFITS COVERAGE BENEFITSWALK (PLAN YEAR 2024)



✓ ABOUT YOU

→ CORE BENEFITS

- ✓ Medical and Pharmacy Benefit Plan
- ✓ Dental Benefit Plan
- ✓ Vision Benefit Plan
- Dental Benefit Plan
- Vision Benefit Plan
- ✓ Employee Assistance Program
- ✓ Basic Life Insurance
- Basic Life Insurance For Your Spouse or Domestic Partner
- ✓ Basic Life Insurance For Your Dependent Child(ren)
- ✓ Basic AD&D Insurance For Employee
- ✓ Basic Long Term Disability

✓ FLEXIBLE SPENDING ACCOUNT

Basic Life Insurance For Your Spouse or Domestic Partner

CURRENT COVERAGE

Coverage: Basic Life For Spouse/Domestic Partner Coverage Date: 01/01/2024
Actual Coverage Amount : \$5,000.00

Employee Cost (Per Pay Period):
Pre Tax: \$0.00
Post Tax: \$0.00
Employer Cost:
Total: \$1.73

I want to waive Basic Life Insurance For Your Spouse or Domestic Partner

● BASIC LIFE FOR SPOUSE/DOMESTIC PARTNER

\$5,000.00



Requested Coverage Amount: \$5,000.00
Actual Coverage Amount: \$5,000.00

Employee Cost: \$0.00
Employer Cost: \$1.73



RUNNING TOTAL Per Pay
Period Deduction
\$1408.57

Basic Life for Spouse or Domestic Partner is Employer Provided Just Click on Save & Continue (the dependent must be covered under Medical and/or Dental/ Vision Plans

SELECT YOUR BENEFITS COVERAGE BENEFITSWALK (PLAN YEAR 2024)



✓ ABOUT YOU

→ CORE BENEFITS

- ✓ Medical and Pharmacy Benefit Plan
- ✓ Dental Benefit Plan
- ✓ Vision Benefit Plan
- Dental Benefit Plan
- Vision Benefit Plan
- ✓ Employee Assistance Program
- ✓ Basic Life Insurance
- ✓ Basic Life Insurance For Your Spouse or Domestic Partner
- Basic Life Insurance For Your Dependent Child(ren)
- ✓ Basic AD&D Insurance For Employee
- ✓ Basic Long Term Disability

✓ FLEXIBLE SPENDING ACCOUNT

✓ VOLUNTARY BENEFITS

Basic Life Insurance For Your Dependent Child(ren)

CURRENT COVERAGE

Coverage: Basic Life for Dependent Child(ren) Actual Coverage Amount : \$5,000.00	Coverage Date: 01/01/2024
Employee Cost (Per Pay Period) : Pre Tax: \$0.00 Post Tax: \$0.00	Employer Cost: \$1.73 Total: \$1.73

I want to waive Basic Life Insurance For Your Dependent Child(ren)

BASIC LIFE FOR DEPENDENT CHILD(REN)

\$5,000.00



Requested Coverage Amount: \$5,000.00
Actual Coverage Amount: \$5,000.00

Employee Cost: \$0.00
Employer Cost: \$1.73

PER PAY PERIOD DEDUCTION FOR THIS PLAN

RUNNING TOTAL Per Pay Period Deduction \$1408.57

Basic Life for Dependent Child(ren) is Employer Provided Just Click on Save & Continue (the dependent must be covered under Medical and/or Dental/ Vision Plans

SELECT YOUR BENEFITS COVERAGE BENEFITWALK (PLAN YEAR 2024)



✓ ABOUT YOU

→ CORE BENEFITS

- ✓ Medical and Pharmacy Benefit Plan
- ✓ Dental Benefit Plan
- ✓ Vision Benefit Plan
- Dental Benefit Plan
- Vision Benefit Plan
- ✓ Employee Assistance Program
- ✓ Basic Life Insurance
- ✓ Basic Life Insurance For Your Spouse or Domestic Partner
- ✓ Basic Life Insurance For Your Dependent Child(ren)
- Basic AD&D Insurance For Employee
- ✓ Basic Long Term Disability

