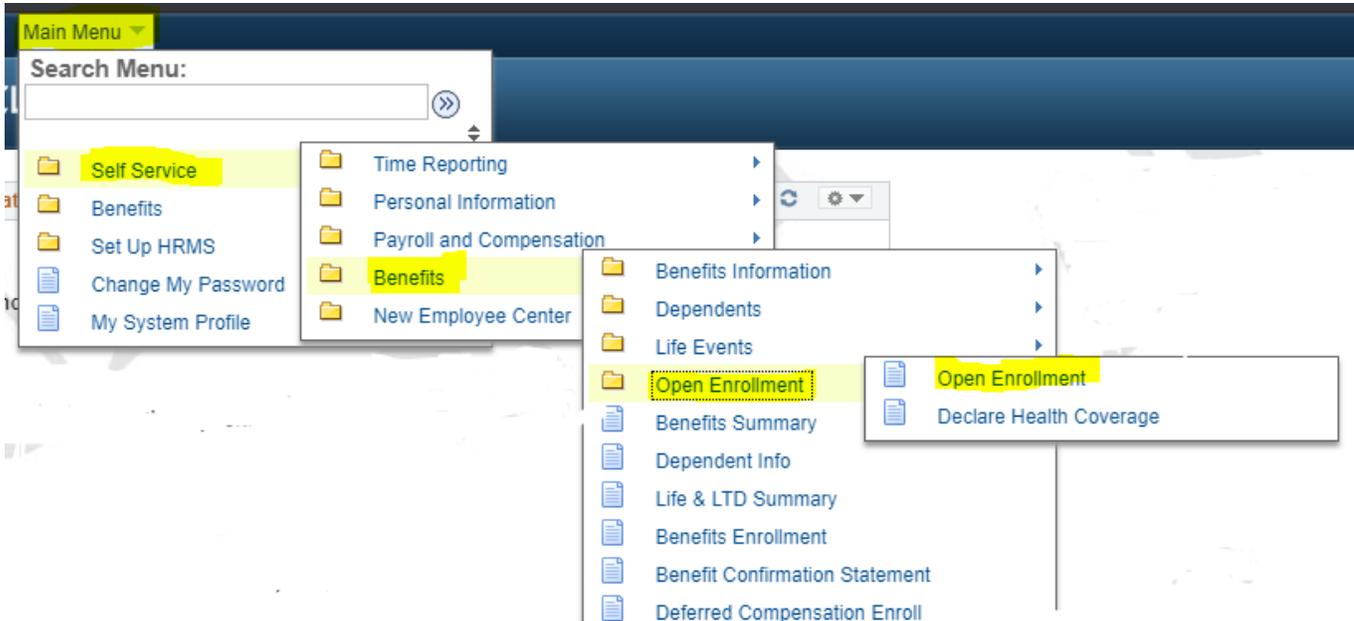


# INSTRUCTIONS FOR ONLINE OPEN ENROLLMENT PROCESS 2021 PLAN YEAR

First, log in to VTHR and Navigate to the Open Enrollment Portal:



This Open Enrollment Module will allow you to:

- Enroll in the Flexible Spending account for 2021; and
- Review and make changes to your current medical/dental elections.

## Important note regarding navigation

Once you have accessed the portal, do not use the tabs at the top to navigate between screens. To advance, scroll down and hit "Next" on each page. After you check "Confirm" and click "Submit" you can re-enter the portal via the self-service menu to edit any of the information you entered previously.

You can access the portal as many times as you want from November 1-30. Your final submission must be submitted by midnight on November 30.

# FLEXIBLE SPENDING PROGRAM

The first screen is for the Flexible Spending Program.

If you do not want to enroll in the Flexible Spending Account for 2021, scroll down to the bottom of the page and click "Next" to move on to the Medical Plan.

