NASA FEDERAL CREDIT UNION

2019 Open Enrollment Guide

Group Insurance Costs

The cost of providing group health and dental for our employees exceeds three million dollars annually and these costs rise each year. We continually look for ways to provide the best possible coverage at the most reasonable employer/employee costs. We currently offer our employees the choice of two group health plans:

- A high deductible HMO with 0% employee premium contribution
- A low deductible HMO with a 20% employee premium contribution

High deductible plans have become one of the best defenses against the rising cost of health care. If you are not currently participating in our High Deductible HMO, we strongly recommend you give it consideration. Very often, you will find that it is more cost effective than the Low Deductible HMO. Be sure to attend an Open Enrollment Meeting to find out if you can save money.

2019 Open Enrollment Benefit Highlights

- We are happy to report that there are no plan design changes for the new plan year. Deductibles and copays remain the same.
- We successfully negotiated with CareFirst for:
  - » No increase to group health premiums
  - » 2.3% increase to dental premiums.
  - » Dental plan year maximum coverage increased to $2,000.
- There are new limits for:
  - » Flexible Spending Accounts ($2,700 for plan year March 1, 2019 thru February 29, 2020)
  - » Health Savings Accounts ($3,500 individual / $7,000 dependent for calendar year 2019). $1,000 annual catch up for participants age 55 and older.

MD, DC & Northern VA Employees
Open Enrollment January 15 - January 29, 2019

Our Group Benefit Plan Year begins March 1, 2019. The Online Open Enrollment period will begin on January 15th with a completion deadline of 4:30 pm on January 29th. This is for both group health plans, the dental plan, Flexible Spending Accounts (FSA), voluntary vision, voluntary life, short term disability (STD), and Long Term Care (LTC).

Passive Enrollment: For the 2019 Open Enrollment Season, we will offer passive enrollments. This means: If you do not complete the group health, dental, and voluntary vision online enrollment process by the January 29th deadline, you will keep your current election(s) and participate with March 1, 2019 premium rates.

Flexible Spending Accounts: All types must be elected every year by regulatory requirement. Participants that do not re-enroll in a Flexible Spending Account by the January 29th deadline will not be eligible to participate until the 2020/2021 plan year.

Voluntary Life, Short-term Disability and Long-Term Care: Employees may apply for/or increase their voluntary life and/or Long-Term Care, or apply for Short-term Disability insurance. To apply, send an email to e-admin@nasafcu.com by the January 29th deadline. See page 8 for details.

Online Open Enrollment Procedures

- Group Health/Dental/Vision: Eligible full-time employees may enroll or re-enroll.
- Flexible Spending Accounts: Full-time employees are eligible to enroll or re-enroll. **Note: Current FSA elections do not roll over automatically**

Option I

1. Log into **EARL**, go to **Employee Resources**, then **Employee Information Center**
2. Under **User Login** enter your **User ID** (Wendy Fairweather = wfairweather@nasafcu)
3. Enter your **Password** (if you forgot your password select the "Forgot Your Password?" option). Select **Log In**.
4. From the 2019 Open Enrollment Welcome Page select "**Start This Enrollment**"
5. Review **Dependents and Beneficiaries**. If you need to add/update a dependent or beneficiary, complete this step. If not, go to Step 6.
6. Select the first option of "**Walk Me Through My Benefit Options**" then select "**Continue**"
7. To go through each eligible plan either click a plan name on the left or the "**Forward To**" option in the top right corner to move to the next plan.
8. New Enrollees - if not currently enrolled in a medical plan select "**ENROLL IN THIS PLAN**", choose a Coverage Level, Enroll Dependents (if applicable), and enter Primary Care Physician (PCP) Info. Select "**ENROLL**".
9. Current Enrollees - your current benefits will be marked as "**ALREADY ENROLLED**". To make a change select "**UNENROLL FROM PLAN**" or "**EDIT PLAN / MORE INFO**".
   - If switching from High Deductible HMO to Low Deductible HMO, you must unenroll from HSA plan, if applicable.
   - In Medical section, enroll in desired plan, enter PCP info, select **"ENROLL"** and select "**YES"**.
   - If you are choosing to drop a dependent, navigate to the medical and/or dental plan you want to change, select "**EDIT PLAN / MORE INFO" > "EDIT PLAN"** and make the appropriate changes, select "**DONE".**
10. After making your changes, select "**REVIEW AND COMPLETE**"
11. ***Review your elections for accuracy. Print and keep statement for Confirmation***.
12. If changes are needed, select "**RETURN TO CHOOSE PLANS**" at the bottom of the page.
13. If no changes are needed, select "**COMPLETE ENROLLMENT**".

