APEA/AFT

EMPLOYEE BENEFITS

New Hire Guide

September 1, 2024– August 31, 2025

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please read the Individual Creditable Coverage Disclosure notice for more information. If you have questions about your options, please contact the Plan Administrator.

Table of Contents

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of a discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. For specific tax or legal advice, please consult with your own tax or legal advisor for assistance. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact the Plan Administrator.

WELCOME TO APEA/AFT HEALTH AND WELFARE TRUST

Your health care claims are processed by Welfare & Pension Administration Service, Inc. (WPAS), however the money used for claims comes directly from APEA-AFT Health & Welfare Trust, which is funded by the premiums paid by both you and your employer.

This guide provides information about the open enrollment process as well as other required notices. Please take a few minutes to review this important information so you can make the best health care coverage decisions for you and your family.

The Affordable Care Act

PLAN STATUS UNDER HEALTH CARE REFORM

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that our plan does not include all identical requirements found in non-grandfathered plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other requirements in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which requirements apply and which requirements do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1-800-732-1121.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at **www.hhs.gov**.

What Do I Have To Do?

- Complete an Enrollment Form, a Salary Reduction Agreement Form and any other required documentation.
- Part-time employees may enroll for coverage, and your monthly employee contributions must be paid on an after-tax basis each month, directly to the Trust Administration Office.
- Full-time employees may elect to waive coverage through the Trust.

ALL FORMS MUST BE COMPLETED AND RETURNED TO **ENROLLMENT@WPAS-INC.COM** OR YOU CAN MAIL COMPLETED FORMS TO THE ADDRESS BELOW.

Contact Information

For changes and new enrollees, please return completed Enrollment Form, Salary Reduction Agreement Form and required documentation to:

APEA-AFT Health & Welfare Trust
Plan Administrator
PO Box 34203
Seattle, WA 98124-1203
Telephone: (800) 732-1121

Or scan and email to: **enrollment@wpas-inc.com**

Be sure to include APEA-AFT in the subject line of your email.

Documentation is Required For All Dependents

To enroll your dependent spouse and dependent children, you must provide documentation that they are eligible dependents. If you have already provided this information, you do not have to provide it again. No claims will be paid on your dependents until we receive acceptable documentation.

Examples of dependent documentation are:

- Spouse – copy of marriage certificate
- Natural Child – copy of birth certificate listing the employee as mother or father; or
- Qualified Medical Child Support Order
- Adopted Child – proof of legal adoption or placement with you in anticipation of adoption
- Stepchild – copy of birth certificate listing your spouse as mother or father
- Foster children or children for whom you have legal responsibility – proof of legal custody or guardianship

How Much Do I Have To Pay?

The following contributions are effective September 1, 2024.

	Your Contribution
Employee	$105 per month

Please note that when your contributions are taken out of your paycheck on a pre-tax basis, as allowed by Section 125 of the Internal Revenue Code. IRS rules state that once you make your enrollment election for the year, you will not be allowed to change that election until the next Open Enrollment period, unless you have a change in family status, such as marriage, divorce, birth of a child, or change in employment status. This means you may not drop coverage for a dependent during the year unless there is a qualified change in family status.

Making Mid-Year Election Changes

The IRS allows distinct tax advantages to you and to the Trust by not considering the value of your employer's contribution as taxable income. In return, the Trust is subject to strict IRS rules on when it may allow mid-year election changes. Elections made during Open Enrollment must apply for the rest of the Plan Year unless you experience a qualifying event and timely request a change in election because of that qualifying event. Any change you make to your election must also be consistent with the qualifying event. Examples of qualifying events include:

- Marriage, birth or adoption of a child, divorce, death of a dependent
- Dependent ceases to be eligible or gains eligibility
- Loss, gain, or significant change in spouse's coverage
- Changing from full-time to part-time status or vice versa

To change your election, you must submit proof of the qualifying event and a revised enrollment form to the Trust Administration Office within 31 days of the qualifying event.

Appealing Your Election

You have the right to appeal your plan election to the Board of Trustees. Because your election impacts your payroll, the Trustees have accelerated the timeline for appealing election choices. If you wish to appeal, you must do so within 45 days after your first payroll deduction resulting from the plan election choice. IRS Revenue Regulations limit the circumstances under which election changes can be made, and the Board of Trustees must abide by those regulations when deciding enrollment appeals. You should use great care in making an enrollment election, as the circumstances for changing your election after the close of Open Enrollment is severely limited.

CONTACT INFORMATION:

APEA-AFT Health & Welfare Trust
Plan Administrator
PO Box 34203
Seattle, WA 98124-1203
Telephone (800) 732-1121

APEA-AFT HEALTH & WELFARE TRUST WEBSITE

APEA-AFT Health and Welfare Trust has established a website to provide you with immediate access to your plan information. The site located at **www.apea-afttrust.com** includes Trust Fund related material such as forms, plan booklets, links to Health Plan Provider Networks and access to paid claims information. We encourage you to visit and use the Trust website.

IMPORTANT LEGAL INFORMATION

Healthcare Reform

The Affordable Care Act (ACA) is complex and you may have questions about how it impacts you, your family and your benefits. There are three items you should know.

First, the individual mandate (the requirement that all individuals have health insurance) remains in place. What has changed is the penalty associated with it. As of January 1, 2019, the ACA tax penalty is repealed and you won't have to pay anything if you don't enroll.

Second, the Health Insurance Marketplace still exists. You can shop for and enroll in insurance plans through the Marketplace Exchange and still apply for income-based subsidies.

Third, for most people, the plans we offer are considered affordable for most employees and you may not be eligible for the federal subsidies available in the Health Insurance Marketplace, even if you choose not to enroll in APEA's plan.

Effective 2023, the IRS updated how eligibility for subsidies are calculated. This means your spouse and/or child(ren) may be eligible for less expensive coverage on the Health Insurance Marketplace as eligibility for a subsidy is now based on your monthly premium contribution to enroll family members in APEA's plan. Be sure to complete a thorough evaluation of the Health Insurance Marketplace's plan benefit designs and networks when comparing insurance coverage.

Please refer to your Notice of Health Insurance Marketplace Coverage for general information. For additional information on Marketplace options in your area and subsidy calculators, go to **www.healthcare.gov** or call 1-800-318-2596.

Annual Reminders

Notice Regarding the Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

Contact Human Resources for more information.

HIPAA Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) requires employers to adhere to strict privacy guidelines and establishes your rights with regard to your personal health information. You received a copy of the APEA/AFT Health and Welfare Trust Group Health Plan Privacy Notice when you were hired. This notice describes how medical information about you may be used and disclosed, and how you can access that information.

If you have any questions regarding the HIPAA Privacy Notice, or would like another copy, please contact Human Resources.

COBRA

COBRA continuation coverage is a temporary continuation of coverage under our employee benefit plan. Please contact Human Resources for a copy of the General Notice of COBRA Continuation Rights. This notice explains your rights and obligations to receive COBRA benefits.

We are not always aware when a COBRA event takes place, unless notified by you. The most common examples are divorce, or when a child exceeds the maximum age. When such an event occurs, the Notice of Qualifying Event must be postmarked within 60 days of the qualifying event for the affected person to be eligible for COBRA continuation. If you have questions about COBRA please contact Human Resources.

Important Notice from APEA/AFT Health and Welfare Trust about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with APEA/AFT Health and Welfare Trust and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. APEA has determined that the prescription drug coverage offered by the APEA/AFT Health and Welfare Trust Employee Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

Plan Participants who also are eligible for Medicare have the following three options concerning prescription drug coverage:

- You may stay in the Plan and not enroll in the Medicare prescription drug coverage at this time. You will be able to enroll in the Medicare prescription drug coverage at a later date without penalty, either (1) during a Medicare prescription drug open enrollment period (October 15–December 7 of each year); or (2) if you lose Plan coverage. This is the best option for most Plan participants who are eligible for Medicare.
- You may stay in the Plan and also enroll in Medicare prescription drug coverage at this time. The Plan will pay prescription drug benefits as the primary payer in most instances. Medicare will pay benefits as a secondary payer,

and thus the value of your Medicare prescription drug coverage will be greatly reduced. Your current coverage under the Plan pays for other health benefits as well as prescription drugs and will not change if you choose to enroll in Medicare prescription drug coverage.

