



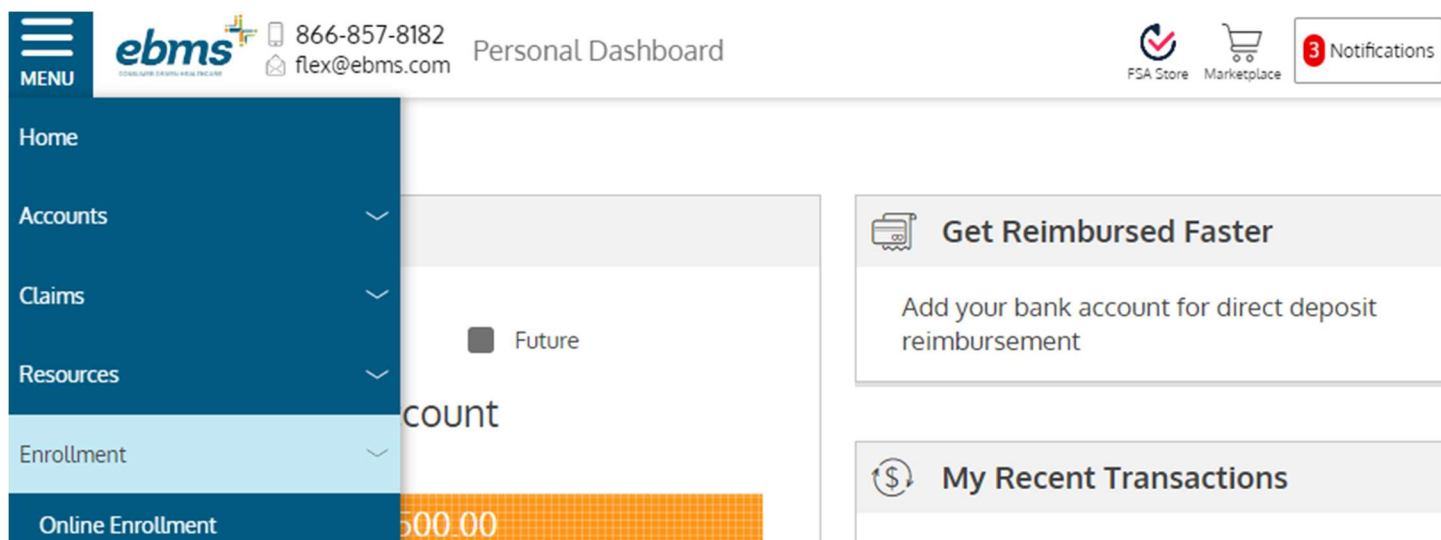
Consumer Driven Health (CDH) Online Open Enrollment Instructions

Please go to www.ebms.com and click on the Login button where you will enter your MiBenefits username and password and click "Sign in". Once successfully logged into your MiBenefits account and click on the orange "FSA, HSA & HRA "Portal button.



Employee Open Enrollment

You will be forwarded to the Personal Dashboard for the CDH benefits where you must either sign up for benefits or waive to participate in the plan year benefits that starts July 1st, 2023. You will go to the blue Menu Box, select Enrollment menu, and click on the option for Online Enrollment



This will take you to the Online Enrollment page which will only be available for members from May 22nd 2023 - June 9th 2023. You must either enroll or waive your participation in the plan.

Enroll Online

Welcome to online enrollment for your benefit plans. Your online enrollment schedule is listed below. For any other questions, please contact us at 866-857-8182.

Dependent Care Flexible Spending Account - Alternate 2	ENROLL
2023 DEPENDENT CARE ACCOUNT <i>New</i>	WAIVE
Enrollment Dates Apr 14, 2023 - May 31, 2023	Annual Election Amount \$0.00

Flexible Spending Account 2	ENROLL
2023 HEALTH FLEXIBLE SPENDING ACCOUNT <i>New</i>	WAIVE
Enrollment Dates Apr 14, 2023 - May 31, 2023	Annual Election Amount \$0.00

Enrolling in a Spending Account Plan

Step 1: Where you can update your demographic information. If the fields are in gray, they are not editable, you will want to make any demographic updates with your Employer or in the MiBenefits portal with your health plan enrollment information.