Option II

If you are logging in from home or another network, type the following web address into your browser: https://workforcenow.adp.com then begin with step 2.

Can I Make Changes?

If you selected "Complete Enrollment" option, you can make changes BEFORE the January 29th deadline (4:30 pm). To make changes go to the "Myself" tab, select "Benefits", select "Enrollments" and continue to the end of the process.

Employee and Dependent Eligibility

Generally, full-time employees and their dependents are eligible to enroll in a NASA FCU Group Health Plan. Your spouse is not eligible to enroll in a NASA FCU Group Health Plan if your spouse is currently enrolled in another employer group health plan. Enrolled employees may cover eligible spouses, and children under the age of 26. Proof of relationship to the employee (such as marriage certificate, birth certificate, adoption paperwork, etc.) is required at time of enrollment. Proof of relationship documents must be submitted to Jason Carcione by the online enrollment deadline of January 29, 2019 or the dependent must wait until the 2020 Open Enrollment Period.

CareFirst My Account and Mobile App

All employees with CareFirst medical/dental coverage are encouraged to create a CareFirst account. If you have not yet registered, follow these simple steps: Go to carefirst.com ▶ Log In or Register ▶ Not Yet Registered in the Member Login ▶ My Account box in the upper right hand section and follow the instructions. The My Account Features Tour is very helpful: carefirst.com/MyAccountDemo

- Locate Providers
- Review Benefits
- View/Print/Order ID Cards
- Check Claim & Deductible Status
- Access Wellness & BlueRewards
- Many more features!

888-567-9155
carefirst.com

Video Visits

- Secure, convenient, 24/7 access to board-certified doctors
- Connect from a personal computer or mobile device
- No driving or crowded waiting rooms
- Receive care for non-emergency conditions such as:
  - » Headache/Migraine
  - » Cough/Cold/Flu
  - » Stomach ache/Diarrhea
  - » Prescription refills and more!

REGISTER & RECEIVE CARE 24/7/365
carefirstvideovisit.com

Medical Plan Highlights

The BlueChoice Open Access High Deductible HMO with Health Savings Account (HSA) and the BlueChoice Open Access Low Deductible HMO are "in-network only" plans and use the same network of doctors.

BlueChoice Open Access High Deductible HMO with Health Savings Account (HSA): The High Deductible HMO is a network-based Health Plan compatible with a Health Savings Account (HSA). The Individual plan year deductible is $1,500. For all other dependent tiers, the deductible is $3,000. Office visit Copays are $10 for primary care physicians and $20 for specialist visits. After meeting the applicable plan year deductible and applicable Copay, most services are covered at 100%. Preventive Services are covered at 100% and are not subject to the plan year deductible. However, if a medical diagnosis is present or discovered during a Preventive Care visit, the deductible will apply.

Additionally, hospitalization is generally paid at 100% after the deductible is met. Upon enrollment, a primary care physician must be designated for each covered member. The Credit Union pays 100% of the premiums for this plan.

Employees enrolling in this plan are encouraged to contribute to a NASA Federal Credit Union Health Savings Account through pre-tax payroll deductions. However, employees cannot begin funding a Health Savings Account while still enrolled in a General-Purpose Health Care Flexible Spending Account (FSA). Once the FSA Plan Year ends (February 28, 2019), as long as his/her FSA has a zero balance, the employee may begin payroll deductions to fund an HSA on or after March 1, 2019. See page 3 for HSA details.