- You may reject all coverage under the Plan and choose coverage under Medicare as your primary and only payer for all medical and prescription drug expenses. If you do so, you will not be able to receive coverage under the Plan, including prescription drug coverage, unless and until you are eligible to reenroll at the next enrollment period for which you are eligible, if any. Your current coverage pays for other types of health expenses, in addition to prescription drugs, and you will not be eligible to receive any of your current health and prescription drug benefits if you reject coverage under the Plan and choose to enroll in Medicare, including a Medicare prescription drug plan, as your primary and only payer.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with APEA and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about this Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through APEA changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	September 1, 2024
Name of Entity/Sender:	APEA/AFT Health and Welfare Trust
Contact—Position/Office:	Plan Administrator
Address:	PO Box 34203
	Seattle, WA 98124-1203
Phone Number:	800-732-1121

Premium Assistance under Medicaid and the Children's Health Insurance Program

If you or your children are eligible for Medicaid or the Children's Health Insurance Program (CHIP) and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: **http://myalhipp.com/**
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: **http://myakhipp.com/**
Phone: 1-866-251-4861
Email: **CustomerService@MyAKHIPP.com**
Medicaid Eligibility: **https://health.alaska.gov/dpa/Pages/default.aspx**

ARKANSAS – Medicaid

Website: **http://myarhipp.com/**
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
Website: **http://dhcs.ca.gov/hipp**
Phone: 916-445-8322 | Fax: 916-440-5676
Email: **hipp@dhcs.ca.gov**

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: **https://hcpf.colorado.gov/child-health-plan-plus**
CHP+ Customer Service:
1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: 678-564-1162, Press 1
GA CHIPRA Website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: **http://www.in.gov/fssa/hip/**
Phone: 1-877-438-4479
All other Medicaid: **https://www.in.gov/medicaid/**
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: **https://dhs.iowa.gov/ime/members**
Medicaid Phone: 1-800-338-8366
Hawki Website: **http://dhs.iowa.gov/Hawki**
Hawki Phone: 1-800-257-8563
HIPP Website: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: **https://www.kancare.ks.gov/**
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**
Phone: 1-855-459-6328
Email: **KIHIPP.PROGRAM@ky.gov**
KCHIP Website: **https://kynect.ky.gov**
Phone: 1-877-524-4718
Kentucky Medicaid Website: **https://chfs.ky.gov/agencies/dms**

LOUISIANA – Medicaid

Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp**
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: **https://www.mymaineconnection.gov/benefits/s/?language=en_US**
Phone: 1-800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms**
Phone: 1-800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: **https://www.mass.gov/masshealth/pa**
Phone: 1-800-862-4840
TTY: 711
Email: **masspremassistance@accenture.com**

MINNESOTA – Medicaid

Website: **https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**
Phone: 573-751-2005

MONTANA – Medicaid

Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**
Phone: 1-800-694-3084
Email: **HHSHIPPProgram@mt.gov**

NEBRASKA – Medicaid

Website: **http://www.ACCESSNebraska.ne.gov**
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: **http://dhcfp.nv.gov**
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: **https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/**
Medicaid Phone: 609-631-2392
CHIP Website: **http://www.njfamilycare.org/index.html**
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: **https://www.health.ny.gov/health_care/medicaid/**
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: **https://medicaid.ncdhhs.gov/**
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: **https://www.hhs.nd.gov/healthcare**
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: **http://www.insureoklahoma.org**
Phone: 1-888-365-3742

OREGON – Medicaid

Website: **http://healthcare.oregon.gov/Pages/index.aspx**
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx**
Phone: 1-800-692-7462
CHIP Website: **https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx**
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: **http://www.eohhs.ri.gov/**
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: **https://www.scdhhs.gov**
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: **http://dss.sd.gov**
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: **https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program**
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: **https://medicaid.utah.gov/**
CHIP Website: **http://health.utah.gov/chip**
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: **https://dvha.vermont.gov/members/medicaid/hipp-program**
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select**
Or: **https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs**
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: **https://www.hca.wa.gov/**
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: **https://dhhr.wv.gov/bms/**
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP
(1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/**
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Service
www.cms.hhs.gov
1-877-267-2323, menu option 4, ext. 61565

FSA member guide

Health flexible spending account (FSA)

*A **simple** way to save*

WE'LL TAKE YOU THERE.

HealthEquity®
Building Health Savings℠

HealthEquity®

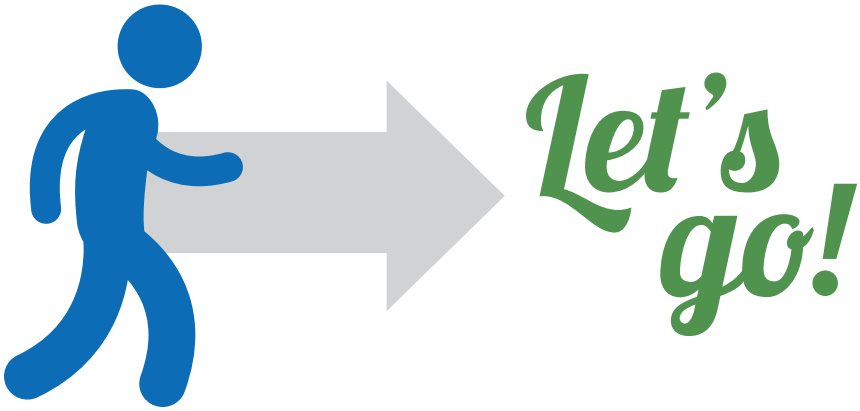
Table of Contents

"This is not intended to be a Summary Plan Description (SPD) or a Summary of Material Modifications (SMM). SPD and SMM are the official documents governing the use of your plan. If any part of this document conflicts with your plan's SPD or SMM, the terms of the SPD and SMM shall govern.

Welcome!

Congratulations for taking the first step towards health care savings by electing to contribute to a flexible spending account. This FSA member guide provides useful insight and tips for getting the most out of your FSA. If you have further questions, please call our "expert friends" who can help you every step along the way. They are available every hour of every day at:

866.346.5800



Easy as 1, 2, 3

1 SIGN UP

During your employer's open enrollment, sign up to participate in an FSA. Select the option that best meets your needs and then determine the amount you would like to contribute from your pre-tax earnings. Typically, anyone whose employer offers an FSA can participate, including employees not covered under the employer's health plan. Your employer may exclude certain types of employees, such as part-time, seasonal, or temporary. Ask your employer benefits team to verify eligibility. Self-employed individuals cannot participate in a flexible spending account.

2 CONTRIBUTE

Your employer will arrange to have the determined amount of your pre-tax earnings contributed to your FSA. Typically the amount withheld from your paycheck is equal each pay period.

3 USE YOUR FUNDS

When you incur a qualified expense, you can either pay with the HealthEquity Visa® Reimbursement Account Card* provided by some plans or submit the expenses through the HealthEquity online tool for reimbursement. Remember to save all receipts; you will need them for reimbursements and to validate your expenses with your employer or administrator.

Eligibility

Anyone whose employer offers an FSA can participate, including employees not covered under the employer's health plan. Your employer may exclude certain types of employees, such as part-time, seasonal, or temporary. Ask your employer benefits team to verify eligibility. Self-employed individuals cannot participate in an FSA.

Significant savings

The scenarios below provide estimated savings if an FSA is used (assuming a 40% combined federal and state tax rate).**

$1000 out-of-pocket medical expenses + $500 out-of-pocket vision expenses + $500 out-of-pocket dental expenses | **$800 tax savings**

$1000 out-of-pocket medical expenses + $1000 vision and dental expenses + $5000 child care expenses | **$2800 tax savings**

* This card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A. Inc. Copyright © 2013 HealthEquity, Inc. All rights reserved. HealthEquity, the HealthEquity logo, and Building Health Savings are service marks of HealthEquity, Inc.

** Example only, taxes vary per individual

Getting started

For new FSA members, the following steps will help you optimize your account:

Activate your debit card

Upon the creation of your FSA, you will receive a member welcome kit which may include a HealthEquity FSA debit card*. Card activation instructions are included with the card. If you would like, you can speak to one of our "expert friends" to activate your card and receive additional insight to maximize your savings.

Log on

Sign in to the member portal by visiting www.myHealthEquity.com. For first-time visitors, select "Begin Now" and follow the step-by-step process to verify your account. Once you are logged in, we encourage you to complete the following:

- Navigate through the portal and familiarize yourself with its features and capabilities. A comprehensive portal guide can be found in this publication, starting on page 14.

Using your funds

Qualified medical payments can be made in the following ways:

- Debit card transactions: Swipe your HealthEquity FSA debit card at the pharmacy or doctor's office for instant payment. Be sure to save all receipts.
- Reimbursement: If paying out-of-pocket for expenses, submit a claim for reimbursement directly on the member portal and have funds electronically transferred to your personal banking account.
- Issue payment to provider: From the HealthEquity member portal, you can issue payments to providers by creating a new claim, or by using existing integrated insurance claims, if available.

Important!

Please keep in mind that all FSA payments require an itemized receipt or an insurance explanation of benefits to substantiate the claim. You may be required to provide this documentation to HealthEquity. We will contact you if it is required.

How it works

At the doctor's office…

1. Receive services

Present your insurance ID card, and pay any required copays. Your FSA debit card is a convenient method of payment.

Your health plan has a network of providers that it recommends, however you can use FSA funds to pay any qualified medical expense even if it is not covered by your insurance. This provides significant tax savings on out-of-network services.

2. Provider bills health plan

Provider submits a claim to your health plan for services rendered.

3. Health plan sends EOB

An explanation of benefits (EOB) is sent to you outlining the negotiated/allowed charges and summarizing your year-to-date deductible and co-insurance totals. In some cases, your health plan may send a copy of your claim to HealthEquity, which will appear in the member portal.

4. Provider sends invoice

The provider sends you an invoice, or statement, reflecting the allowed charges. Make sure the amount matches the EOB sent to you by your health plan. If not, contact your health plan.

5. Pay invoice with FSA

You can pay with your FSA debit card or set up an online payment that is sent directly to the provider or as a reimbursement to you if you pay out-of-pocket.

At the pharmacy…

1. Obtain prescription

Obtain a legal prescription from your doctor for needed medication and submit it along with your insurance ID card to a pharmacy.

2. Pharmacy verifies insurance coverage

The pharmacy checks with your health insurance on-the-spot to determine the amount you owe for the prescription.

3. Pay for your prescription

The pharmacy fills your prescription and you pay the determined amount owed. Your FSA debit card is a convenient method of payment. You may be required to submit your receipt to verify the expense.