✓ FLEXIBLE SPENDING ACCOUNT

✓ VOLUNTARY BENEFITS

Basic AD&D Insurance For Employee

CURRENT COVERAGE

Coverage: Basic AD&D Insurance for Employee Actual Coverage Amount : \$50,000.00	Coverage Date: 01/01/2024
Employee Cost (Per Pay Period) :	Employer Cost:
Pre Tax: \$0.00	\$0.75
Post Tax: \$0.00	Total: \$0.75

● BASIC AD&D INSURANCE FOR EMPLOYEE

\$50,000.00



Requested Coverage Amount: \$50,000.00
Actual Coverage Amount: \$50,000.00

Employee Cost: \$0.00
Employer Cost: \$0.75

PER PAY PERIOD DEDUCTION FOR THIS PLAN
\$0.00



**RUNNING TOTAL Per Pay
Period Deduction
\$1408.57**

**Basic AD&D Insurance is Employer Provided
Just Click on Save & Continue**

SELECT YOUR BENEFITS COVERAGE BENEFITWALK (PLAN YEAR 2024)



✓ ABOUT YOU

→ CORE BENEFITS

- ✓ Medical and Pharmacy Benefit Plan
- ✓ Dental Benefit Plan
- ✓ Vision Benefit Plan
- Dental Benefit Plan
- Vision Benefit Plan
- ✓ Employee Assistance Program
- ✓ Basic Life Insurance
- ✓ Basic Life Insurance For Your Spouse or Domestic Partner
- ✓ Basic Life Insurance For Your Dependent Child(ren)
- ✓ Basic AD&D Insurance For Employee
- Basic Long Term Disability

✓ FLEXIBLE SPENDING ACCOUNT

✓ VOLUNTARY BENEFITS

✓ BENEFICIARY INFORMATION

✓ ELECTION SUMMARY

Basic Long Term Disability

CURRENT COVERAGE

Coverage:
LTD 66 2/3% of Salary
Actual Coverage Amount : \$6,000.00

Coverage Date:
01/01/2024

Employee Cost (Per Pay Period) :
Pre Tax: \$0.00
Post Tax: \$0.00

Employer Cost:
\$11.59
Total:
\$11.59

● LTD 66 2/3% OF SALARY

\$6,000.00



Requested Coverage Amount: \$6,000.00
Actual Coverage Amount: \$6,000.00

Employee Cost: \$0.00
Employer Cost: \$11.59

PER PAY PERIOD DEDUCTION FOR THIS PLAN
\$0.00

CANCEL

SAVE & CONTINUE →



RUNNING TOTAL Per Pay
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Basic LTD is Employer Provided Just
Click on Save & Continue

SELECT YOUR BENEFITS COVERAGE BENEFITSWALK (PLAN YEAR 2024)



✓ ABOUT YOU

✓ CORE BENEFITS

→ FLEXIBLE SPENDING ACCOUNT

→ FSA - Health Care Reimbursement Account

✓ FSA - Dependent Care Reimbursement Account

✓ Commuter Benefits - Parking Account

✓ Commuter Benefits - Transit Account

✓ VOLUNTARY BENEFITS

✓ BENEFICIARY INFORMATION

✓ ELECTION SUMMARY

The minimum annual contribution amount is \$500 for both FSA Health Care and Dependent Care accounts. Due to the system limitation, the calculation of the monthly contribution amount cannot be less than \$41.67. Please enter \$500.04 for the minimum annual goal amount (\$41.67x12=\$500.04)

FSA - Health Care Reimbursement Account

CURRENT COVERAGE

Coverage:
FSA - Health Care Reimbursement Account
Annual Goal Amount : \$2,750.00

Coverage Date:
01/01/2024

Employee Cost (Per Pay Period) :
Pre Tax: \$229.17
Post Tax: \$0.00

Employer Cost:
\$0.00
Total:
\$229.17

I WANT TO WAIVE FSA - HEALTH CARE REIMBURSEMENT ACCOUNT

OR

ENTER GOAL AMOUNTS:

