

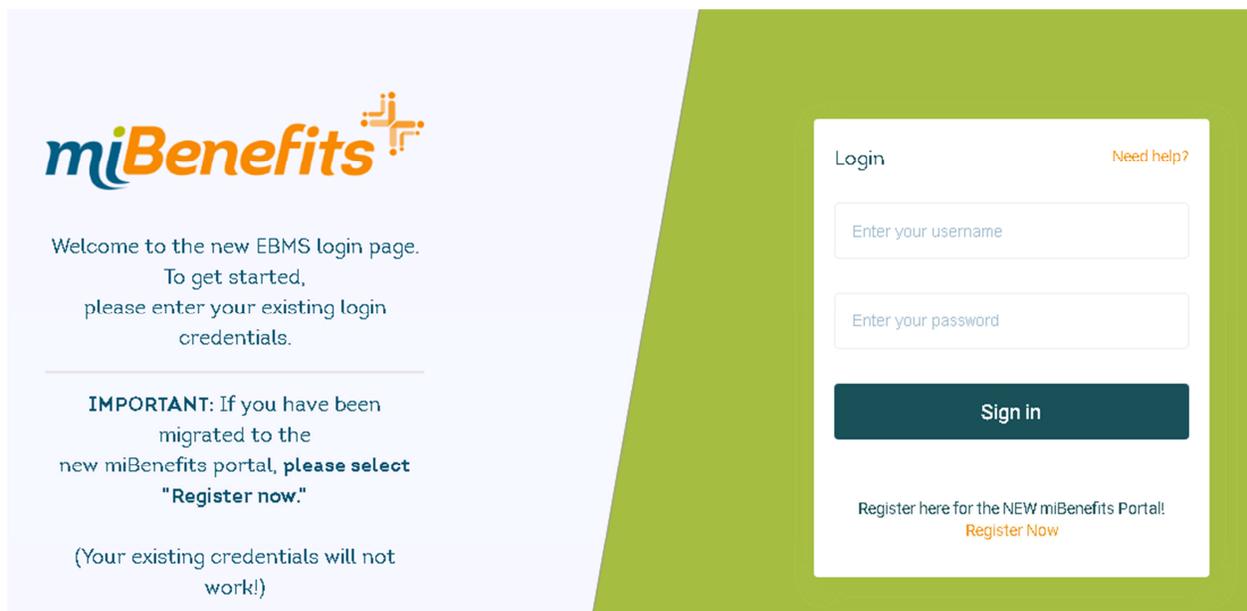


CDH Online Open Enrollment Instructions

Please access your miBenefits CDH account at www.ebms.com.

If you have any troubles signing into your account, please contact EBMS Customer Service at 866-857-8182

The log in page displays as shown below. Enter the user name and password for your miBenefits account and click “Sign in”.

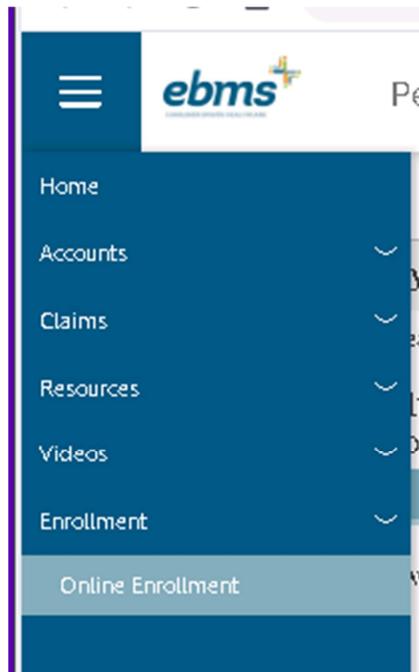


Once logged into miBenefits, click on the orange “FSA, HSA & HRA Portal” button on the homepage. This will take you to the CDH homepage where you can sign up for (or decline to participate in) the renewal plan year benefits.



Employee Open Enrollment

After you log into miBenefits and click on the orange “FSA, HSA & HRA Portal” link provided, the homepage appears. Under the Main header menu, click “Enrollment”, “Online Enrollment” to continue.



Clicking on the “Enrollment” link opens the page and shows you the available plans offered by your Employer.

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.

<p>Dependent Care Account 2021 Dependent Care Flexible Spending Account <i>New</i></p> <p>Enrollment Dates March 2021 - Jun 11, 2021</p>	<p>ENROLL</p> <p>WAIVE</p> <p>Annual Election Amount \$0.00</p>	<p>Flexible Spending Account 2021 Health Flexible Spending Account <i>New</i></p> <p>Enrollment Dates March 2021 - Jun 11, 2021</p>	<p>ENROLL</p> <p>WAIVE</p> <p>Annual Election Amount \$0.00</p>
--	---	---	---

You have the option to “Enroll” or “Waive” by clicking on the appropriate link to either plan.

Enrolling in Employer Plan

Clicking on “Enroll” takes you to the below screen. If your Employer allows, you can update your demographic information or add a new dependent at this point. If the fields are grayed out and not be editable, you will want to make any demographic updates with your Employer or in the miBenefits portal with your health plan enrollment information.