FSA Online Enrollment

STEP 1 STEP 2 STEP 3

You are on step 1 of 3

Please verify/update your demographic information. You are also able to add or update your dependent information by clicking "Add Dependents".

Here is a Checklist of all information you should have on-hand:

- Your address as well as your dependent's address
- Your contribution or Annual Election Amount

**Your demographic information will be updated at the end of the open enrollment period.

General Info			
First Name *	CAROL	Gender *	Female
Initial		Phone	
Last Name *	BURNETT	Email	
Date of Birth *	Mar 14, 1956	Re-Enter Re-enter Email	
SSN *	517842849		
Marital	Single		

Address

Home Address* ?

Address 1 *

15666 BROWN LANE

Address 2

City *

BILLINGS

State *

Montana

ZIP *

59102-2347

Country *

Select country

CANCEL

SAVE FOR LATER

NEXT

Step 2: This screen allows you to enter your annual election amount for the new plan year, *be sure to include the decimal point on your election amount.*

FSA Online Enrollment

STEP 1

STEP 2

STEP 3

You are on step 2 of 3

Please enter your election amount for the plan year.

Account Details

Plan Description

HEALTH FLEXIBLE SPENDING ...

Plan Start Date

07/01/2023

Plan End Date

06/30/2024

Election

3050.00

* Annual election can be from \$0.00 - \$3,050.00

Claims Crossover Auto-Pay:

☐

?

☐

I elect to receive the above coverage under the Cafeteria Plan. *

CANCEL

SAVE FOR LATER

NEXT

The Auto-Flex option will **NOT** be carried over from the previous plan year. Participants must enroll in this option each year by putting a check mark in the Claims Crossover Auto Pay box.

Step 3: Where you review your Account Details. At the bottom of the confirmation page, there is an Agreements section that you must review and check each box (to the right) to indicate that you agree with the plan information listed.

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EMPLOYEE BENEFIT MANAGEMENT SYSTEM

FSA Online Enrollment

FSA Store

Marketplace

Notifications

FSA Online Enrollment

STEP 1STEP 2STEP 3

You are on step 3 of 3

Account Details

Plan Description

HEALTH FLEXIBLE SPENDING ...

Plan Start Date

07/01/2022

Plan End Date

06/30/2023

Participant Demographics

JEAN ROCKFORD , Female

Date of Birth

Aug 6, 1941

SSN

*****4444

Phone

815 777 9999

Email

kmusson@ebms.com

Home Address

9898 CDA LAKE DRIVE
CDA, 12345
US

Mailing Address

9898 CDA LAKE DRIVE
CDA, 12345
US

EDIT INFO

Account Details

Annual Election:

\$2,850.00

EDIT INFO

Claims Crossover Auto-Pay:

Yes

Agreements

I may not change the election during the Plan Year unless there is a change in my family status (e.g. termination of employment or change to part time status by either myself or my spouse, marriage, divorce, death of my spouse or child, adoption or birth of my child) if the change is allowed by my Flex Plan Document.

I agree.*☒

My employer and I agree that my compensation will be reduced by the amounts set forth above for each pay period during the Plan Year (or during such portion of the year after the date of this agreement). My Social Security benefits may also be reduced as a result of my election.

I agree.*☒

The Plan Administrator is authorized to adjust the amount of my salary reduction and benefits if it is necessary to satisfy certain provision of the Internal Revenue Code or as a result of changes in premiums for benefits that are insured.

I agree.*☒

My election of salary reduction and benefits will remain in effect only for the Plan Year for which these elections are made. Failure to enroll during the election period prior to each subsequent Plan Year will be considered an election not to participate in the Plan for that Plan Year.