FSA - Health Care Reimbursement Account

Pay Period Goal Amount

\$ 229.17

Annual Goal Amount

\$ 2,750.00



**RUNNING TOTAL Per Pay
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\$1408.57**

If you choose to elect FSA enter the Pay Period Goal Amount, Scroll Down and Click on Save & Continue

SELECT YOUR BENEFITS COVERAGE BENEFITWALK (PLAN YEAR 2024)



✓ ABOUT YOU

✓ CORE BENEFITS

→ FLEXIBLE SPENDING ACCOUNT

→ FSA - Health Care Reimbursement Account

✓ FSA - Dependent Care Reimbursement Account

✓ Commuter Benefits - Parking Account

✓ Commuter Benefits - Transit Account

✓ VOLUNTARY BENEFITS

✓ BENEFICIARY INFORMATION

✓ ELECTION SUMMARY

The minimum annual contribution amount is \$500 for both FSA Health Care and Dependent Care accounts. Due to the system limitation, the calculation of the monthly contribution amount cannot be less than \$41.67. Please enter \$500.04 for the minimum annual goal amount (\$41.67x12=\$500.04)

FSA - Health Care Reimbursement Account

CURRENT COVERAGE	
Coverage: FSA - Health Care Reimbursement Account Annual Goal Amount : \$2,750.00	Coverage Date: 01/01/2024
Employee Cost (Per Pay Period) : Pre Tax: \$229.17 Post Tax: \$0.00	Employer Cost: \$0.00 Total: \$229.17

RUNNING TOTAL Per Pay Period Deduction
\$1408.57

I WANT TO WAIVE FSA - HEALTH CARE REIMBURSEMENT ACCOUNT

OR

ENTER GOAL AMOUNTS:

FSA - Health Care Reimbursement Account

You have to uncheck the box before making elections in the FSA. Note, this process applies to all FSA election, not only the Medical FSA.

SELECT YOUR BENEFITS COVERAGE BENEFITWALK (PLAN YEAR 2024)

- ✓ ABOUT YOU
- ✓ CORE BENEFITS
- FLEXIBLE SPENDING ACCOUNT
 - FSA - Health Care Reimbursement Account
 - ✓ FSA - Dependent Care Reimbursement Account
 - ✓ Commuter Benefits - Parking Account
 - ✓ Commuter Benefits - Transit Account
- ✓ VOLUNTARY BENEFITS
- ✓ BENEFICIARY INFORMATION
- ✓ ELECTION SUMMARY

The minimum annual contribution be less than \$41.67. Please enter

The monthly contribution amount cannot

YOU HAVE OPTED TO WAIVE THIS FEATURE
PLEASE CONFIRM

YES CANCEL

FSA - Health Care Reimbursement

Coverage:
FSA - Health Care Reimbursement A
Annual Goal Amount - \$2,750.00

Please select YES to confirm unwaive the coverage.

Employee Cost (Per Pay Period) :
Pre Tax: \$229.17
Post Tax: \$0.00

Employer Cost:
\$0.00
Total:
\$229.17

I WANT TO WAIVE FSA - HEALTH CARE REIMBURSEMENT ACCOUNT

OR

ENTER GOAL AMOUNTS:

FSA - Health Care Reimbursement Account

Pay Period Goal Amount

Annual Goal Amount



RUNNING TOTAL Per Pay
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\$1408.57

→ FLEXIBLE SPENDING ACCOUNT

- FSA - Health Care Reimbursement Account
- ✓ FSA - Dependent Care Reimbursement Account
- ✓ Commuter Benefits - Parking Account
- ✓ Commuter Benefits - Transit Account

- ✓ VOLUNTARY BENEFITS
- ✓ BENEFICIARY INFORMATION
- ✓ ELECTION SUMMARY

FSA - Health Care Reimbursement Account

<u>CURRENT COVERAGE</u>	
Coverage: FSA - Health Care Reimbursement Account Annual Goal Amount : \$2,750.00	Coverage Date: 01/01/2024
Employee Cost (Per Pay Period) : Pre Tax: \$229.17 Post Tax: \$0.00	Employer Cost: \$0.00 Total: \$229.17

I WANT TO WAIVE FSA - HEALTH CARE REIMBURSEMENT ACCOUNT
OR

You should be able to elect your FSA amount. As noted, employee who are selecting \$500, if the error message popped up, please enter \$500.04.