Those enrolled in the High Deductible HMO with HSA may contribute to a NASA FCU Limited-Purpose (dental/vision only) Health Care Flexible Spending Account (FSA) Account through pre-tax payroll deductions. New enrollees who wish to carry over General-Purpose Health Care FSA funds (up to $500), must elect the Limited-Purpose Health Care FSA to avoid forfeiture of your funds. See page 6 for FSA details.

BlueChoice Open Access Low Deductible HMO: The Low Deductible HMO is a network-based Health Plan compatible with a General-Purpose Health Care Flexible Spending Account (FSA). The individual plan year deductible is $250. For all other dependent tiers, the deductible is $500. The deductible applies to most services, prior to Copays and co-insurance. After meeting the applicable deductible, office visit Copays are $30 for primary care visits and $40 for specialist visits. Preventive Services are covered at 100% and are not subject to the plan year deductible. However, if a medical diagnosis is present or discovered during a Preventive Care visit, the deductible will apply.

Additionally, hospitalization is covered at 80% after the deductible is met and employees are responsible for the remaining 20%. Upon enrollment, a primary care physician must be designated for each covered member. The Credit Union pays 80% of the premiums for this plan.

Those enrolled in the Low Deductible HMO may contribute to a NASA FCU General-Purpose Health Care Flexible Spending Account (FSA) through pre-tax payroll deductions. Employees enrolling in the Low Deductible HMO are not eligible to open a Health Savings Account (HSA). *See page 6 for FSA details*.

Selecting a Primary Care Physician

At the time of enrollment in the BlueChoice Low Deductible HMO or the BlueChoice High Deductible HMO with HSA, you will need to select a Primary Care Physician (PCP) that participates in the HMO network. You will need to include your PCP's identification number on the appropriate enrollment screen. To select a PCP, refer to section on **Locating Medical Plan Providers**.* You may also call the Member Services toll-free phone number (888-567-9155) for assistance in selecting a PCP or to obtain a printed copy of the BlueChoice HMO provider directory. For children, you may designate a pediatrician as the primary care provider. If this is a new doctor for you, we highly recommend you schedule an introductory appointment to ensure you can be seen in a timely fashion should the need arise. New patients typically wait more than 30 days for the first appointment.

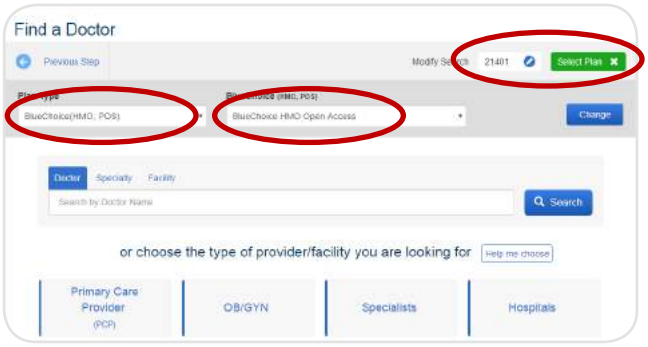
*Only legitimate PCP numbers will create a usable insurance card. Do not enter zeros or any other number that is not a PCP number.

Reminder: If you or a covered dependent changed a Primary Care Physician (PCP), you will need to update this information in the Online Enrollment Process. Otherwise, you'll receive a new insurance card(s) with incorrect PCP information. An easy way to verify a PCP for you & your dependent(s) is to go to the EIC > Myself tab > Benefits > Enrollment > Medical Plan. Compare the PCP listed on your CareFirst card(s) and update the EIC as necessary.