I agree.*☒

I understand and agree that this agreement is: 1. Subject to the terms of the company's Cafeteria Plan, Health Flexible Spending Account, and/or Dependent Care Assistance Plan as amended from time to time; 2. Shall be governed by and construed in accordance with applicable laws; 3. Shall take effect under applicable laws; and 4. Revokes any prior election and compensation reduction agreement relating to such plan(s).

I agree.*☒

CANCEL

SAVE FOR LATER

SUBMIT

Updated April 18, 2023

After you have checked each box, click “Submit” to continue. When the enrollment process is completed, a final confirmation page will appear to show the enrollment was processed.

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CONNECTION DEPENDENT HEALTHCARE

FSA Online Enrollment

PSA Store

Marketplace

2 Notifications

✓

Thank you!

Your application has been submitted.

You have completed the enrollment application and your account will be effective on the first day of your new plan year.

✓

DONE

Click “Done” when complete and you will return to the Online Enrollment election section. You can now edit your election if needed or you can choose to enroll in or to waive any additional plans.

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CONNECTION DEPENDENT HEALTHCARE

866-857-8182
flex@ebms.com Online Enrollment

PSA Store

Marketplace

5 Notifications

Enroll Online

Welcome to online enrollment for your benefit plans. Your online enrollment schedule is listed below. For any other questions, please contact us at 866-857-8182.

Dependent Care Flexible Spending Account - Alternate 2

2023
DEPENDENT CARE ACCOUNT
Completed

WAIVE

EDIT

Enrollment Dates
Apr 14, 2023 - May 31, 2023

Annual Election Amount
\$5,000.00

Flexible Spending Account 2

2023
HEALTH FLEXIBLE SPENDING ACCOUNT
Completed

WAIVE

EDIT

Enrollment Dates
Apr 14, 2023 - May 31, 2023

Annual Election Amount
\$3,050.00

Waiving Enrollment into Employer Plan

If you choose not to Enroll into a specific CDH plan clicking on the “Waive” button to be taken to the “Waive Enrollment” screen where you will waive your participation in either the FSA or DCA by selecting the box and clicking the Waive button.

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CONNECTION DEPENDENT HEALTHCARE

866-857-8182
flex@ebms.com Waive Enrollment

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5 Notifications

Waive Enrollment

Plan ID

DCA

Plan Description

DEPENDENT CARE ACCOUNT

Plan Start Date

Jul 01, 2023

Plan End Date

Jun 30, 2024

Waive Enrollment *

☒

I waive the above coverage under the Cafeteria Plan.

✕

CANCEL

✓

WAIVE

Updated April 18, 2023

PLAN DEADLINES FOR CLAIMS SUBMISSIONS

Plan Year Dates: 7/1/22-6/30/23

Last Day to submit claims: 9/28/23



Tips to ensure that your Flexible Spending Account (FSA) or Dependent Care Account (DCA) claim can be processed timely:

1. When submitting claims by fax/email/mail you must include the FSA/DCA claim form, or you can submit your request online from the Personal Dashboard.
2. You must include supporting documentation for all services.
 - a. Documentation for the FSA must be the insurance EOB or legibly show the patient's name, date of service, service provider name, total amount owed (including insurance amounts if applicable), and the eligible service or product. Prescription claims require the RX tag that includes the fill date, RX number, patient name and the amount owed.
 - b. Documentation for the DCA must include a copy of the receipt or bill for dependent care service detailing the name, address, and tax ID/SSN of the provider, as well as dates of service being claimed. Receipts are not necessary if the provider has signed the Request for Flex Reimbursement Form.
 - i. *Note: The tax identification number or Social Security number of the provider is required on all submissions.*
3. Do **NOT** submit credit card payment receipts, balance due statements, cancelled checks and "estimated" insurance references as they not acceptable forms of documentation.

Frequently Asked Questions regarding the FSA Carry Over

Q: What happens to any remaining funds after the last day to submit claims?

A: Any funds except the eligible FSA carry over amount will be forfeited back to your employer, and you are no longer eligible to claim these funds. This is commonly known by the IRS as the "Use it or Lose it" rule.

Q: What is the FSA Carry Over Amount for this plan year?