ENTER GOAL AMOUNTS:

FSA - Health Care Reimbursement Account

Pay Period Goal Amount

\$ 0.00

Annual Goal Amount

\$ 0.00



RUNNING TOTAL Per Pay Period Deduction
\$1408.57

✓ ABOUT YOU

✓ CORE BENEFITS

→ FLEXIBLE SPENDING ACCOUNT

The minimum annual contribution amount is \$500 for both FSA Health Care and Dependent Care accounts. Due to the system limitation, the calculation of the monthly contribution amount cannot be less than \$41.67. Please enter \$500.04 for the minimum annual goal amount (\$41.67x12=\$500.04)

✓ FSA - Health Care Reimbursement Account

→ FSA - Dependent Care Reimbursement Account

✓ Commuter Benefits - Parking Account

✓ Commuter Benefits - Transit Account

✓ VOLUNTARY BENEFITS

✓ BENEFICIARY INFORMATION

✓ ELECTION SUMMARY

FSA - Dependent Care Reimbursement Account

CURRENT COVERAGE	
Coverage: FSA - Dependent Care Reimbursement Account Annual Goal Amount : \$2,750.00	Coverage Date: 01/01/2024
Employee Cost (Per Pay Period) : Pre Tax: \$229.17 Post Tax: \$0.00	Employer Cost: \$0.00 Total: \$229.17

\$
**RUNNING TOTAL Per Pay
Period Deduction
\$1408.57**

I WANT TO WAIVE FSA - DEPENDENT CARE REIMBURSEMENT ACCOUNT

OR

ENTER GOAL AMOUNTS:

FSA - Dependent Care Reimbursement Account

Pay Period Goal Amount

\$ 229.17

Annual Goal Amount

\$ 2,750.00

If you choose to elect FSA – Dependent Care Reimbursement Account enter the Pay Period Goal Amount, Scroll Down and Click on Save & Continue

SELECT YOUR BENEFITS COVERAGE BENEFITSWALK (PLAN YEAR 2024)



✓ ABOUT YOU

✓ CORE BENEFITS

→ FLEXIBLE SPENDING ACCOUNT

✓ FSA - Health Care Reimbursement Account

✓ FSA - Dependent Care Reimbursement Account

→ Commuter Benefits - Parking Account

✓ Commuter Benefits - Transit Account

✓ VOLUNTARY BENEFITS

✓ BENEFICIARY INFORMATION

✓ ELECTION SUMMARY

Commuter Benefits - Parking Account

CURRENT COVERAGE

Coverage:

FSA - Parking Account

Annual Goal Amount : \$3,000.00

Coverage Date:

01/01/2024

Employee Cost (Per Pay Period) :

Pre Tax: \$250.00

Post Tax: \$0.00

Employer Cost:

\$0.00

Total:

\$250.00

I WANT TO WAIVE COMMUTER BENEFITS - PARKING ACCOUNT

OR

ENTER GOAL AMOUNTS:

FSA - Parking Account

Pay Period Goal Amount

\$ 250.00

Annual Goal Amount

\$ 3,000.00



RUNNING TOTAL Per Pay
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\$1408.57



If you choose to elect Commuter Benefits – Parking Account enter the Pay Period Goal Amount, Scroll Down and Click on Save & Continue

SELECT YOUR BENEFITS COVERAGE BENEFITWALK (PLAN YEAR 2024)



- ✓ ABOUT YOU
- ✓ CORE BENEFITS
- FLEXIBLE SPENDING ACCOUNT
 - ✓ FSA - Health Care Reimbursement Account
 - ✓ FSA - Dependent Care Reimbursement Account
 - ✓ Commuter Benefits - Parking Account
 - Commuter Benefits - Transit Account

- ✓ VOLUNTARY BENEFITS
- ✓ BENEFICIARY INFORMATION
- ✓ ELECTION SUMMARY

Commuter Benefits - Transit Account

CURRENT COVERAGE	
Coverage: FSA - Transit Account Annual Goal Amount : \$2,500.00	Coverage Date: 01/01/2024
Employee Cost (Per Pay Period) :	Employer Cost:
Pre Tax: \$208.33	\$0.00
Post Tax: \$0.00	Total: \$208.33