Over-the-counter medication

The IRS does not allow FSA funds to be used for over-the-counter (OTC) medicines without a prescription. We encourage you to ask your doctor if he or she can write a prescription for OTC medicines or supplies that you frequently need to utilize. You can then use your FSA to pay for these items by using your debit card or reimbursing yourself if you pay out-of-pocket.

HealthEquity

Your FSA

Introduction

An FSA is an employer-sponsored benefits program that enables employees to save pre-tax dollars to pay for qualified medical expenses, regardless if they participate in the employer's health plan. Because health FSAs are employer-sponsored, an employee has access to the entire year's funds on the first day of the plan year.

How do I sign up for an FSA?

During your employer's open enrollment, sign up to participate in an FSA, then determine the amount you would like to contribute from your pre-tax earnings. Typically, anyone whose employer offers an FSA can participate, including employees not covered under the employer's health plan. Your employer may exclude certain types of employees, such as part-time, seasonal, or temporary. Ask your employer benefits team to verify eligibility. Self-employed individuals cannot participate in a flexible spending account.

Contributions

FSAs are typically funded through payroll contributions. While your entire election amount is available at the beginning of the plan year, your payroll deduction amounts will be divided equally among each paycheck for the benefit year.

Contribution limits

Contributions to an FSA are limited by the IRS to $2,550 per year. If you are married, each spouse may contribute up to $2,550 to his or her own FSA, even if both participate in the same FSA-sponsored by the same employer. However, your employer's plan may further limit the contributions into an FSA.

Spouse and other dependents

Your FSA funds can be used to pay for your qualified medical expenses, as well as those of your spouse and other dependents. This is true, even if the dependent is not a tax dependent or covered under your health plan. Funds can also be used for children until age 26 (see page 31).

Medical expenses after your FSA is established

Once a qualified medical expense is incurred by you or an eligible dependent, you can use your FSA funds to make payment. Payments, also referred to as distributions, are tax-free as long as they are used for qualified medical expenses (see page 9). You can pay a provider from your FSA directly, or you can pay out-of-pocket and reimburse yourself later (see instructions on pages 21-22). Simply keep the documentation (itemized receipt/invoice/explanation of benefits) of the expense, or upload it to the HealthEquity member portal Documentation Library. You'll need to be able to provide proof, or substantiation, that a purchase is eligible for any FSA usage.

Use it or lose it!

FSA funds do not roll over from year to year. You should use all of your FSA dollars within the plan year or they may be forfeited. Some plans allow for a grace period to use remaining funds or permit a set amount to roll over to the next plan year.

FSA debit card payments

After you have received an invoice from your provider and matched it with an EOB from your health plan, you are ready to make a payment. You can use your HealthEquity FSA debit card to make payments to your provider(s). This is especially convenient at the pharmacy. Most providers will also accept the card over the phone, online or written-in on the statement for payment. In order for your card to work, you must have the balance available in your FSA; no overdraft is available. The card will not work at ATMs and will typically only work at appropriate medical facilities. The card should always be run as "credit" and no PIN is required. Lastly, be sure to keep all receipts as documentation of your purchases or upload them to the HealthEquity Documentation Library in the member portal.

example

Direct payments to providers

You can also use the HealthEquity member portal to setup a direct payment using our online payment tool. We'll send the payment directly to the provider and include all of the information necessary to apply the payment to your bill.

Qualified medical expenses

Qualified medical expenses are designated by the IRS. They include medical, dental, vision and prescription expenses. See IRS publication 502 for a list of specific examples. Some highlights include:

- Acupuncture
- Alcoholism (rehab, transportation for medically advised attendance at AA)
- Ambulance
- Amounts not covered under another health plan
- Annual physical examination
- Artificial limbs/teeth
- Birth control pills/prescription contraceptives
- Body scans
- Breast reconstruction surgery following mastectomy for cancer
- Chiropractor
- Contact lenses
- Crutches
- Dental treatments
- Eyeglasses/eye surgery
- Hearing aids
- Long-term care expenses
- Medicines (prescribed, not imported from other countries)
- Nursing home medical care
- Nursing services
- Optometrist
- Orthodontia
- Oxygen
- Stop-smoking programs
- Surgery, other than unnecessary cosmetic surgery
- Telephone equipment and repair for hearing-impaired
- Therapy (medical, psychiatric)
- Transplants
- Weight-loss program (if prescribed by a physician for a specific disease)
- Wheelchairs
- Wigs (if prescribed)

Note: Some employers may institute exclusions to this list. Consult with your benefits administrator or call HealthEquity for details.

Non-qualified medical expenses

You are not able to use FSA funds for non-qualified medical expenses, and ineligible expenses will be recouped from the member when necessary. Some examples of non-qualified medical expenses include:

- Concierge services
- Dancing lessons
- Diaper service
- Elective cosmetic surgery
- Electrolysis or hair removal
- Funeral expenses
- Future medical care
- Hair transplants
- Health club dues
- Insurance premiums other than those explicitly included
- Medicines and drugs from other countries
- Nonprescription drugs, medicines (unless prescribed)
- Nutritional supplements, unless recommended by a medical practitioner as treatment for a specific medical condition diagnosed by a physician
- Teeth whitening

HealthEquity®

Expert friends

Helpful support for our members, available every hour of every day

Our team of specialists based in Salt Lake City is available 24 hours a day, providing you with the tools and information you need to optimize your FSA. They can answer any questions you may have.

866.346.5800

Tips to maximize your savings

Generic prescriptions

Generic prescriptions typically cost 30-80% less than their brand equivalent. We encourage you to consult your provider about generic prescription options. Your insurance plan may offer a prescription pricing tool for comparisons.

Urgent care vs. emergency room

A visit to the emergency room can cost three to seven times more than a visit to an urgent care facility that can provide the same treatment. You should consider only going to the emergency room in a potentially life-threatening situation. Furthermore, an appointment made with your primary physician will typically be less expensive than a visit to the urgent care.

Optimize your elected FSA amount

If you aren't contributing at least the amount you spend on health care, you are essentially leaving money on the table for the government. This worksheet may help you estimate your election amount as well as your estimated tax savings.

	Eligible Expenses	Sample estimate	Your estimated amount
Estimated annual expenses	Annual dental plan deductible	$100	
	Dental fillings and crowns	$150	
	Orthodontics	$1500	
	Annual health plan deductible	$300	
	Chiropractor visits		
	Counselor or therapist visits		
	Doctor's office visits	$60	
	Contact lenses and solutions	$30	
	Corrective eye surgery		
	Prescription sunglasses/glasses		
Estimated election amount*	**Estimated expense total:**	**$2,140**	
Your effective tax rate		**x 0.40 (40%)**	**x**
Savings estimate*		**$856**	

*Estimated savings are based on an assumed combined federal and state income tax bracket of 40%. Actual savings will depend on your taxable income and tax status. This information is intended to be used for FSA education purposes only. You should consult your tax advisor or account consultant regarding you own personal situation and as to whether participating in an FSA is right for you.

What is substantiation?

What is substantiation?

Because FSAs use pre-tax dollars, the IRS requires that all FSA payments be validated to confirm that funds were used for qualified medical expenses. Substantiation is the proof that a purchase is eligible, which is confirmed through itemized receipts/ invoices/explanations of benefits.

When is it needed?

Always. Every transaction using FSA dollars must be validated. Some transactions can be verified automatically, but others may require you to submit documentation or receipts supporting your purchases. Because of this, HealthEquity recommends keeping an itemized receipt for every debit card purchase you make.

Convenient, automatic substantiation

Our debit card process allows for auto-substantiation at the point of service in many different cases:

- CoPay matching – If your employer notifies HealthEquity of your health plan copay amounts, HealthEquity will attempt to match transactions against those copay amounts.
- Recurring claims logic – By sending in documentation for the first transaction, any subsequent transactions at the same location for the same amount will not require documentation.
- Claims file matching – If HealthEquity receives claim files from your health plan and can match that claim to a card transaction, no additional documentation will be required. You are also able to manually match a card transaction to a claim if it did not match automatically.

Where can I use my debit card?

IRS rules state that FSA debit cards cannot be used at locations unless the retailer uses a certain type of medical coding. If your pharmacy or provider does not have these merchant category codes, your debit card may be declined. However, you can still submit a reimbursement request if purchasing a qualified item or service.

Requests for Documentation

Card transactions that are not substantiated at the point of service will trigger a communication to the member with clear and concise instructions on how to submit supporting documentation. Please respond to these requests as quickly as possible to ensure continued use of your FSA debit card funds.

Your documentation type can vary. It can be an itemized receipt, invoice, explanation of benefits or other, but must include the patient name, name of the provider/pharmacy, the service/item purchased, date of the service/transaction, and dollar amount. If used for prescribed over-the-counter items, you must also include a letter of medical necessity detailing the condition being treated, medication type and dosage, and duration of the treatment. Letters of medical necessity must be renewed each year.

Once appropriate documentation is received, it is routed to a HealthEquity team member for review and approval.

Where can I view which transactions still need substantiating?

You can view all transactions requiring substantiation by visiting the HealthEquity member portal. The 'Debit Cards' tab on the 'Reimbursement Account Detail' page provides a complete list of transactions requiring additional documentation, and allows you to upload your receipts directly to the member portal for review.

What if I can't find the required documentation?

In cases when a transaction is deemed ineligible or documentation is not provided, members may submit an alternate receipt that has not yet been reimbursed, or a personal check to reimburse the account.

Documentation Library

HealthEquity makes it easy for you to keep track of your documentation and archive items for later access. You can upload receipts on our easy-to-use online member portal. Your files will remain stored in a safe, secure place. You can also see the status of current substantiation requests online at any time.