Locating Medical Plan Providers

To locate providers:

- Visit: **www.carefirst.com/doctor**
- Login or Select **"Continue as Guest"**
- Select **"Medical"**
- Enter your **Zip Code** in the "**Modifiy Search**" box
- Choose "**Select Plan**"
- Select **"BlueChoice (HMO, POS)"** and "**BlueChoice HMO Open Access**"



Health Savings Accounts

Employees enrolled or enrolling in the **High Deductible HMO** medical plan are eligible to open a Health Savings Account (HSA). HSAs allow you to pay for current health expenses and/or save for future health expenses on a tax-free basis. To be eligible, you must be covered under an HSA-qualified High Deductible Health Plan such as the NASA FCU High Deductible Health Plan (HDHP). Additionally, you cannot be:

- Covered by a spouse's non-HSA compatible medical plan
- Covered by a General-Purpose Health Care FSA set up through NASA FCU or through your spouse
- Enrolled in Medicaid, Medicare or Tricare
- Eligible to be claimed as a dependent on another person's tax return

HSA funds may be used to pay for medical, dental or vision care expenses not covered or reimbursed through another plan. Funds can be used to pay for medical expenses for you, your spouse, and/or your tax dependent children (funds cannot be used for children who are no longer IRS tax dependents, even if they are covered under your medical plan). If you use your funds for over-the-counter medications, you must have a prescription from your doctor. Funds used for purposes other than to pay for "qualified medical expenses" are taxable as income, and are also subject to a 20% tax penalty (except if you are disabled or over age 65) (refer to the **Online Reference List of Qualified Expenses Publication 502:** irs.gov/publications/p502). You should keep all receipts and documentation to verify your expenses in the event of an IRS audit. **Only expenses incurred after the establishment of an HSA are eligible**.

The 2019 calendar year HSA maximum allowable contribution limit is $3,500 if enrolling in Individual coverage and $7,000 if enrolling in other dependent tiers. Special rules apply for annual contributions that exceed $2,961.42 if enrolling in Individual coverage and $5,923.06 if enrolling in other dependent tiers. If both an employee and spouse have independent High Deductible Health Plan coverage with established independent Health Savings Accounts, their combined annual contributions may not exceed the IRS annual limit. Generally, employees age 55 and older who are covered by the High Deductible Health Plan can make an annual catch-up contribution to a maximum of $1,000 (additional rules apply for annual contributions that exceed $846.12). Please see Human Resources for details. The Internal Revenue Service (IRS) regulates Health Savings Accounts. For more information, please refer to **IRS Publication 969:** irs.gov/publications/p969.

Additional rules: For the employee to contribute the maximum IRS limit, the employee must participate in a high deductible plan for two consecutive plan years. There are tax consequences if this requirement is not met.

Medical Plan Comparison Chart

Open Access Plans - *No PCP or referrals necessary* **Services Per Plan Year**	**BlueChoice High Deductible HMO HSA** **In-Network Only - You Pay**	**BlueChoice Low Deductible HMO** **In-Network Only - You Pay**
Maximum Benefit	Unlimited	Unlimited
Deductible: Individual/Non- Individual	$1,500/$3,000	$250/$500
Out-of-Pocket Maximum: Individual/Non-Individual	$3,000/$6,550	$2,500/$5,000
Preventive Services	**Deductible Waived**	**Deductible Waived**
Well Child Care, Adult Physical Exam	No Copay	No Copay
Routine GYN Visit, Mammogram	No Copay	No Copay
Preventive Prenatal and Postnatal Office Visits	No Copay	No Copay
Cancer Screening (Pap, Prostate, Colorectal)	No Copay	No Copay
Outpatient Services	**Deductible Applies**	**Deductible Applies Unless Noted**
Physician Visits: Primary Care (PCP)/Specialist	$10/$20 Copay	$30/$40 Copay
Telemedicine Video Visits	$10 Copay	$30 Copay
Lab Tests, X-Rays & Imaging (MRI, PET & CAT scans)	No Copay	No Copay, Ded. Waived
Outpatient Facility Services	No Copay	No Copay
Routine Eye Exam	$10 Copay, Ded. Waived	$10 Copay, Ded. Waived
Urgent Care Center	$20 Copay	$40 Copay
Emergency Room - Copay Waived if Admitted	$100 Copay	$100 Copay
Hospitalization	**Deductible Applies**	**Deductible Applies**
Room & Board - Per Admission	$250 Copay	20%
Ancillaries & Surgery	No Copay	No Copay
Physicians Visits	No Copay	No Copay
Skilled Nursing Facility	No Copay	No Copay
Prescription Drug Coverage	**Deductible Applies**	
Out-of-Pocket Maximum: Individual/Non-Individual	Combined with Medical	$4,500/$9,000