I WANT TO WAIVE COMMUTER BENEFITS - TRANSIT ACCOUNT

OR

ENTER GOAL AMOUNTS:

FSA - Transit Account

Pay Period Goal Amount

\$ 208.33

Annual Goal Amount

\$ 2,500.00



RUNNING TOTAL Per Pay Period Deduction \$1408.57

If you choose to elect Commuter Benefits – Transit Account enter the Pay Period Goal Amount, Scroll Down and Click on Save & Continue

ENROLLMENT - BENEFITSWALK

SELECT YOUR BENEFITS COVERAGE BENEFITSWALK (PLAN YEAR 2024)



- ✓ ABOUT YOU
- ✓ CORE BENEFITS
- ✓ FLEXIBLE SPENDING ACCOUNT

- VOLUNTARY BENEFITS**
- Supplemental Life Insurance and AD&D For Employee
- ✓ Supplemental Life Insurance For Your Spouse
- ✓ Supplemental Life Insurance For Your Child(ren)
- ✓ Long Term Disability Buy-up
- ✓ Legal Plan
- ✓ Critical Illness
- ✓ Group Accident Insurance

- ✓ BENEFICIARY INFORMATION
- ✓ ELECTION SUMMARY

Supplemental Life Insurance and AD&D For Employee

CURRENT COVERAGE	
Coverage: Supplemental Life and AD&D Actual Coverage Amount : \$50,000.00	Coverage Date: 01/01/2024
Employee Cost (Per Pay Period) : Pre Tax: \$0.00 Post Tax: \$0.00	Employer Cost: \$0.00 Total: \$0.00

I want to waive Supplemental Life Insurance and AD&D For Employee

SUPPLEMENTAL LIFE AND AD&D

\$50,000.00
~~\$60,000.00~~

(Please click on 'Calculate Premium' to view the cost for your selected Coverage Amount. Once calculated, click 'Save & Continue' to save your Election)

After choosing the Coverage Amount, please Click on Calculate Premium, Scroll Down and Click on Save & Continue

CALCULATE PREMIUM

If you choose to elect Supplemental Life and AD&D, please use the "Down" Arrow to increase Coverage & "UP" Arrow to reduce the Coverage

RUNNING TOTAL Per Pay Period Deduction \$1408.57

ENROLLMENT - BENEFITSWALK

SELECT YOUR BENEFITS COVERAGE BENEFITSWALK (PLAN YEAR 2024)



- ✓ ABOUT YOU
- ✓ CORE BENEFITS
- ✓ FLEXIBLE SPENDING ACCOUNT

→ VOLUNTARY BENEFITS

- ✓ Supplemental Life Insurance and AD&D For Employee
- Supplemental Life Insurance For Your Spouse
- ✓ Supplemental Life Insurance For Your Child(ren)
- ✓ Long Term Disability Buy-up
- ✓ Legal Plan
- ✓ Critical Illness
- ✓ Group Accident Insurance

✓ BENEFICIARY INFORMATION

✓ ELECTION SUMMARY

Supplemental Life Insurance For Your Spouse

CURRENT COVERAGE

Coverage:
Supplemental Life Insurance for Spouse
Actual Coverage Amount : \$50,000.00

Coverage Date:
01/01/2024

Employee Cost (Per Pay Period) :
Pre Tax: \$0.00
Post Tax: \$0.00

Employer Cost:
\$0.00
Total:
\$0.00

I want to waive Supplemental Life Insurance For Your Spouse

SUPPLEMENTAL LIFE INSURANCE FOR SPOUSE

\$40,000.00
\$50,000.00

If you choose to elect Supplemental Life for Spouse, please use the "Down" Arrow to increase Coverage & "UP" Arrow to reduce the Coverage

After choosing the Coverage Amount, please Click on Calculate Premium, Scroll Down and Click on Save & Continue