How to submit substantiation:

Online:

Select the 'Debit Cards' tab on the 'Account Detail' page, located in the 'FSA' menu under the 'My Account' tab. From here you will be able to view all transactions requiring substantiation and attach your receipts directly to the claim.

Fax:

(801) 999-7829

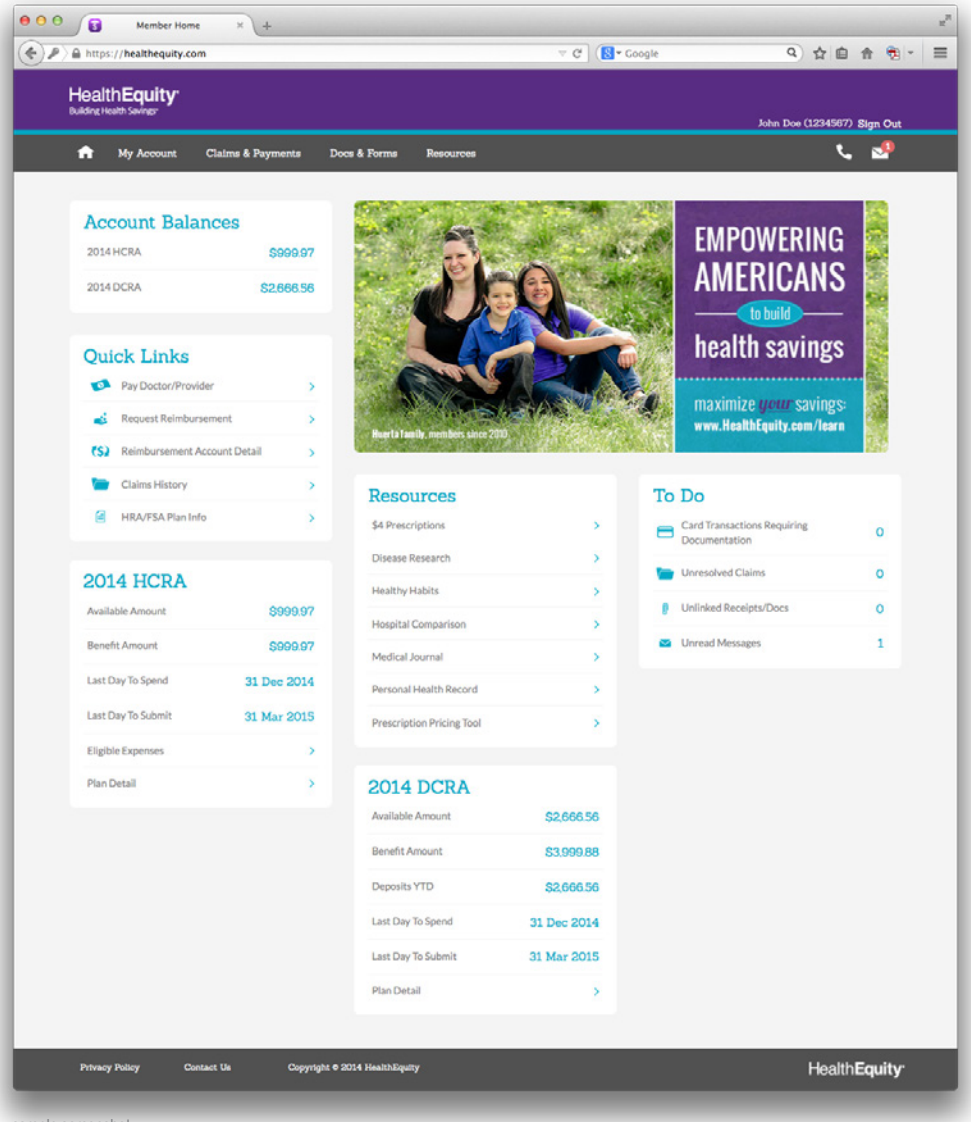
• Please include the original request specifying which transaction is being substantiated.

HealthEquity

Online member portal

Introduction

Your online member portal is a powerful tool that gives you access to all of your account management features. To access your account, visit www.myHealthEquity.com. The portal is best experienced using Internet Explorer (8.0 or later) and current versions of Firefox, Chrome and Safari.



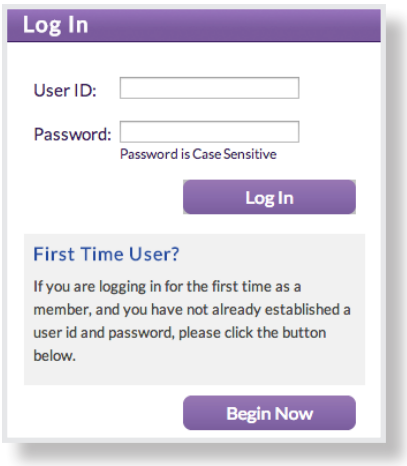
sample screenshot

Portal guide

Using the HealthEquity member portal, you can check your balance, review transactions, view insurance claims, pay providers and submit for reimbursement online.

Member portal login page

Logging into your member portal is easy. Simply follow the steps below to access your HealthEquity FSA.



sample screenshot

Logging in to your portal the first time:

1. Go to www.myHealthEquity.com, click “Begin Now.”
2. Enter the information requested on the “Find your account” screen.
3. Enter the information asked for on the “Verify your identity” screen.
4. On the “Set up your login” screen:
   - Pick a user/login name of at least six characters with numbers and letters on the “Set up your login” screen.
   - Choose a password of at least eight characters with an uppercase letter, a lowercase letter and a number.
   - Follow password creation recommendations as listed in the log in screen
5. On the “Your email settings” screen, enter your email address.
6. Click the box to agree to the terms of the web site and save the agreement.

Logging in to your portal after your first login:

1. Go to www.myHealthEquity.com.
2. Log in with the username and password you created the first time you logged in.

Home page dashboard

Welcome to the HealthEquity member portal home page. This interactive and dynamic dashboard provides you with all the information you need to easily manage and build your health savings.

sample screenshot

Dashboard widgets

The home page dashboard gives you quick and easy access to key information and common account actions. This provides for a complete account overview at a glance by using informative widgets containing your account's most important details:

Account balance

Your account balance is the first item on the home page dashboard. To view balance details, click on each type of account to view your transaction history.

Quick links

In a hurry? The 'Quick Links' panel expedites common account action items such as making payments, requesting reimbursement, and viewing claims. This allows for simplified account management with one click of the mouse.

FSA/HRA plan info

There is an FSA widget on your dashboard. Including your current balance and important plan dates, click on the links provided for a comprehensive overview of your reimbursement account(s). If you elect for an HRA in addition to your FSA, an HRA widget will also be displayed.

Resources

Working in conjunction with your insurance/employer, the 'Resources' widget displays the tools and links you need to become a better consumer of health care, and improve your overall wellness.

To do

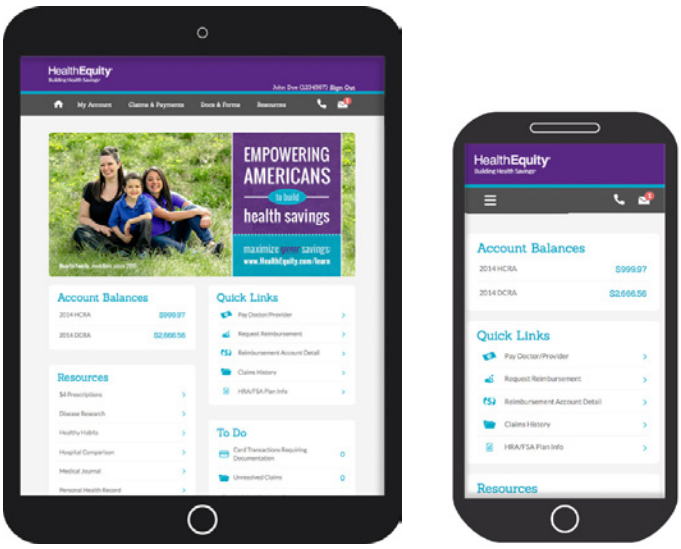
With suggested action items, your 'To Do' list features helpful reminders and alerts to keep you up to date with your account. The 'To Do' list includes important alerts, any open claims that might require payment, unlinked receipts located in the Documentation Library (see page 23), and any unread messages in the Message Center. Clicking on each item takes you to the page where you can view/resolve any incidents.

Intuitive navigation

The member portal navigation provides a new intuitive and user-friendly interface for easy, self-service account management. Simply hover your mouse over the tabs to view the complete list of sub-menu options. Clicking on a specific link will take you directly to the desired page. For common action items, view the 'Quick Links' widget on the home page dashboard for faster access.

Responsive web design

Customized to all viewing devices, the HealthEquity member portal dashboard is optimized for desktop, laptop, tablet, and mobile access. Including an ever-present navigation bar, your tabs and other helpful features remain visible as you scroll.



sample screenshots

My account

The 'My Account' tab gives you access to information and settings regarding your health savings account.

Account balance:

From the 'My Account' tab, you can review your account balance. Always refer to the 'Available Balance' for the most accurate account balance.

Profile:

'Profile' is where you can review and edit your profile settings, including personal information, login credentials, and system preferences.