TIER ***34/90 Day Supply***	**DRUG DESCRIPTION** **MORE INFO: carefirst.com/acarx**
Tier 0 *$0 with RX*	**Preventive Drugs**: Drugs with certain medical criteria are available for a $0 copay (e.g. aspirin, folic acid, fluoride, iron supplements, smoking cessation products, FDA-approved contraceptives for women, oral chemotherapy drugs and diabetic supplies).
$ Tier 1 *$10 / $20*	**Generic Drugs** are the same as brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. Generic drugs generally cost less than brand-name drugs.
$$ Tier 2 *$25 / $50*	**Preferred Brand Drugs:** Brand-name medications that do not have a generic equivalent - chosen for their cost-effectiveness to alternatives. If a generic drug becomes available, the preferred brand drug will be moved to the non-preferred brand tier.
$$$ Tier 3 *$45 / $90*	**Non-Preferred Brand Drugs** often have a generic or preferred brand drug option where your cost-share will be lower.
$$$$ Tier 4 *50% up to $100 / $200 Max.*	**Preferred Specialty Drugs:** Brand-name drugs that treat chronic, complex, and/or rare health conditions. These drugs may have a lower cost-share than non-preferred specialty drugs.
$$$$ Tier 5 *50% up to $150 / $300 Max.*	**Non-Preferred Specialty Drugs** have a more cost-effective preferred generic or brand specialty drug alternative available.

Ways to Save: Use Generic Drugs ▶ Use Drugs on the Preferred Drug List ▶ Use Maintenance Medications ▶ Use Mail Service Pharmacy

Compare Costs & Choose the Appropriate Tier

Participants ***choosing*** a non-preferred brand name drug (Tier 3) over its generic equivalent (Tier 1), will pay the highest copay PLUS the difference in cost between the non-preferred brand name drug and the generic drug up to the cost of the prescription. It is recommended that generic drugs be used when available. Tiers 4 and 5 for Specialty Drugs are new to the plan to help provide cost-effective solutions to treat chronic, complex and/or rare health conditions.

Formulary (Drug List) Structure Online Tools

Prescription drugs fall into one of six drug tiers which determines the price you pay. Members can view specific cost-share (copay or coinsurance) details by logging in to My Account or reviewing their annual summary of benefits. Visit **carefirst.com/acarx** or call the number on your ID card for the Preferred Drug List and pharmacy locations.

CareFirst BlueDental Plus Coverage

All full-time employees are eligible to enroll in the stand alone dental plan. Spouses cannot be enrolled in a CU dental plan if they are already covered by their employer's insurance. See page 2 for Employee and Dependent Eligibility requirements. The CareFirst BlueDental Plus Plan covers services through any dental provider, however, participants receiving services through non-CareFirst providers may pay a higher deductible and are responsible for charges that exceed the CareFirst Allowed Benefit.*

CareFirst BlueDental Plus	In-Network	Out-of-Network Reimbursement*
Plan Year Maximum	$2,000 Per Person - Combined	
Plan Year Deductible *Individual | Family*	$25 / $75	$50 / $100
Preventive/Diagnostic: *Deductible Waived* *Exams, Cleanings, X-Rays*	100%	100% AB
Basic & Major Surgical Services *Deductible Applies* *Fillings, Extractions, Oral Surgery, Endodontics (Root Canal)*	80%	80% AB
Major Restorative Services *Deductible Applies* *Dentures, Fixed Bridges, Inlays, Onlays, Crowns*	50%	50% AB

**Allowed Benefit (AB): The amount that would have been paid had the participant obtained services from a participating in-network CareFirst Preferred provider.*

YOU HAVE 3 OPTIONS FOR CARE:

$ **1. PREFERRED NETWORK**

$$ **2. CAREFIRST NETWORK**

$$$ **3. NON-NETWORK PROVIDER**

LOCATE PROVIDERS
Review Benefits & Claims
carefirst.com/doctor

SELECT: ***BlueDental Plus***

CUSTOMER SERVICE
866-891-2802

CareFirst Davis Vision Plan

All medical plans include a basic in-network vision plan through the BlueVision Davis Vision Plan, which is included in the premium. Participants may access participating providers online by visiting davisvision.com.