CALCULATE PREMIUM



RUNNING TOTAL Per Pay Period Deduction
\$1408.57

ENROLLMENT - BENEFITSWALK

SELECT YOUR BENEFITS COVERAGE BENEFITSWALK (PLAN YEAR 2024)



- ✓ ABOUT YOU
- ✓ CORE BENEFITS
- ✓ FLEXIBLE SPENDING ACCOUNT
- VOLUNTARY BENEFITS**
 - ✓ Supplemental Life Insurance and AD&D For Employee
 - ✓ Supplemental Life Insurance For Your Spouse
 - Supplemental Life Insurance For Your Child(ren)**
 - ✓ Long Term Disability Buy-up
 - ✓ Legal Plan
 - ✓ Critical Illness
 - ✓ Group Accident Insurance
- ✓ BENEFICIARY INFORMATION
- ✓ ELECTION SUMMARY

Supplemental Life Insurance For Your Child(ren)

CURRENT COVERAGE

Coverage: Supplemental Life Insurance for Child(ren) Coverage Date: 01/01/2024
Actual Coverage Amount : \$10,000.00

Employee Cost (Per Pay Period) : Employer Cost:
Pre Tax: \$0.00 \$0.00
Post Tax: \$3.14 Total: \$3.14

I want to waive Supplemental Life Insurance For Your Child(ren)

SUPPLEMENTAL LIFE INSURANCE FOR CHILD(REN)

\$10,000.00



Requested Coverage Amount: \$10,000.00
Actual Coverage Amount: \$10,000.00

Employee Cost: \$3.14
Employer Cost: \$0.00



**RUNNING TOTAL Per Pay
Period Deduction
\$1408.57**

**If you choose to elect Supplemental Life for
Child(ren), after electing, please Scroll Down
and Click on Save & Continue**

ENROLLMENT - BENEFITSWALK

SELECT YOUR BENEFITS COVERAGE BENEFITSWALK (PLAN YEAR 2024)



- ✓ ABOUT YOU
- ✓ CORE BENEFITS
- ✓ FLEXIBLE SPENDING ACCOUNT
- VOLUNTARY BENEFITS**
 - ✓ Supplemental Life Insurance and AD&D For Employee
 - ✓ Supplemental Life Insurance For Your Spouse
 - ✓ Supplemental Life Insurance For Your Child(ren)
 - Long Term Disability Buy-up**
 - ✓ Legal Plan
 - ✓ Critical Illness
 - ✓ Group Accident Insurance
- ✓ BENEFICIARY INFORMATION
- ✓ ELECTION SUMMARY

Long Term Disability Buy-up

CURRENT COVERAGE

Coverage:
LTD Buy-Up - 66 2/3% of Salary
Actual Coverage Amount : \$6,055.86

Coverage Date:
01/01/2024

Employee Cost (Per Pay Period) :
Pre Tax: \$0.00
Post Tax: \$0.00

Employer Cost:
\$0.00
Total:
\$0.00

I want to waive Long Term Disability Buy-up

LTD BUY-UP - 66 2/3% OF SALARY

If you choose to Waive LTD Buy-Up Click on "I want to waive LTD Buy-up and Click on Save & Continue"

66.67% Monthly Salary



Requested Coverage Amount: \$0.00
Actual Coverage Amount: \$0.00

Employee Cost: \$0.00
Employer Cost: \$0.00



**RUNNING TOTAL Per Pay
Period Deduction
\$1408.57**

ENROLLMENT - BENEFITWALK

SELECT YOUR BENEFITS COVERAGE BENEFITWALK (PLAN YEAR 2024)



✓ ABOUT YOU

✓ CORE BENEFITS

✓ FLEXIBLE SPENDING ACCOUNT

→ VOLUNTARY BENEFITS

- ✓ Supplemental Life Insurance and AD&D For Employee
- ✓ Supplemental Life Insurance For Your Spouse
- ✓ Supplemental Life Insurance For Your Child(ren)
- ✓ Long Term Disability Buy-up
- Legal Plan
- ✓ Critical Illness
- ✓ Group Accident Insurance