If you have not done so already, you can add your banking information directly on the 'Profile Details' page for EFT reimbursements:

1. Go to the 'Account Information' section.
2. Click on the blue 'Add/Edit' button under 'External Accounts.'
3. Enter your bank account's routing number, account number, financial institution name and indicate how the account will be used.
   - If solely used for reimbursement, account verification is not required.
   - You can add as many accounts as you would like, however, if you will be adding the same account to multiple accounts (i.e. yours and a spouse's account), HealthEquity requires a voided check to be submitted to verify the account information.

FSA:

From this menu, you are able to access account details such as current balance, payment history, transactions requiring card substantiation, and important plan dates. Use the drop down to view account details for previous years.

Statements:

View your monthly statements here at any time. Select a year to view a statement and click the link to download and print. A document reader that is compatible with Adobe Acrobat's PDF format is required to view all account statements. You are able to download Adobe Reader by clicking the icon on this page.

Manage cards:

If available, the 'Card Manager' page allows you to view and activate cards from the member portal. To request additional cards or to report your card lost or stolen, contact Member Services (additional fees may apply).

Add individuals:

'Add Individuals' will allow you to add dependents to your account, and to authorize any users you would like to have access to your account information.

'Authorized Account Users' lists those associated with your account. For anyone other than the primary account holder to receive specific account information over the phone, the primary account holder must first authorize them. An authorization form is located under the 'Docs & Forms' tab.

Insurance information:

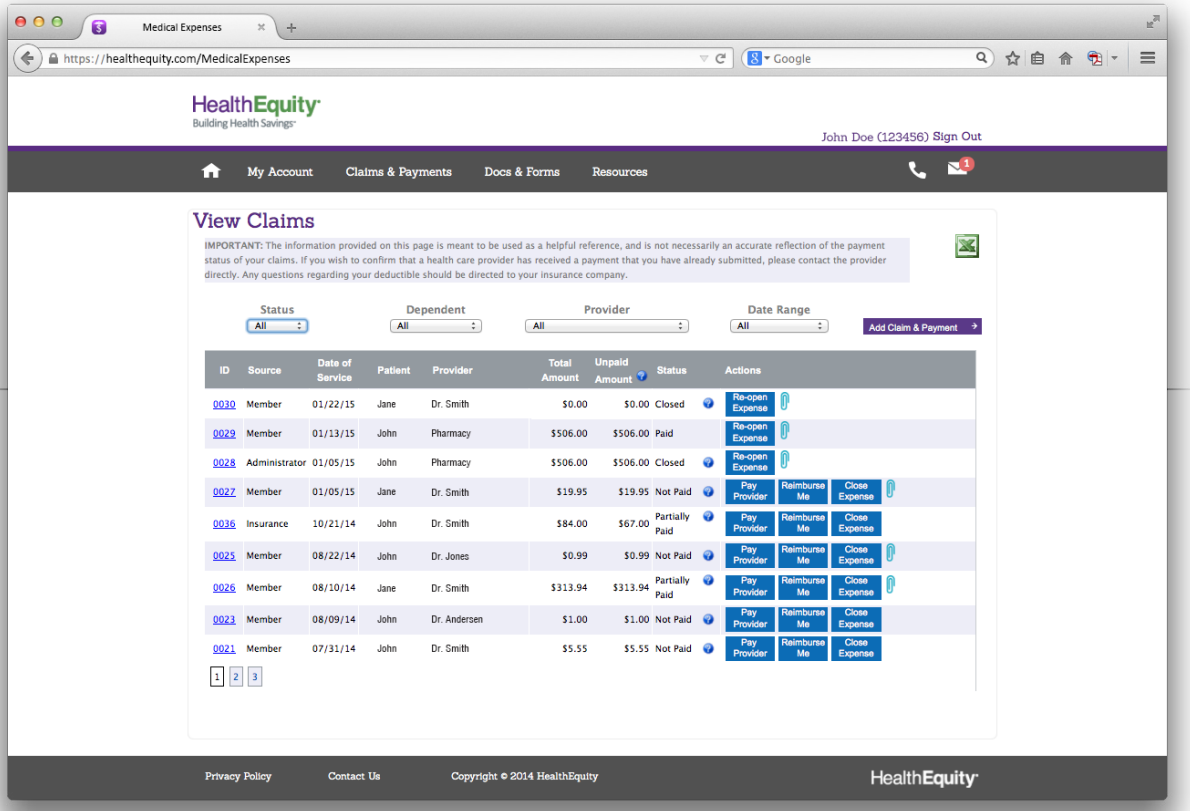
Insurance Information contains specific insurance information like provider, policy number, coverage type, deductible, and employer, when available. If your information is not listed here, contact your insurance company for specific coverage details.

Claims & payments

Claims:

Occasionally you might receive an email notification of a new claim received for you or one of your dependents. This is usually due to the fact that your health insurance has chosen to integrate with HealthEquity, meaning that when your doctors and pharmacies bill your insurance company, the insurance sends a copy of that claim to HealthEquity. Each claim listed gives you a breakdown of services, what was applied to your deductible and the estimated patient responsibility.

When your insurance pays the expense, the claim will display in the HealthEquity member portal as “Closed.” When the insurance shows that there is a patient responsibility, HealthEquity’s system will give you the option to ‘Pay Provider,’ ‘Reimburse Me,’ or ‘Close Expense.’ Selecting ‘Pay Provider’ will issue a payment directly to the provider from your HealthEquity account. If you pay out-of-pocket for that expense, you can use your HealthEquity funds to reimburse yourself by clicking ‘Reimburse Me.’ If you paid the provider with your HealthEquity debit card, or do not want to use your HealthEquity funds to pay that expense, simply click ‘Close Expense.’



sample screenshot

To view/pay a claim:

1. Go to the 'View Claims' page located under the 'Claims & Payments' tab.
2. To send a check to a provider or reimburse yourself for expenses you paid out-of-pocket, select the action buttons that accompany open claims.
   - Provider information is usually included on claims sent to us by your insurance, but we recommend verifying the address before submitting for payment.
   - If you pay with your HealthEquity debit card, the payment status of the claim will not update automatically on the 'View Claims' page; you can manually match the transaction to the claim by following the prompts when clicking 'Close Expense.'

Claims marked as 'Private'

You may see claims in the member portal that are marked 'Private.' HealthEquity protects personal health information and does not display details of claims for any dependent without their consent. To access 'Private' claim information, a Dependent Privacy Access form must be completed by your dependent(s) and submitted to HealthEquity. Forms are available under the 'Docs & Forms' tab in the HealthEquity member portal.

Pay doctor/provider:

The 'Pay Doctor/Provider' page allows you to make payments to your provider for expenses incurred for procedures performed. To pay your provider, simply:

1. From the 'Claims & Payments' tab, select 'Pay doctor/provider.'
2. Select to have the funds come out of your HSA and then select 'Enter claim record and send payment' before clicking 'Next.'
3. Select 'Pay Provider' to send payment directly to a provider.
4. Choose to enter new expense or select an existing expense if HealthEquity has received claim information from your insurance.
   - Clicking 'New' will allow you to enter specific claim details such as patient and date(s) of service.
5. The 'Payment Detail' page will allow you to enter the amount of the expense, as well as the provider's billing information, such as invoice number or account number.
   - Clicking 'Next' will take you to a review page to confirm the payment before it is sent.

In the event that recurring payments need to be sent to a provider, on the 'Payment Detail' page, enter the entire balance of the expense in the 'Unpaid Amount' box. Under 'Payment Amount,' select the option for 'Scheduled Payments.' You will be able to specify the number of payments you would like to send, the amount of each payment, and the dates you would like them to be made. If you want each payment to be equal and sent on the same date each month, the 'Divide Payments' button will do the computing for you.

Request reimbursement:

Easily reimburse yourself from your HSA for payments you made out-of-pocket:

1. From the 'Claims & Payments' tab, select 'Request Reimbursement.'
2. Select to have the funds come out of your HSA and then select 'Enter claim record and send payment' before clicking 'Next.'
3. Select 'Reimburse Me.'
4. Choose to enter new expense or select an existing expense if HealthEquity has received claim information from your insurance.
   - Clicking 'New' will allow you to enter specific claim details such as the provider originally paid, patient, and date(s) of service.
5. The Payment Detail page will allow you to enter the amount of the expense, as well as how you would like to be reimbursed.
6. If you have not done so already, you can add your banking information (for EFTs) directly on the member portal by clicking 'Add Account.'
   - Clicking 'Next' will take you to a review page to confirm the payment before it is sent.

If you would like to schedule reimbursements, instead of completing the 'Amount' section, select the button for 'Scheduled Payments.' You will be able to specify the number of reimbursements you would like, the amount of each reimbursement, and the date you would like them to be paid out.

Orthodontia

Orthodontia claims can only be reimbursed as payments are made to your provider. If you pay the total balance up-front, you can be reimbursed the available balance in your reimbursement account up-front. If you are paying the provider in monthly installments, you can be reimbursed as the scheduled contracted payments are made.

You can submit for reimbursement manually after each individual payment, or set up annual recurring reimbursements. By selecting "Annual" on the Orthodontia Reimbursement form, HealthEquity will set up automatic payments to you as specified in your contract. Reimbursements can only be paid using funds for the plan year in which the services are provided. Additionally, you can only be reimbursed up to the total amount elected for that given year. This assumes that you participate in the FSA annually. The election on the HealthEquity site does not automatically enroll you in the FSA. You need to do that through your employer.

If your request for reimbursement exceeds your available balance, you will only be reimbursed the available amount in your account. If orthodontic services continue into the following plan year, you can be reimbursed the remaining claimed amount when next year's funds become available.