Avesis Voluntary Vision Plan

Employees interested in a higher level of vision benefits may enroll in the Avesis Premier Vision Plan. Participants may access participating providers online by visiting avesis.com. See chart below for a comparison of the Davis Vision and the voluntary Avesis plans.

Vision Plan Comparison	BlueVision Core Included in Medical	Avesis Premier (voluntary)
Frequency of Service	**Davis Vision**	**Avesis**
Vision Exam	Once Per Plan Year	12 Months
Lenses, Frames, Contact Lenses	Once Per Plan Year	No Limit
Vision Exam	$10 Copayment	No Copayment
Lenses		
Single Vision, Bifocal, Tifocal, Lenticular	$35 - $110 Copay	Savings up to 20%
Frames	$40 plus 10% off the amount over $70	Savings up to 20%
Contact Lenses (in lieu of glasses)	10% - 20% Savings	Savings up to 20%
Laser Vision Correction	Up to 25% Savings or 5% off advertised special	Savings up to 25%

LOCATE PROVIDERS
Review Benefits & Claims
avesis.com

CUSTOMER SERVICE
800-828-9341

Employer / Employee Plan Costs

2019 Medical, Dental and Vision Plan Premiums				
Medical Plan Costs	**Coverage Level**	**Employer Annual Plan Cost**	**Employee Annual Premium (P) / Deductible (D)**	**Employee Bi-Weekly Payroll Deduction**
BlueChoice High Deductible HMO HSA with Vision	Employee	$5,963.52	$1,500 (D)	$0.00
	Employee & Child(ren)	$11,981.16	$3,000 (D)	$0.00
	Employee & Spouse	$14,503.44	$3,000 (D)	$0.00
	Family	$18,917.64	$3,000 (D)	$0.00
BlueChoice Low Deductible HMO with Vision	Employee	$5,591.90	$1,397.98 (P) + $250 (D)	$58.25
	Employee & Child(ren)	$11,234.59	$2,808.65 (P) + $500 (D)	$117.03
	Employee & Spouse	$13,599.94	$3,399.98 (P) + $500 (D)	$141.67
	Family	$17,738.88	$4,434.72 (P) + $500 (D)	$184.78
CareFirst Dental Plan Costs	**Coverage Level**	**Employer Annual Plan Cost**	**Employee Annual Premium (P) / Deductible (D)**	**Employee Bi-Weekly Payroll Deduction**
CareFirst BlueDental Plus Plan	Employee	$347.52	$61.20 (P) + $25 (D)	$2.55
	Employee & Child(ren)	$699.84	$123.60 (P) + up to $75 (D)	$5.15
	Employee & Spouse	$847.20	$149.52 (P) + up to $50 (D)	$6.23
*** Deductibles listed are for in-network claims**	Family	$1,105.08	$194.88 (P) + up to $75 (D)	$8.12
Avesis Vision Plan Costs	**Coverage Level**	**Employer Annual Plan Cost**	**Employee Annual Premium (P)**	**Employee Bi-Weekly Payroll Deduction**
Avesis Premier (voluntary supplemental)	Employee	$0.00	$60.00 (P)	$2.50
	Employee & Child(ren)	$0.00	$120.00 (P)	$5.00
	Employee & Spouse	$0.00	$120.00 (P)	$5.00
	Family	$0.00	$120.00 (P)	$5.00
BlueVision	Included in CareFirst Medical Plan Coverage			

Types of Flexible Spending Accounts

All full-time employees are eligible for Flexible Spending Accounts. Eligible employees must make a Flexible Spending Account enrollment decision (even when declining). We offer two types of Health Care Flexible Spending Accounts and the Dependent Care Flexible Spending Account:

- **General-Purpose Health Care Flexible Spending Account** is only available to employees enrolled in the Low Deductible HMO (BlueChoice Open Access Low Deductible HMO).
- **Limited-Purpose Health Care Flexible Spending Account** is only available to employees enrolled in the High Deductible HMO with Health Savings Account (BlueChoice Open Acess High Deductible HMO w/HSA).
- **Dependent Care Flexible Spending Account** is available to employees with daycare expenses incurred for the care of child(ren) under the age of 13 or other eligible dependents.