HRA Online Enrollment
 STEP 1 STEP 2 STEP 3

Please verify/update your demographic information. Any changes should be given to your HR. Your demographic information will be updated at the end of the open enrollment period.
 Please note if you or your spouse participate or plan to participate in a Health Savings Account, you are ineligible to participate in a Health FSA.

General Info

First Name *	<input type="text" value="JEAN"/>	Gender	<input type="text" value="Female"/>
Initial	<input type="text" value="S"/>	Phone	<input type="text" value="815 777 9999"/>
Last Name *	<input type="text" value="ROCKFORD"/>	Email	<input type="text" value="jrockford@test.com"/>
Date of Birth	<input type="text" value="Aug 6, 1941"/>	Re-Enter Re-enter Email	<input type="text" value="jrockford@test.com"/>
SSN	<input type="text" value="444554444"/>		
Marital	<input type="text" value="Married"/>		

Address

Home Address *	<input type="text" value="9898 CDA LAKE DRIVE"/>	Address 1 *	<input type="text" value="9898 CDA LAKE DRIVE"/>
Address 1 *	<input type="text" value="9898 CDA LAKE DRIVE"/>	Address 2	<input type="text"/>
Address 2	<input type="text"/>	City *	<input type="text" value="CDA"/>
City *	<input type="text" value="CDA"/>	State *	<input type="text" value="Idaho"/>
State *	<input type="text" value="Idaho"/>	ZIP *	<input type="text" value="12345"/>

Dependent

ADD DEPENDENT

LOUIS ROCKFORD , Male

Authorized signer ID
999-98-0072-02

Date of Birth
Apr 20, 1940

SSN

Relationship
Spouse Or Common Law Spouse

Home Address
4444 MARYLAND WAY
LOVES PARK, 61111
US

EDIT DEPENDENT
DELETE DEPENDENT

JON ROCKFORD , Male

Authorized signer ID
999-98-0072-03

Date of Birth
Jun 4, 2000

SSN

Relationship
Child

Home Address
4444 MARYLAND WAY
LOVES PARK, 61111
US

EDIT DEPENDENT
DELETE DEPENDENT

NEXT SAVE FOR LATER CANCEL

After changes are made, click on "Next" to continue.

The "Next" screen allows you to enter your annual election amount for the new plan year.



Please enter your election amount for the plan year.

Account Details

Plan Description Health Flexible Spending Account

Plan Start Date 07/01,

Plan End Date 06/30

Election

Claims Crossover Auto-Pay: ?

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

Plan Election Agreement

By electing Claims Crossover Auto-Pay, I agree that I (or a tax dependent) have incurred the expenses and they were not reimbursed and are not reimbursable by any other benefit plan and I will not claim the expenses reimbursed through my Health FSA as deductions or credits when filing my individual tax returns. I agree to refund the Plan for any Health FSA reimbursement I receive that fails to meet any of the previously stated conditions.

from \$0.00 - \$2,650.00

Claims Crossover Auto-Pay: ?

Enter an Annual Election amount. Check the "Claims Crossover Auto-Pay" box if you wish to enroll. After you have entered the election amount and checked the "Election" box, click on "Next" to continue. A confirmation page will appear and provide you with a recap of your demographic information, dependent information and election amounts.

Dependent

ADD DEPENDENT

LOUIS ROCKFORD , *Male*

Authorized signer ID
999-98-0072-02

Date of Birth
Apr 20, 1940

SSN

Relationship
Spouse Or Common Law Spouse

Home Address
4444 MARYLAND WAY
LOVES PARK, 61111
US

 EDIT DEPENDENT

 DELETE DEPENDENT

JON ROCKFORD , *Male*

Authorized signer ID
999-98-0072-03

Date of Birth
Jun 4, 2000

SSN

Relationship
Child

Home Address
4444 MARYLAND WAY
LOVES PARK, 61111
US

 EDIT DEPENDENT

 DELETE DEPENDENT

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.

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.*

SUBMIT SAVE FOR LATER CANCEL

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.

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 change your election if needed or you can choose to enroll in or to waive any additional plans.

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.

<p>Dependent Care Account 2021 Dependent Care Flexible Spending Account <i>New</i></p> <p>Enrollment Dates Mar 23, 2021 - Jun 11, 2021</p> <p>Annual Election Amount \$0.00</p> <p>ENROLL</p> <p>WAIVE</p>	<p>Flexible Spending Account 2021 Health Flexible Spending Account <i>New</i></p> <p>Enrollment Dates Mar 23, 2021 - Jun 11, 2021</p> <p>Annual Election Amount \$0.00</p> <p>ENROLL</p> <p>WAIVE</p>
--	---

Waiving Enrollment into Employer Plan

If you choose **not** to Enroll into a specific Employer plan, you have chosen to waive enrollment. Clicking on the "Waive" button will take you to the "Waive Enrollment" screen.

Waive Enrollment

Waive Enrollment

	Plan ID	FSA
	Plan Description	Health Flexible Spending Account
	Plan Start Date	Jul 01,
	Plan End Date	Jun 30,
<input type="checkbox"/>	Waive Enrollment	<input type="checkbox"/> I do not elect to receive the above coverage under the Cafeteria Plan.

Please click in the Waive box and click on the blue "Waive" button, you will be returned to the Open Enrollment election page and it shows that you have waived or declined enrollment into that benefit plan.

This completes the Employee online enrollment process. Please contact EBMS with any questions.