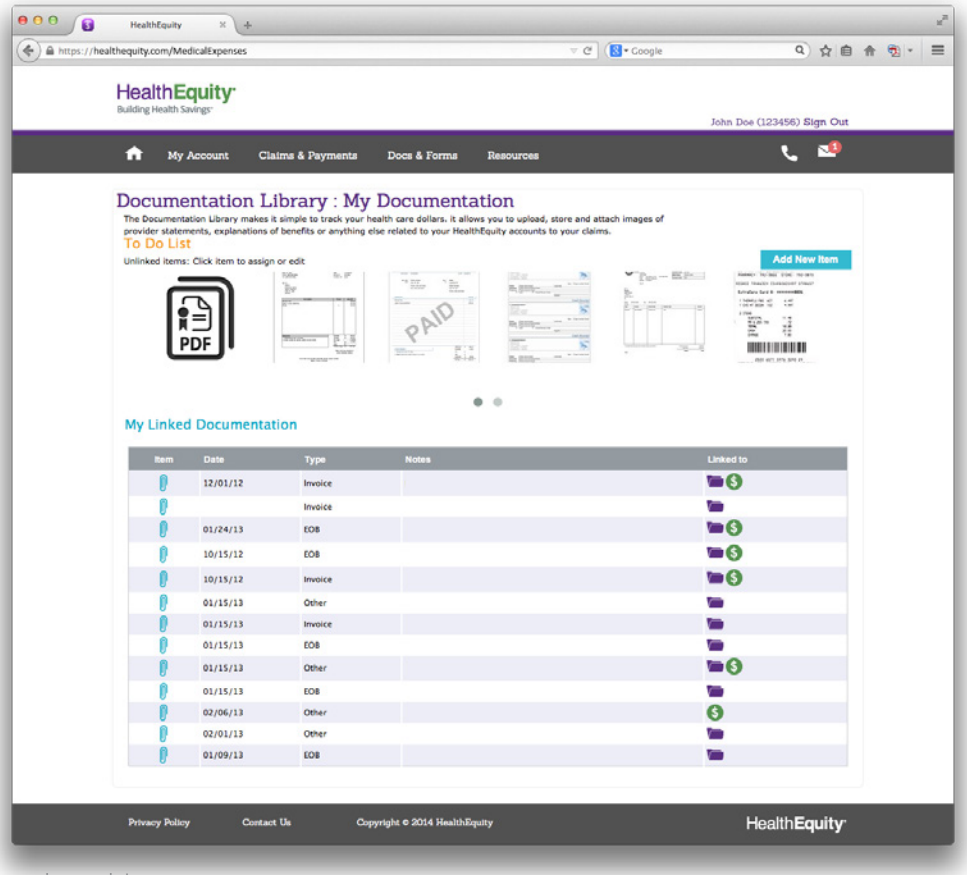
The most common reason orthodontia claims are denied is because HealthEquity does not have a copy of your orthodontia contract on file. Make sure to provide your contract that includes: patient's full name, date treatment begins, total cost, amount covered by insurance, initial/down payment, monthly payment amount, and number of months treatment will occur.

Set up an EFT (electronic funds transfer)

1. Select 'Profile Details' from the 'Profile' menu under the 'My Account' tab.
2. Under 'Account Information,' click the 'Add/Edit' button. (You will need a copy of a personal check for reference).
3. Enter the requested information.
4. Select an account purpose.
5. Click 'Authorize.'

Documentation Library:

The Documentation Library, also located under the 'Claims & Payments' tab, is a convenient way to store and manage your receipts, EOBs, invoices, etc. By uploading your medical documentation here, not only is everything kept in one central location, but you can access the documents for years to come; eliminating the need to hold onto originals that are easily lost or damaged. While this action is not required, it's a powerful tool for electronic record keeping.



sample screenshot

Getting started:

By selecting 'View Receipts & Documentation' from the 'Claims & Payments' tab, you will be taken to a page to either upload or view your medical documents. Any uploaded documentation that has not been linked to a claim or payment will display in the 'To Do List.' Images that have already been linked will display under 'My Linked Documentation.' Hovering over the paper clip icon will allow you to preview the image. To view specific details, click on the icon. To see which claim or payment an image is linked to, click on the icons to view more specific information.

Add new documentation:

To upload a new document:

1. Click 'Add New Item,' where you will be able to browse for the file.
2. Specify the date of expense, type of documentation ('Receipt,' 'EOB,' 'Invoice,' 'Other').
3. Add any applicable notes.
4. Check the box confirming quality of the image and click 'Submit.' This will take you to a page with a preview of the documentation, as well as the ability to 'Create New Claim,' 'Link to Claim,' 'Link to Payment,' 'Update,' or 'Delete.'

Create new claim:

By creating a new claim, you will be able to request either a provider payment or a reimbursement using the same process located in the 'Pay Doctor/Provider' and 'Request Reimbursement' sections (pages 21-22).

Link to claim or payment:

By selecting 'Link to Claim' or 'Link to Payment,' you will be able to associate the uploaded image to an existing claim or payment. When linking to a transaction, if the payment you are looking for does not appear, select 'Show All Transactions.' Once linked, the specific claim or payment will display underneath the image details section.

To do list:

Any documentation that is not linked to a claim or payment will appear in the 'To Do List.' To complete the linking process, click on the image, and select one of the action buttons ('Create New Claim,' 'Link to Claim,' 'Link to Payment').

Docs & forms

Account documents and statements are located under the 'Docs & Forms' tab, including account maintenance forms, tax documents, and monthly account statements. You can also access any uploaded receipts and medical documentation using this tab.

For a complete list and description of each available form, refer to your personal member portal.

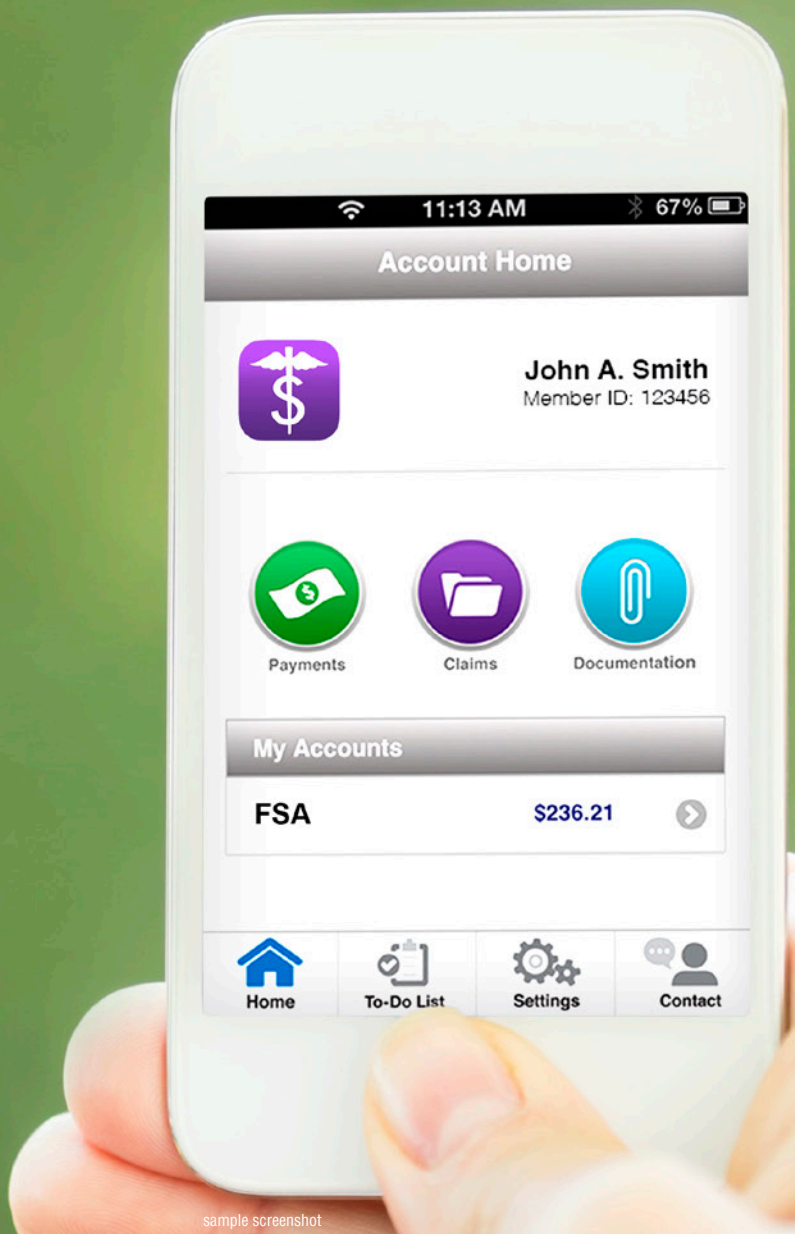
Resources

The 'Resources' tab provides useful tools and resources to help you maximize your health savings and overall wellness.

For a complete list of available resources, refer to your personal member portal.

Convenience at your fingertips

The new HealthEquity mobile app



sample screenshot

Easy access to your account

Wherever you are.

HealthEquity®

Mobile app

HealthEquity available on-the-go

The new HealthEquity mobile app provides easy, on-the-go access to all of your health accounts. The free app provides comprehensive tools to help you manage transactions and maximize your health savings.

Convenient, powerful tools:

On-the-go access
You can access all account types wherever you go.

Photo documentation
Simply take a photo with your device to initiate claims and payments.

Send payments & reimbursements
You can send payments to providers or reimburse yourself for qualified out-of-pocket expenses from your FSA.