Please see pages 7-8 for further information on the Flexible Spending Account Program.

Flexible Spending Account Program (FSA)

BESTFLEX FSA PROGRAM INFORMATION

The FSA Program offers employees the opportunity to set aside pre-tax dollars to pay for unreimbursed health care and dependent care expenses. Spending pre-tax dollars saves money!

NOTE: The IRS requires annual FSA enrollment. You must enroll through the EIC if you would like to have an FSA for the 2019/2020 plan year.

FSA elections chosen during Open Enrollment are in effect for the entire Plan Year and can only be changed due to a life status change, such as a decrease in work hours or a change in marital status. IRS rules prohibit returning unused dollars to you; therefore, careful planning of your funding is important!

You will be able to carry over a maximum of $500 in Health Care FSA funds at the end of the year as long as you elect FSA participation in the following plan year.

To learn more about this benefit, read on or visit the Employee Information Center, https://workforcenow.adp.com. From the Resources tab select Company Information, go to the Tools/References and select "EBC FSA Summary Plan Description." Direct enrollment questions to Jason Carcione at e-admin@nasafcu.com or on ext. 696. For program information, please contact Employee Benefits Corporation about the BESTflex FSA Plan, Monday - Friday, 8:00- 5:00 CST, Toll Free: (800) 346-2126, or via E-mail: participantservices@ebcflex.com.

General-Purpose Health Care Flexible Spending Account (only available to employees who elect the Low Deductible HMO)

The General-Purpose Health Care FSA can be used for out-of-pocket, unreimbursed medical expenses such as Copays, some over-the-counter medications and expenses, deductibles, co-insurance, vision, dental and orthodontic expenses incurred by you, your spouse or eligible dependent(s). There is a $2,700 limit per Plan Year on the amount you can contribute to the General-Purpose Health Care FSA. All receipts and documentation should be retained in the event of an audit.

Over-the-counter drugs and medications require a written prescription from your doctor to be an eligible expense. This limitation applies only to drugs and medications; other items such as bandages, contact lens supplies, etc. are eligible without a prescription.

Funds in the account can be spent any time during the Plan Year. A large expense incurred early in the Plan Year can be reimbursed at the time you incur it, and the balance will be withheld from your paycheck throughout the Plan Year.

Internal Revenue Code, Section 213, defines expenses for "medical care" as amounts paid for "the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body." Employee Benefits Corporation will provide reimbursement of all eligible expenses as defined within the parameters of the law.

Limited-Purpose Health Care Flexible Spending Account (only available to employees who elect the High Deductible HMO with Health Savings Account)

The Limited-Purpose Health Care FSA is similar to the General-Purpose Health Care FSA. The only difference is that it can be used solely for dental and vision expenses. Reimbursement for any other type of medical expense is not permitted.

The annual contribution limit is the same as with the General-Purpose Health Care FSA.

Dependent Care Flexible Spending Account

The Dependent Care FSA can be used for daycare expenses incurred for the care of your child(ren) under the age of 13 or other eligible dependents. You, and your spouse if you are married, must work or be a full-time student to use this account. The Dependent Care FSA maximum limit is $5,000. Employees may deposit up to $5,000 pre-tax dollars per Plan Year if married and filing a joint tax return, or up to $2,500 if single or married and filing a separate tax return.

The Dependent Care FSA differs from the Health Care FSA in that you are reimbursed for expenses incurred only up to the balance in your account at the time of the request for reimbursement. Your current balance is the maximum reimbursement you can receive.

If you pay daycare expenses in advance and send in your Reimbursement Form, you are not reimbursed until after the daycare service has been provided. For example, if a dependent care provider is paid by you on Monday for the current week, you can have the provider sign the claim form on Monday and can submit the claim, but Employee Benefits Corporation will not process the claim until the last business day of the current week.