FSA | Medical | Dental | Confirm and Submit

**Reminder: Do NOT use these tabs for navigation. (See note on previous page.)**

## FSA Enrollment

[Open Enrollment Information](#)

Open Enrollment for year 2021

This form must be submitted during Open Enrollment each November to remain in the program

### STEP 1 - SELECT AN ACTION

Enroll in Flexible Spending Account program

**Step 1: Click enroll box to activate the selection boxes. The page will show your current elections.**

### STEP 2 - VERIFY YOUR INFORMATION

Name

Date of Birth

Address Line 1

Address Line 2

City

State

Postal Code

Empl ID

**Step 2 – Verify that your personal information is correct.**

### STEP 3 - SELECT FSA PROGRAMS

#### For Healthcare Expenses

What expenses qualify for this program? [?](#)

Enroll in FSA Program for Health Care Expenses

Annual Salary Reduction amount  Estimated Deduction per Pay-Period

(Annual maximum of \$2,750; Minimum amount of \$130)

**Step 3 – Click the Enroll button if you are enrolling in the Health Care account and enter an amount.**

#### For Dependent/Daycare Expenses

What expenses qualify for this program? [?](#)

Enroll in FSA Program for Dependent/Daycare Expense

Annual Salary Reduction amount  Estimated Deduction per Pay-Period

(Cannot exceed \$5,000 or \$2,500 if Married filing separate income tax returns; Minimum amount of \$130)

**Click the Enroll button if you are enrolling in the Dependent Care account and enter an amount.**

### STEP 4 - SELECT REIMBURSEMENT METHOD

Direct Deposit to my account  Mail Check

#### Direct Deposit Information

Populate Banking Information from Direct Deposit

Name of Financial Institution/Bank

Bank Routing Number (9-digit)  [View check example](#)

Account Number  Account Type

**Step 4 - If you choose reimbursement via Direct Deposit, you can automatically populate the remaining fields with your current Direct Deposit information. You may also choose reimbursement via check.**

### STEP 5 - ORDER ASIFLEX DEBIT CARDS

#### FSA Debit Card Order (for Healthcare Expenses only)

Do I have to order a card? [?](#)

ASIFlex Card Order - Check ONLY if you currently do not have a card

For replacement/additional cards, please contact Benefits

**Step 5 - Check the box if you would like to order a debit card. Do not check if you have a card already. If your card is expiring, a new one will automatically be mailed to you.**

**Click "Next" to advance to the Medical and Dental pages.**

# MEDICAL AND DENTAL PAGES

Both the medical and dental pages are similar and follow the same enrollment procedures. If you want to keep your current elections, scroll down and click "Next" on each page.

Please note: If you are newly adding a Domestic Partner, you must complete and submit a Domestic Partner Application to the Benefits Division, or your Enrollment will not be processed. The paperwork is available here: [Domestic Partner Enrollment Package](#)

For questions, contact the Benefits Division:  
[dhrr.benefits@vermont.gov](mailto:dhrr.benefits@vermont.gov) or 802-828-6700 option 1, option 3

FSA | **Medical** | Dental | Confirm and Submit

## Medical Enrollment

[Open Enrollment Information](#) **Your current coverage election is indicated here.**

This is your Current Medical Coverage

Type of Benefit	Plan Selected	Coverage	Covered Participants
Medical	SelectCare, After-Tax	Employee Only	

Would you like to make a change to your coverage?  Yes  No **If you want to make a change, click yes. If not, click no and scroll down and click "Next"**

Please use the "Next" button to validate selections and proceed to the next step

Plan Type	*Medical Plan	Last Name	First Name	Social Security #	Date of Birth	Gender	Relationship to Employee	*Action Request
1 Medical	SelectCare Before-Tax					Female	Self	Enroll

**If enrolling for the first time or changing your plan, select a plan from the drop-down menu and "Enroll" for you and each dependent. For the Action Request, select "Enroll", "Cancel Coverage" or "No Change" for yourself and/or each dependent listed here.**

Would you like to add new dependents?  
Use the + sign to add more lines  
Please contact Benefits if you are adding a Domestic Partner **Use the (+) or (-) arrows to add or delete dependents.**

Plan Type	*First Name	Middle Name	*Last Name	Social Security #	*Date of Birth	*Gender	*Relationship to Employee	Enroll Dependents In Dental
1 Medical								<input type="checkbox"/>