Manage debit card transactions
Link your debit card transactions to claims and documentation.

View claims status
View the status of claims as well as link payments and documentation to claims.

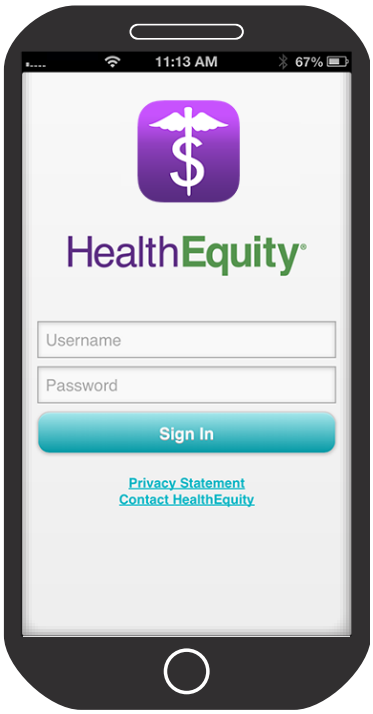
Available for *free* at:

iTunes App Store

Google Play

*iTunes App Store and Google Play are respective trademarks of Apple, Inc. and Google.

Login page



sample screenshot

Home screen

Central access to payments, claims & documents

Access multiple accounts

"Ever present" buttons for easy navigation

sample screenshot

Logging in

To log into the mobile app, you will use the same username and password created during your first-time log in to the member portal. If you have not logged in before, please do so online, preferably with a computer, prior to logging into the mobile app. If you are unsure of your login credentials, please contact member services for assistance at the phone number located on the back of your HealthEquity debit card.

If your password needs to be reset, you will need to create a new password on the member portal before it can be used to log into the mobile app.

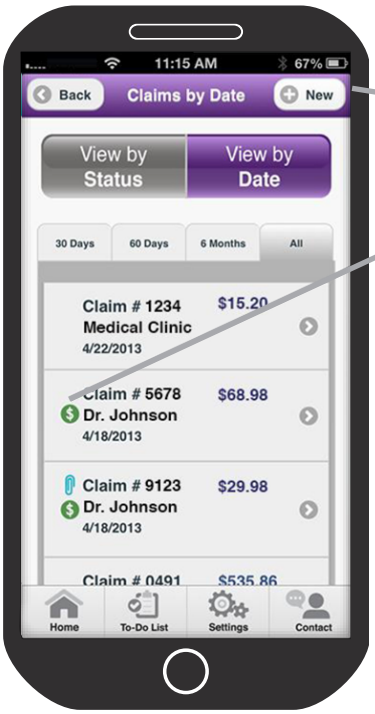
Mobile app home

On the home screen, you will see:

- Your name
- Member ID
- Buttons to access
  1. Payments
  2. Claims
  3. Documentation
- A list of your accounts and balances
- "Ever-present" navigation buttons:
  1. Home
  2. To-Do List
  3. Settings
  4. Contact

To view Account History, simply tap the gray arrow next to your account balance. Here you will see contributions, distributions, as well as any fees.

Claims home

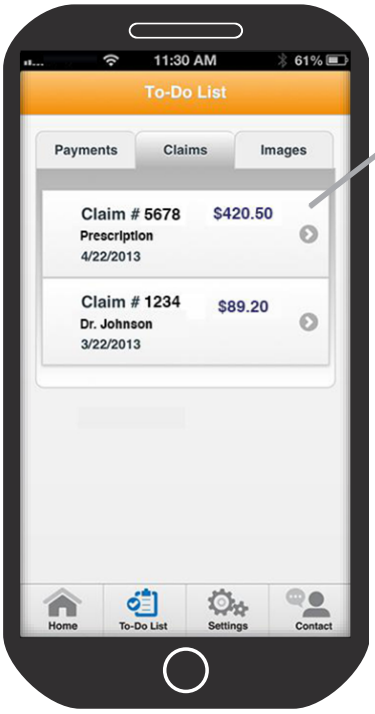


Add new claim

Icons indicate if a claim is linked to documentation or payment

sample screenshot

"To-Do" screen



"To-Do" items are those that have not been linked to a claim, payment or documentation

They are noted with an orange flag to set themselves apart from other items

sample screenshot

Add a claim

To add a new claim or view existing claims tap the Claims icon. On this screen you can see all of the integrated claims HealthEquity has received from your insurance company (if applicable), as well as claims you have entered manually.

To create a new claim, tap New in the top right corner and follow the prompts to enter the necessary information; tap Next. Review Claim Details and tap Finalize if accurate. You will have the option to add documentation to your claim by tapping Link Documentation and taking a picture of the receipt, EOB, or invoice, using your mobile device's camera.

Add an EFT account

To add banking information for electronic fund transfers (EFT), tap Settings at the bottom of the screen, and then select Bank Accounts. To add an account, you will tap New in the top right corner. Enter the requested information, like routing and account number and click Next.

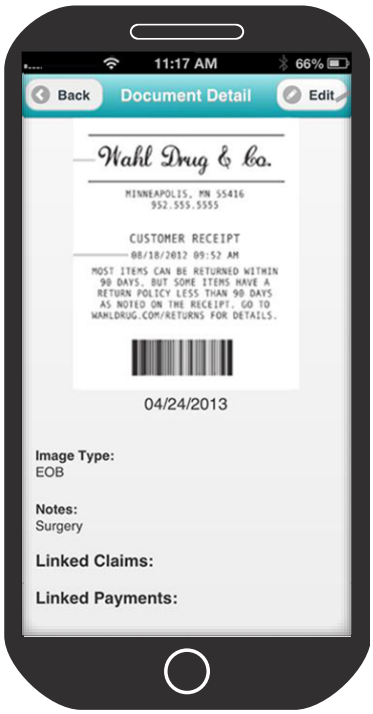
*The banking information added through the app can only be used for reimbursements.

To-Do list

To-Do items are those that have not yet been linked to a claim, payment or documentation. They are noted with an orange flag to set themselves apart from other items.

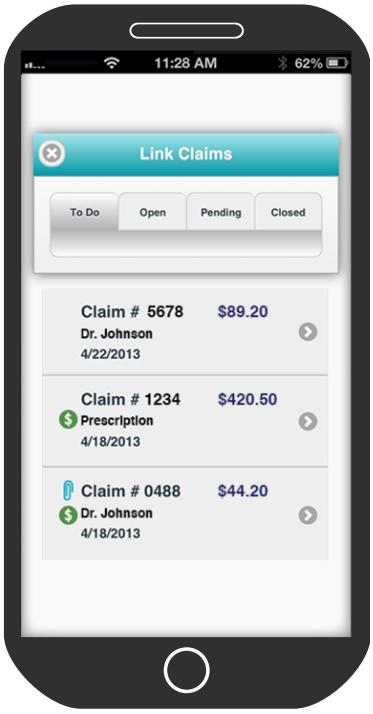
Documentation home

Documentation detail



sample screenshots

Link documentation to payment or claim



sample screenshots

Add and link to documentation

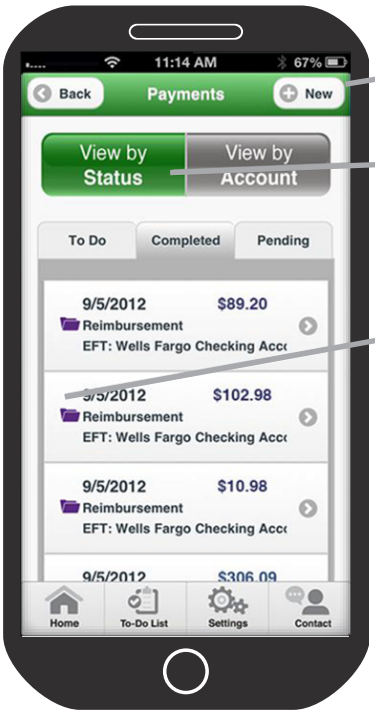
To upload a receipt, EOB or invoice to the mobile app, tap the Documentation icon. You will be able to select Camera, which will allow you take a picture right on the spot, or Image Library to use a picture you have already taken. Once the image is selected, you can enter the date of the expense, type of documentation, and any applicable notes. Once saved, your image will be visible as an Unlinked document. To link it to a particular claim or expense, select the picture and click Edit in the top right corner. Under Linked Payments, you can choose to link to a claim or payment. You can select whether you are linking to a new or existing claim/payment. If existing, you will select the correct claim/payment and tap Link. If adding new, you will be able to create a new entry using the steps listed in the Make a Payment section on page 28 and Add a Claim section on page 26.