A: \$610

Q: When are the carry over amounts eligible to use on dates of service after 7/1/23?

A: After the last day to submit claims has passed, so 9/29/23.

Q: What if I have any other questions?

A: You can reach the Member Services team toll free at 866-857-8182 or flex@ebms.com.



P.O. Box 21367 Billings, MT 59104-1367
Phone: 866.857.8182 Fax: 844.791.8315 Email: EBMS_receipts@alegeus.com

Request for Flex/DCA Reimbursement

Employer Name		Employer Group Number
Employee's Last Name	First Name	Employee's ID Number
Address		E-mail Address

Healthcare Expenses

Date of Service	Provider	Description of expense (office visit, co-pay, prescription, etc.)	Patient Name	Amount Requested
				\$
				\$
				\$
				\$
				\$
Total amount requested				\$

You must include supporting documentation from the provider so that your claim can be processed timely. Documentation must legibly show the patient's name, date of service, service provider name, total amount owed (including insurance amounts if applicable), and the eligible service or product. Prescription claims require the RX tag that includes the fill date, RX number, patient name and the amount owed. **Note: Credit card receipts, balance due statements, cancelled checks and "estimated" insurance references are not acceptable forms of documentation**

Dependent Daycare Expenses

Name of dependent	Date of birth	Daycare Provider Name & Tax ID number	Dates of Service	Amount Requested
				\$
				\$
				\$
Total amount requested				\$

Participants must submit a copy of the receipt or bill for dependent care service detailing the name, address, and tax ID/SSN of the provider, as well as dates of service being claimed. Receipts are not necessary if the provider has signed the Request for Flex Reimbursement Form. **Note: The tax identification number or Social Security number of the provider is required on all submissions.**

Daycare Provider's Signature: _____ Date: _____

To the best of my knowledge and belief, my statements in the Request for Flex Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. The expense(s) listed has not been reimbursed or is not reimbursable under any other health plan coverage and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account be reduced by the amount requested above.

Employee's Signature: _____ Date: _____

Revised on 8/4/2021

CDH Online Submissions

You can access your Consumer Driven Health (CDH) spending account by logging into your MiBenefits account at www.ebms.com with your username and password. Once logged into miBenefits, click on the CDH portal button that appears in your MiBenefits account.

miBenefits

CLICK HERE TO VIEW ACCOUNT AND OTHER BENEFIT INFORMATION.

Forms AND DOCUMENTS **FSA, HSA & HRA PORTAL** **View CLAIMS INFORMATION**

Flexible Spending Account
(01-01-2019 - 12-31-2019)

Available Balance: **\$796.50**

Annual Election	YTD Contribution	Spent
\$2,600.00	\$1,100.00	\$1,803.50

Available Balance: **\$796.50**

Details

This will take you to Personal Dashboard where you will view the My Accounts Menu which will default to the current plan year; however, you can change your view to a previous plan year.

ebms Personal Dashboard

My Accounts

Plan years to show: ☐ Previous ☒ Current ☐ Future

Flexible Spending Account - FSA (01/01/2022-12/31/2022)

\$2,400.00

Balance \$2,400.00 Spent \$0.00

You can click anywhere on the current available balance to be redirected to the Accounts Details page.

Flexible Spending Account - FSA (01/01/2022-12/31/2022)

DASHBOARD

TRANSACTIONS

ADD EXPENSE

Account Balance

Balance
\$2,400.00

Annual Election Summary

\$2400.00

\$1800.00

\$1200.00

\$2,400.00

Remaining Payroll Deposits
\$2,400.00

You will click on the Add Expense button where you will select the type of expense from the drop-down menu and click Next.

Expense Type

Add New Expense

Let's Get Started

On the next few screens, we will ask you some questions about the expense you would like to submit.

SUBMIT
EXPENSE
NOW

Select from your available service options:

* - Required Field

General Medical Expenses

Please fill out the fields below and make sure to attach the proper documentation.