You cannot apply the Federal Tax Credit for dependent care expenses covered by this account. Expenses for services from daycare centers which have more than six individuals may be reimbursed only if the center complies with all state and local rules. In-home day care providers are eligible for reimbursement. Please contact Employee Benefits Corporation or a tax accountant if you have questions.

Flexible Spending Account Access & Reimbursements

Account Access: As a participant, you receive 24/7 access to personal account information by visiting the EBC website at www.ebcflex.com. This website allows you to:

- Access your account balance
- Find out when your reimbursement check was issued
- Download forms
- Update your personal information
- Obtain a detailed account history

Account Reimbursement: Employee Benefits Corporation (EBC) provides quick claims turnaround, issuing checks and direct deposit transactions daily. You will need to send a Reimbursement Form to Employee Benefits Corporation when 1) you incur an unreimbursed medical expense and you do not use your Benny Benefits Debit Card or 2) to submit for daycare expense reimbursement. Forms are located in the Employee Information Center.

1. Attach supporting documentation (invoices, receipts, or Explanation of Benefits (EOB)).
2. Photocopy the Reimbursement Form and supporting documentation for your records.
3. Mail or fax to:
   Employee Benefits Corporation
   PO Box 44347
   Madison WI 53744-4347
   Fax: (608) 831-4790

A check will be mailed to your home or if you prefer, you may receive your reimbursement by Direct Deposit. For Direct Deposit:

1. At the time of Enrollment, obtain the Direct Deposit Authorization Form located under the Open Enrollment Tab in the EIC.
2. Print, complete and mail or fax as listed above.

Documentation must include a description of the product or service, date provided, and cost of the service to be reimbursed. An expense is incurred at the time of purchase, not when the expense is billed or paid. You may submit for expenses incurred within the Plan Year (March 1, 2019 - February 28, 2020). You will have up to 90 days after the end of the Plan Year to request reimbursement. There is no grace period to incur claims.
Note: The IRS does not recognize personal checks or credit card statements as valid proof of an expense.

Flexible Spending Account Benny Benefit Debit Card

All types of Health Care Flexible Spending Accounts participants will receive a Benny Benefit Debit Card by mail. The Benny Benefit Debit Card allows participants to swipe their debit card at the point of sale or to use it in place of a credit card for reimbursable health care expenses. No longer do you have to pay out-of-pocket or manually file a claim for every expense! Many retailers and providers use automatic validation which greatly reduces requests for documentation. There will be times when documentation is required and you will be notified by EBC when this occurs. Save all receipts in case documentation is required. You can use your Benny Benefits Debit Card to:

- Pay for Copays at the doctor's office
- Pay for Copays for prescriptions
- Pay a bill for out-of-pocket expenses by writing the debit card number in the credit card section of the bill

Long Term Care (LTC)

NASA FCU offers Long Term Care (LTC) insurance for you and your spouse, underwritten by Unum Life Insurance Company of America. The LTC plan provides coverage for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home. This plan provides coverage in the form of a fixed dollar indemnity benefit if you become disabled and you are receiving care while confined in a Long Term Care Facility. If you purchase Total Home Care or Professional Home Care Services coverage, UNUM will pay a benefit if you elect to receive care other than in a Long Term Care Facility.

Coverage is subject to policy limitations, benefit maximums and elimination periods. For questions regarding Long Term Care coverage please call (800) 227-4165. To calculate premium costs for this benefit and obtain an enrollment for please visit the Unum website: unuminfo.com/nasafcu002.

Voluntary Life Insurance and Short-term Disability Reminder

Employees increasing their Voluntary Life coverage or applying for Voluntary Life or Short-term Disability insurance must send an email to Jason Carcione at e-admin@nasafcu.com requesting coverage by January 29th.

Proof of relationship documents are required for new dependent life insurance applications and must be submitted to Jason Carcione by the January 29th deadline. Decisions are made by the carrier and are subject to underwriting.