Upload new documentation:
- Use the mobile device's camera to capture image of receipt, EOB, or invoice

View by status, date, or type

Select to view details

Payments home



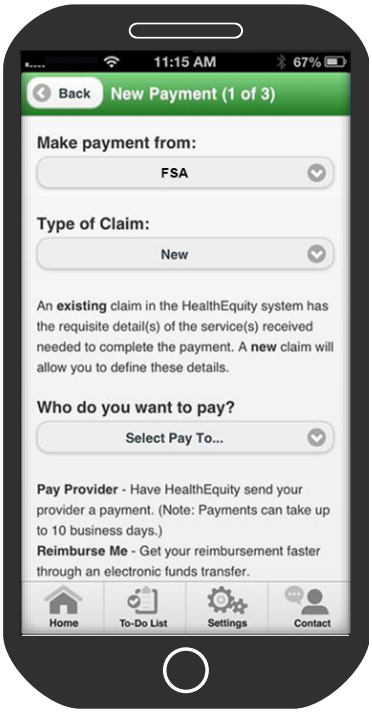
sample screenshot

Add new payment

Payments organized by status or date

Icons indicate if a payment has been linked to documentation, payment or claim

New payment screen



sample screenshot

Make payments from your phone

1. Choose which account to make payment from
2. Select a claim
3. Choose payee

Make a payment

To make a payment or reimbursement, tap the Payments icon. You can view previous payments made by status or date, but to add a new payment tap New in the top right corner. You will select the account you would like the funds to come out of, and select either New or Existing type of expense. If HealthEquity receives integrated claims from your insurance company, you can send a payment using the existing information from the open claim on the following screen. If it is a new expense, you will be required to enter expense information, like provider, date of service, patient, etc., on the following screen. Next, indicate whether HealthEquity will be sending a payment to a provider or reimbursing you before continuing to the next screen. Enter in all requested information and tap Next. If everything is correct on the confirmation screen, tap Finalize to send the payment.

Glossary of terms

Administrator
This term can be applied to many types of organizations. For the purpose of this guide, administrator refers to the company who holds, or administers, your FSA.

Claim
The information about a specific medical service submitted by your provider to your insurance company for processing. You can enter new claims records and access existing claims records in the member portal for payment and documentation purposes, as needed.

Contribution
The technical term used to refer to deposits to your FSA.

Contribution limits
The maximum amounts established by the IRS that you can contribute to your FSA. See page 8 for specific limits.

Copay
The fixed dollar amount you pay for specified services and prescriptions under most traditional health plans.

Dependent
Any individual other than yourself, who you can use your FSA dollars for. This can include your spouse, children under 27, any tax dependents or any person you could have claimed on your taxes except:

1. The person filed a joint return
2. The person had a gross income of $3,900 or more
3. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's tax return

Distribution
The technical term used to refer to withdrawals from your FSA.

EFT (electronic funds transfer)
A quick method of transferring funds directly between your FSA and personal financial institution. You can setup EFT reimbursements in the member portal.

Election amount
The amount you decide to contribute to your FSA annually.

EOB (explanation of benefits)

A statement from your insurance that shows the service billed from your provider and the deductible, coinsurance and other covered amounts, as applicable. Compare this to the invoice from your provider to ensure accuracy.

Expert friends

Our endearing term for our member services team, who are available every hour of every day to offer helpful insight to you.

FSA carryover

The opportunity to rollover up to $500 of unused FSA dollars to the next year, if offered by your employer.

Grace period

An extension, during which you may still incur eligible FSA expenses and use the funds remaining in your account to cover those expenses.

In-network

A provider that participates in your health plan network, who agrees to charge negotiated rates established with your health plan.

Insurance ID card

The card, provided by your health plan, that your provider uses to verify coverage and process billing of your claim. It is important that you present this card each time you use health care services.

Out-of-network

A provider who does not participate in your health plan network, and has no agreement with your health plan. You can still use your FSA to pay qualified medical expenses incurred with out-of-network providers.

Qualified medical expenses

Expenses that can be paid tax-free using your flexible spending account. See page 9 for some examples of qualified medical expenses.

Reimbursement

Money you withdraw from your FSA to pay yourself back for out-of-pocket expenses.

Run out period

A period of time after your plan year ends, during which you are still able to submit reimbursement claims for expenses incurred during the plan year.

About us

Building Health Savings℠

HealthEquity empowers Americans to build health savings by providing powerful tools for health savings accounts (HSAs) and other health financial services. We manage over $1.6 billion in deposits, which makes us the largest dedicated health account custodian in the nation. Our convenient solutions serve more than 1.3 million accounts, owned by individuals at more than 25,000 companies across the country. With member support available every hour of every day, our team provides around-the-clock insight to maximize health savings.

NEW MOBILE APP
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HealthEquity®

15 West Scenic Pointe Drive, Suite 100
Draper, UT 84020
info@healthequity.com
www.HealthEquity.com

FSA_Member_Guide_June_2014

Flexible spending account (FSA) employee enrollment form

HealthEquity®

Please return this form to your HR department.

Employer information

Employer name

Account holder information

First name	M.I.	Last name	
SSN	Gender ☐ Male ☐ Female	Date of birth (mm/dd/yyyy)	
Email address		Home phone	
Physical street address	City	State	ZIP
Mailing address (if different)	City	State	ZIP

FSA coverage

Coverage effective date

Annual elections

	Contribution per pay period	Number of pay periods remaining in plan year		Your annual election amount
Flexible spending account	$ 0.00	X 0	=	$ 0.00
Limited purpose flexible spending account (LPFSA)	$ 0.00	X 0	=	$ 0.00
Dependent care flexible spending account (DCRA)	$ 0.00	X 0	=	$ 0.00
Contribution per pay period x number of pay periods = your annual election amount				

Signature

☐ I decline to participate in the FSA plan.

Print name	Signature	Date

Claim filing requirements

HealthEquity®

READ BEFORE SUBMITTING YOUR REIMBURSEMENT FORM.
DO NOT FAX THESE INSTRUCTIONS WITH YOUR REIMBURSEMENT FORM.

Required information for reimbursement

The IRS requires you to substantiate all claims with documentation. The documentation must detail the healthcare expenses and include five key data points:

1. Name of provider
2. Name of patient
3. Description of services
4. Date(s) of service. The paid date may or may not be the same as the date of service; the date of service is required.
5. The cost of the service

Requests submitted without the above information cannot be processed.

Claim reimbursement checklist:

- For faster processing, submit a claim online via the 'Claims & Payments' tab. Otherwise, complete the claim form in its entirety. Incomplete requests cannot be processed.
- Include the required documentation that includes all of the five key data requirements listed above.
- Sign the claim form.
- Keep the original receipts for your records and send copies to us.

For faster payment, add EFT by logging in to www.MyHealthEquity.com or submitting the direct deposit form.

Over-the-counter medications

Over-the-counter (OTC) drugs and medicines along with menstrual care products are now eligible without a written prescription as of January 1, 2020. A Letter of Medical Necessity (LMN) will still be required for vitamins and dual-purpose OTC items. The LMN is good for a 12 month period and must be dated on or before services rendered. The LMN form is available under Forms and Docs in the Member Portal. Note: OTCs purchased in 2019 will still require the written prescription and do not allow for menstrual products.

Online claims submissions and account information

For assistance submitting claims online, to access your account, or for assistance in adding your EFT, please contact HealthEquity® member services at 877.472.8632, they are available every hour of every day to assist you, or log in to www.MyHealthEquity.com.

FSA/HRA Reimbursement Form

HealthEquity®

Mail or fax completed forms to:

Address: **HealthEquity, Attn: Reimbursement Accounts**
PO Box 14374, Lexington, KY 40512

Fax: 801.999.7829 (cover sheet not required)

For faster processing, enter the claim and upload required documentation using the 'Claims & Payments' tab on the member portal.

Account holder information

Company name	Last 4 of SSN or HealthEquity ID number		
Last name	First name		M.I.
Street address	City	State	ZIP
Email address (required)	Daytime phone ( )	Work phone ( )	

Reimbursement information

Patient name	Service provider	Actual date(s) of service Start date:____ /____ /____ End date:____ /____ /____
Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____ /____ End date:____ /____ /____
Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____ /____ End date:____ /____ /____
Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____ /____ End date:____ /____ /____
Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____ /____ End date:____ /____ /____
Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____ /____ End date:____ /____ /____
Description		Amount $
	TOTAL AMOUNT REQUESTED	$

CERTIFICATION AND AUTHORIZATION:

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.) I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one healthcare account, reimbursement will be made according to the payment order determined by those plans and as stated on the website. Use of this service indicates my acceptance of the HealthEquity's User Agreement.

Reimbursement method

☐ **Option 1—Check**
This method is slower. Please allow 7–10 business days to receive your check.

☐ **Option 2—Use the verified electronic funds transfer (EFT) account already tied to my HealthEquity® FSA.**
(If an EFT is not on file, a check will be sent. Please allow 7-10 business days for the check to arrive.)

☐ **Option 3—Transfer the funds to the following account.**
(**Note**: E-mail address is required for EFT.)

Account type: ☐ Checking ☐ Savings

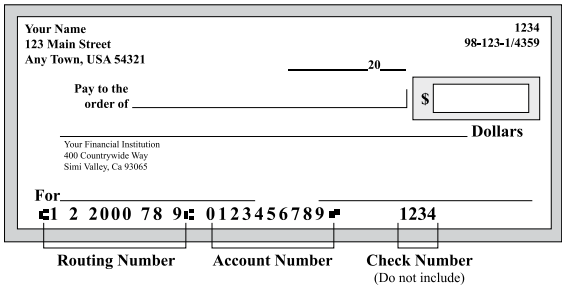
Financial institution:_____

City/state:_____

Routing number:_____

Account number:_____

A copy of a voided check must be included to verify banking information otherwise a check will be sent and a $2.00 fee may apply.



Note: Please attach proper documentation to this form. An explanation of benefits or itemized receipt is required. Documentation must include the actual date(s) of service, patient name, provider's name, description of service, and the cost. If you have additional expenses, please complete an additional form. **Send only copies of receipts.** Keep original receipts for your records.

Update: Effective Jan. 1, 2011, a letter of medical necessity may be required for medicinal over-the-counter items (i.e. aspirin). A letter of medical necessity form is available on your HealthEquity® member portal.

Reimbursement requests can also be made online at www.MyHealthEquity.com.