✓ BENEFICIARY INFORMATION

✓ ELECTION SUMMARY

Legal Plan

CURRENT COVERAGE	
Coverage: Legal Plan	Coverage Date: 01/01/2024
Employee Cost (Per Pay Period) :	Employer Cost:
Pre Tax: \$0.00	\$0.00
Post Tax: \$21.45	Total: \$21.45

I WANT TO WAIVE LEGAL PLAN

OR

Legal Plan

Employee Cost \$21.45	Employer Cost \$ 0.00
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RUNNING TOTAL Per Pay Period Deduction \$1408.57



If you choose to elect the Legal Plan, after electing, please Scroll Down and Click on Save & Continue

SELECT YOUR BENEFITS COVERAGE BENEFITWALK (PLAN YEAR 2024)



- ✓ ABOUT YOU
- ✓ CORE BENEFITS
- ✓ FLEXIBLE SPENDING ACCOUNT
- VOLUNTARY BENEFITS**
 - ✓ Supplemental Life Insurance and AD&D For Employee
 - ✓ Supplemental Life Insurance For Your Spouse
 - ✓ Supplemental Life Insurance For Your Child(ren)
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 - ✓ Legal Plan
 - Critical Illness**
 - ✓ Group Accident Insurance
- ✓ BENEFICIARY INFORMATION
- ✓ ELECTION SUMMARY

Critical Illness

CURRENT COVERAGE

Coverage : 30000 Coverage Date: 01/01/2024
 Actual Coverage Amount : \$30,000.00

Covered:
Employee+Family

I want to waive Critical Illness

OR

30000 [Add Dependents](#)

\$30,000.00

[VIEW BENEFIT INFORMATION](#)

Employee Only \$21.90
 Employee + Spouse \$44.70
 Employee+Family \$59.10
 Employee + Child(ren) \$36.30

Requested Coverage Amount: \$30,000.00 Employee Cost: \$59.10

**RUNNING TOTAL Per Pay
Period Deduction
\$1.00**

If you choose to elect Critical Illness, please elect the Tier Level of your choice, after electing. Please Scroll Down and Click on Save & Continue

ENROLLMENT - BENEFITSWALK

SELECT YOUR BENEFITS COVERAGE BENEFITSWALK (PLAN YEAR 2024)



- ✓ ABOUT YOU
- ✓ CORE BENEFITS
- ✓ FLEXIBLE SPENDING ACCOUNT

→ VOLUNTARY BENEFITS

- ✓ Supplemental Life Insurance and AD&D For Employee
- ✓ Supplemental Life Insurance For Your Spouse
- ✓ Supplemental Life Insurance For Your Child(ren)
- ✓ Long Term Disability Buy-up
- ✓ Legal Plan
- ✓ Critical Illness
- Group Accident Insurance

✓ BENEFICIARY INFORMATION

Group Accident Insurance

CURRENT COVERAGE

High Plan	Employee+Family
Employee Cost (Per Pay Period):	Employer Cost:
Pre Tax: \$0.00	\$0.00
Post Tax: \$35.34	Total:
	\$35.34

I WANT TO WAIVE GROUP ACCIDENT INSURANCE

OR

Add Dependents

HIGH PLAN

View Benefit Information

- Employee Only \$14.37 Employee Cost: \$35.34
- Employee + Spouse \$21.55 Employer Cost: \$0.00
- Employee+Family \$35.34
- Employee + Child(ren) \$27.43



PER PAY PERIOD DEDUCTION FOR THIS PLAN
\$35.34

Select Dependents



RUNNING TOTAL Per Pay
Period Deduction
\$1408.57

If you choose to elect Group Accident Insurance, please elect the Tier Level of your choice, after electing. Please Scroll Down and Click on Save & Continue

- ✓ ABOUT YOU
- ✓ CORE BENEFITS
- ✓ FLEXIBLE SPENDING ACCOUNT
- ✓ VOLUNTARY BENEFITS
- ➔ BENEFICIARY INFORMATION
- ✓ ELECTION SUMMARY

Beneficiary Information

BENEFICIARY ALLOCATION

Select the Plan Type:

All Elected Plan Type(s)

Apply this allocation to all plan types: Yes No

↓ Select
Beneficiary

ADD →
BENEFICIARY

Please Click Here to
Add Beneficiary

BENEFICIARY 1

NAME:
SAM SAMPLE

SSN:
XXX-XX-6789

DATE OF BIRTH:
10/08/1980

BENEFICIARY TYPE:
SPOUSE

BENEFIT TYPE:
Primary

% ALLOCATION:
100.00

AMOUNT:
\$50,000.00

Please select the type
Here, Primary or
Contingent

Please Allocate the amount
Here, enter percentage.