Next **New dependents can be automatically added to the Dental plan via the check box.**

**Click "Next" to advance onto the Dental Page and follow the same instructions to make any changes. Then, click "Next" to advance to the submission page.**

## Submit Enrollment Choices

### For Enrollment and or Changes to my Medical and/or Dental Insurance:

I hereby request the above action and authorize the Department of Human Resources to withhold from my wages appropriate deduction(s), if any, toward the cost of coverage. I understand that any medical information that is pertinent and necessary for the payment of claims for me or my eligible dependents can be used in accordance with the privacy rules established by the Health Insurance Portability and Accountability Act. I certify that the above information is complete and correct and that all claims submitted will only be for eligible plan members.

### For Enrollment in Flexible Spending Account Plan, I understand:

- I have elected to have pretax deductions from my pay based on the number of pay periods as set up by my employer during the plan year, and that this election will continue until this Agreement is amended or terminated as allowed under the Plan.
- Pretax deductions reduce my compensation for tax purposes which reduces my Social Security benefits.
- I cannot change or terminate my election unless I experience a qualified change in status as allowed under the Plan.
- My employer may change my election if necessary in order to satisfy certain provisions of the Internal Revenue Code.
- My election and this Agreement will cease and unused funds will be forfeited upon termination of my employment, including retirement.
- Complete claims with correct supporting documentation must be submitted timely as described in the Plan in order to be considered for reimbursement.
- Expenses for which I claim a tax deduction under my income tax return cannot also be reimbursed under this Plan.
- Unused funds are forfeited at the end of the Plan Year, except for a maximum carryover of \$500 from the Health Care FSA into the next plan year.
- The Dependent/Daycare FSA and Health Care FSA benefits, and my rights and obligations under this plan, as specified in my employer's Plan materials.
- Re-enrollment is required annually and a new form with annual elections must be submitted each November to remain in the program.
- This Agreement cancels any prior election agreement I have made under the Plan and cannot be changed except as stated in my employer's Plan.

### For the ASIFlex Debit Card, I understand:

- The card is optional and I can choose at each point-of-sale if I want to use the card, or file a traditional claim.
- I may be required to provide supporting documentation to substantiate certain card transactions. ASIFlex will notify me if documentation is required.
- I must read my messages posted to my secure message center at [www.asiflex.com](http://www.asiflex.com) to understand the documentation that may be required.
- I must submit correct and appropriate documentation upon request.
- It is my responsibility to request appropriate documentation from health care providers in order to substantiate card transactions.
- If I do not supply the requested documentation in the timeframe requested, my card will be temporarily deactivated as required by IRS regulations.
- I will receive two debit cards, both in my name. The cards will be mailed to my home address approximately two to three weeks from the date my application is processed.
- I must activate my card(s) by calling the toll-free number as provided, and I can select a PIN if I wish.
- I can sign for credit transactions or I can supply my PIN for debit transactions.
- Each employer plan is different. There may be an annual fee for the card so I must review my employer plan materials. Fees for additional or replacement card sets are \$5 and will be deducted from my flexible spending account balance.
- Additional information regarding card usage can be found online at [www.asiflex.com/debitcards](http://www.asiflex.com/debitcards).
- I hereby state that the above information is accurate, to the best of my knowledge. Additionally, I certify that the card will only be used to pay for eligible health care expenses as defined in the plan and IRC §213(d). I will not seek reimbursement from any other source for the expenses paid for with the card. I also acknowledge that if I do not provide requested documentation in a timely fashion, my card will be deactivated, in accordance with IRS regulations.

Confirm and Accept

Submit

**Click "Confirm and Accept" to indicate your authorization and acceptance of the terms outlined, and then "Submit".**

**If you need to make changes on previous screens, hit "Submit" first, and then return to the portal via Self-Service.**

**For questions and assistance, contact the Benefits Division:**

**[ahr.benefits@vermont.gov](mailto:ahr.benefits@vermont.gov) or 802-828-6700 option 1, option 3**