

*This worksheet is a planning tool only. Enrollment requires Summit Self Service online entry between 11/8/23 and 11/15/23 at 11:59pm. Refer to the **Employee Benefit Plan Reference Guide and the Open Enrollment website** (<https://www.ramseycounty.us/employees/employee-open-enrollment-2024-benefits>) for plan information, rates, and enrollment restrictions.*

Medical Insurance	<p>⇒ Elect 1 Medical plan or waive _____ coverage BCBS Preferred Plan _____ BCBS Broad Plan _____ BCBS High Deductible Health Plan with Health Saving Account (HSA) _____</p> <p>Elect coverage for ___ yourself ___ yourself + legally married spouse ___ yourself + child(ren) ___ family Follow the instructions to enroll dependents including providing social security number(s)</p>
Dental Insurance	<p>⇒ Elect 1 Dental plan or waive _____ coverage MetLife Select Plan _____ MetLife Open Plan _____</p> <p>Elect coverage for ___ yourself ___ yourself + legally married spouse ___ yourself + child(ren) ___ family Follow the instructions to enroll dependents including providing social security number(s)</p>
Vision Insurance	<p>⇒ Elect the VSP Advantage Plan _____ or waive _____ coverage</p> <p>Elect coverage for ___ yourself ___ yourself + legally married spouse ___ yourself + child(ren) ___ family Follow the instructions to enroll dependents including providing social security number(s)</p>
Flex Spending Accounts (FSA)	<p>⇒ Elect either a Regular or Limited Health Care Reimbursement Account annual amount or waive _____ participation</p> <p>Regular Health Care Reimbursement Account annual amount (if enrolled in Preferred or Broad Medical Plan) \$ _____ (max \$3200)</p>
Health Care (Regular or Limited w/HSA)	<p>Limited Health Care Reimbursement Account annual amount (must be enrolled in the High Deductible Plan w/HSA per IRS rules). \$ _____ (max \$3200) Please note: eligible expenses include dental and vision expenses only. Medical expenses can be reimbursed from employee HSA account.</p>
Dependent Care	<p><i>Note: Unused funds may be forfeitted if not used by year end according to the County's 2024 Cafeteria plan. Consider known or predictable upcoming expenses when electing an annual amount to avoid forfeitting funds.</i></p>
Annual re-enrollment required	<p>⇒ Elect Dependent Care Reimbursement Account amount \$ _____ (max \$5000) or waive _____ participation. Funds not used by year end are forfeitted.</p>
Employee Contribution to Health Savings Account (HSA)	<p>Only applies to employees who elect the High Deductible BCBS medical plan with a Health Savings Account (HSA) who elect to contribute an amount monthly in addition to the County's monthly contribution to their Health Saving Account (HSA). The 2024 combined annual HSA contribution (County + employee) max for single coverage is \$4150 and max for all other coverages is \$8300. The County's annual contribution for single coverage will be \$60/month * 12 mos = \$720 and for all other coverages will be \$125 * 12 mos = \$1500. Subtract the County's total contribution amount from the max allowed to determine employee max annual contribution amount.</p>
Only applies to those enrolled in the High Deductible medical plan	<p>⇒ Employee voluntary annual HSA contribution amount (in addition to the County's contribution) \$ _____ (max \$3430 Single, max \$6800 all other coverages). Mid-year changes are allowed by the IRS upon a qualifying event.</p>

Optional Life Insurance	<p>⇒ Add or increase optional employee life coverage? Yes ___ No ___ Amount \$ _____</p> <p>Refer to the Employee Benefit Plan Reference Guide for maximum amount allowed <i>(In most cases, Evidence of insurability is required to enroll or increase coverage. Review the Evidence of Insurability form available in the Employee Life enrollment panel. You will be notified by HR if you need to complete and send the form to Minnesota Life for approval.)</i></p>
	<p>⇒ Add or increase spouse-domestic partner life insurance? Yes ___ No ___ Amount \$ _____</p> <p>Refer to the Employee Benefit Plan Reference Guide for maximum amounts allowable. <i>(Evidence of insurability is required to enroll or increase coverage. Complete the Evidence of Insurability form available in the Spouse Life enrollment panel and send to Minnesota Life for approval.)</i></p>
	<p>⇒ Add Accidental Death and Dismemberment (AD&D) Insurance? Yes ___ No ___ <i>(You must have optional employee and/or spouse-domestic partner life and the amount of AD&D coverage must equal the total of your optional employee and spouse-domestic partner life coverage.)</i></p> <p>⇒ Add ___ or Drop ___ Dependent Life Insurance? <i>Provides \$20,000/eligible dependent(s), including spouse or domestic partner. Evidence of insurability not required during open enrollment. Review eligible dependnet criteria.</i></p>
	Disability Insurance
<p>⇒ Drop, add or change Short-Term Disability elimination period? Elimination period opitons: ___30 day ___60 day ___90 day or ___Waive <i>Evidence of insurability not required during open enrollment.</i></p>	

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After submitting your 2024 benefit elections in Summit Self Service, print a Confirmation Statement.

Please note: Changes in life insurance that require evidence of insurability (optional employee life and spouse/domestic partner life) will not appear on the Confirmation Statement you print. If coverage changes are approved by Minnesota Life, you will receive a Confirmation Statement from HR Benefits after approval.