BENEFICIARY 2

NAME:
SAM SAMPLE

SSN:
XXX-XX-6700

DATE OF BIRTH:
05/12/2021

BENEFICIARY TYPE:
CHILD

BENEFIT TYPE:
Contingent

% ALLOCATION:
100.00

AMOUNT:
\$50,000.00

SELECT YOUR BENEFITS COVERAGE BENEFITSWALK (PLAN YEAR 2024)



- ✓ ABOUT YOU
- ✓ CORE BENEFITS
- ✓ FLEXIBLE SPENDING ACCOUNT
- ✓ VOLUNTARY BENEFITS
- ✓ BENEFICIARY INFORMATION
- ELECTION SUMMARY**

Election Summary → Confirm Election

ELECTED

CORE BENEFITS

→ Medical and Pharmacy Benefit Plan Dental Benefit Plan Vision Benefit Plan Employee Assistance Program Basic Life Insurance

Basic Life Insurance For Your Spouse or Domestic Partner Basic Life Insurance For Your Dependent Child(ren) Basic AD&D Insurance For Employee Basic Long Term Disability

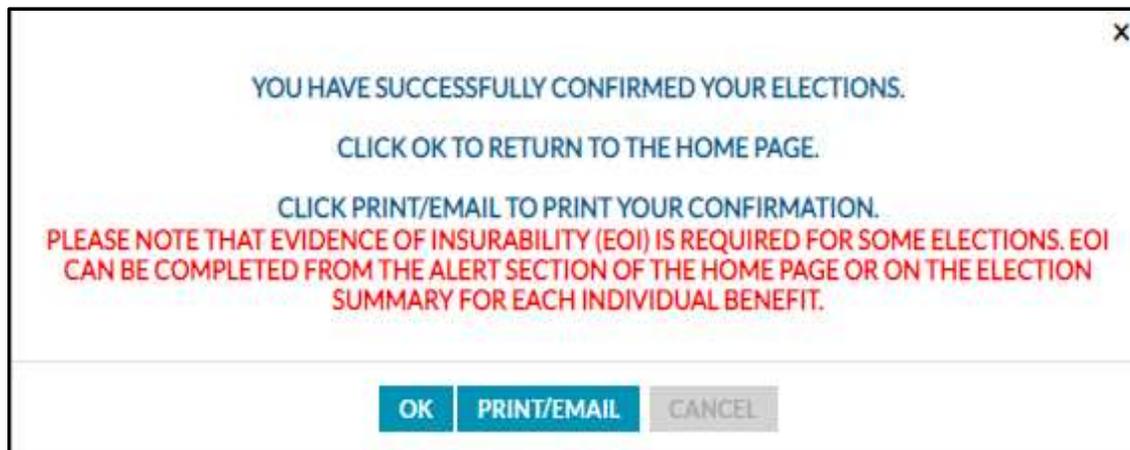
BLUE SHIELD ACCESS+ HMO

(Employee+Family)
(Eff From 01/01/2024)
Employee Cost (Per Pay Period)

Pre Tax:	\$430.00
Post Tax:	\$0.00
Employer Cost:	\$2,369.78
Total:	\$2,799.78
Coverage Date:	01/01/2024
Dependents:	Sam Sample (Eff From 01/01/2024) Sam Sample

After you complete your elections you will reach at "Election Summary" page. Please Click on "Confirm Elections" on the "TOP" right corner or the "Bottom" right corner


**RUNNING TOTAL Per Pay
Period Deduction
\$1,405.43**



After you Confirm your elections you will get this "POPUP" you can choose "OK" or "PRINT/EMAIL" to print or email the election summary

THANK YOU 😊😊😊