[ADDITIONAL INSTRUCTIONS](#)

NEXT

You will then enter the date of service for when the actual services were provided and go to the Next screen. Please note that eligible dates of services are not determined on when you are invoiced by the provider or pay the bill.

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Add New Expense

PSA Store

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Notifications

Expense Type / Service Date

Add New Expense

Select the service date:

What day did you incur the service?

SERVICE DATE*02/01/2022

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NEXT

You should enter the total amount that is patient responsibility owed to the provider for that date of service and click Next.

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Add New Expense

PSA Store

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Expense Type / Service Date / Amount

Add New Expense

Enter the amount of your eligible expense.

CLAIM AMOUNT*\$300.00

* Required Field

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NEXT

You will then be asked to preview your request, add a note if the request is for a spouse or taxable dependent child, and add documentation.

You must add supporting documentation so that your claim can be processed timely. The best documentation will be your insurance EOB, however we can also accept an itemized receipt that legibly show the patient's name, date of service, service provider name, total amount owed (including insurance amounts if applicable), and the eligible service or product. Prescription claims require the RX tag that includes the fill date, RX number, patient name, and the amount owed. **Note: Credit card receipts, balance due statements, cancelled checks, and "estimated" insurance references are not acceptable forms of documentation. Daycare expense submissions must include the tax ID or social security number of that provider.**

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Add New Expense

PSA Score

Marketplace

Notifications

Expense Type / Service Date / Amount / Preview

Add New Expense Preview

Please confirm the following information is correct:

Pay Self

\$300.00 (Edit)

General Medical Expenses Expense for SANDRA SMITH (Edit)

Service Date: Feb 01, 2022 (Edit)

One Time Payment

Note for records:

This date of service is for my spouse Sam Smith.

+

ADD DOCUMENTATION

DOCUMENTATION HELP

Cancel

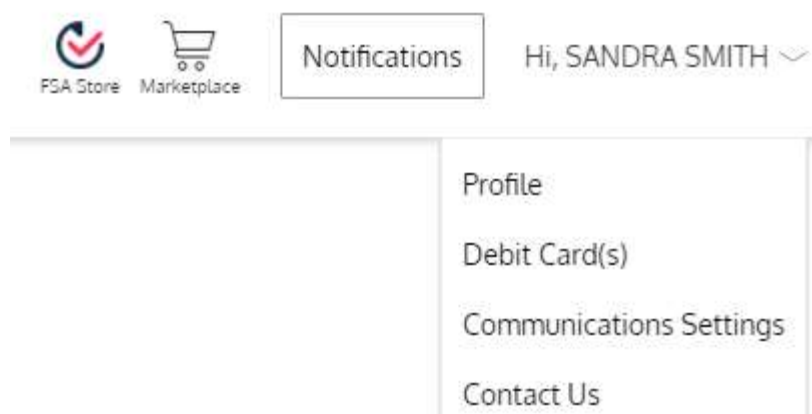
I certify the claim is accurate. I understand and agree to the terms and conditions.

I certify that I have not been reimbursed by any other source, and that to the best of my knowledge, this expense is eligible for reimbursement. I additionally understand that I must submit documentation in to support my submission and in order to receive reimbursement. If I am not eligible to receive reimbursement you will receive notification of the claim determination.

SUBMIT

If everything is correct, place a checkmark in the box to the right of the disclosure at the bottom of the screen to certify that the expenses you're submitting are valid and click on the blue "Submit" button at the bottom of the screen.

Anytime a CDH claim is successfully submitted a confirmation message will be found in the Notifications box on the Personal Dashboard. You can update your Communication Settings by hovering over your name in the right side of the screen.



Claims submitted online take up to 24-48 business hours to be processed. If a request is pended for additional information or is denied, a written message will be added to the Notification Box the next business day after the transaction is processed.

When the claim has been processed the completed transaction and any reimbursement information can be found by going to the Menu box, clicking on Accounts, and selecting My Transactions. The date of service will be listed based on the date the transaction was processed; you can then select a transaction and the box will expand to show the date of service, amounts, reimbursement methods, and any applicable denial reasons.

