



# OHR Employee Benefits

January 2002

## PLANNING TO RETIRE IN 2002?

If you are thinking of retiring in calendar year 2002, here are some suggestions:

- Schedule a counseling session with Carol Mehallick in the Benefits Office, extension 3-2507, 4-6 months before your anticipated retirement date.
- Request a retirement printout. This will assist in planning your monthly expenses in retirement.
- If you have military service, will be eligible for Social Security at age 62, and have not paid your military deposit, please contact Carol Mehallick in the Benefits Office, extension 3-2507, for information on how this will impact your annuity.
- Update your Designations of Beneficiary. If you are married and there are no designations on file, all of your benefits will be paid to your spouse. If you are single or divorced, it is recommended that designations be on file to ensure that your benefits are paid to the recipients of your choice.
- Attend a Retirement Seminar. We usually offer two seminars a year, in the spring and fall. Watch [Today@Glenn](mailto:Today@Glenn) for announcements.

## NEBA

NEBA, an insurance program for NASA employees, was founded in 1952, 2 years prior to the Federal Government's own insurance program (FGLI). Its coverage is outstanding, its cost extremely competitive, and its membership apparently very healthy. As a result of excellent actuarial experience coincident with strong financial reserves, NEBA's Board of Directors has voted for a return of premium (refund) for the past 4 years (approximately one-third return each year). Applications for NEBA are available in the Benefits Office.

## Leave Transfer Program

The Federal voluntary Leave Transfer Program allows Federal employees to donate **annual** leave to assist other Federal employees in their agency or other Federal agencies, who have personal or family medical emergencies and have exhausted their own leave.

Under leave transfer, an employee (leave donor) may donate annual leave directly to an approved leave recipient. There is no limit on the amount of donated leave a recipient may receive from leave donors. However, any unused donated leave must be returned to the donors when the medical emergency ends.

Any accrued annual and sick leave and comp and credit hours must be used; then Payroll will credit your account with any transferred leave you have received.

It is your responsibility to obtain leave donors. Each donor must submit a Leave Donation Form (OPM 630-A) to the Payroll Office.

If you need additional information regarding this Program, please contact Carol Mehallick in the Benefits Office at extension 3-2507.

## INSIDE THIS ISSUE

1	Planning to Retire in 2002?
1	NEBA
1	Leave Transfer Program
2	Medicare and FEHB
2	Continuing FEHB Coverage for a Child Incapable of Self-Support
3	Long-Term Care Insurance
4	Telecommuting
4	Thrift Savings Plan
4	2001 Year End Return
4	Thrift Savings Plan Loan Information

## Medicare and FEHB

Medicare started in 1966. Effective January 1, 1983, Federal employees were required to pay Medicare taxes as part of the move to get all Federal employees under Social Security.

Part A (Hospital Insurance) helps pay for inpatient hospital care, skilled nursing facility care, home health care, and hospice care.

Part B (Medical Insurance) helps pay for doctor's services, outpatient hospital care, x-rays and laboratory test, durable medical equipment and supplies, home health care, certain preventive care, limited ambulance transportation, other outpatient services, and some other medical services Part A doesn't cover, such as physical and occupational therapy.

You are eligible for Medicare if you are age 65 or over. Also, certain younger disabled person and persons with permanent kidney failure are eligible.

You are entitled to Part A without having to pay premiums if you or your spouse worked for at least 10 years in Medicare covered employment. You automatically qualify if you were a Federal employee on January 1, 1983. If you don't qualify for premium-free Part A and you are age 65 or older, you may be able to buy it; contact the Social Security Administration.

You must pay premiums for Part B coverage, which are withheld from your monthly Social Security payment or your annuity. Part B coverage can be waived for people who are Medicare eligible and still employed while covered by an employer health plan. Medicare is the secondary payer. Therefore, it is recommended that you take Part A coverage when you become eligible and waive enrollment in Part B until you retire. For every year over age 65 that you do not enroll in Part B, there is a 10-percent premium penalty. That penalty is waived for those that are Medicare eligible and still covered by an employer health plan. As an annuitant, Medicare becomes the primary payer. For annuitants who carry Medicare and are covered under an FEHB Fee-for-Service plan, generally, with the exception of prescription drugs, the plans waive most of their deductibles, coinsurance, and copayments. HMO enrollees may not need Medicare Part B. HMO's provide most medical services for small copayments. HMO enrollees may not recover the cost of Part B expenses in terms of benefits received.

## Continuing FEHB Coverage for a Child Incapable of Self-Support

Your self and family enrollment covers your unmarried dependent child age 22 or over who is incapable of self-support because of a physical or mental disability that existed before the child reached age 22.

Your child age 22 or over may be considered incapable of self-support only if his/her physical or mental disability is expected to continue for at least 1 year and, because of the disability, he/she isn't capable of working at a self-supporting job.

A disability such as blindness or deafness isn't qualifying because it doesn't necessarily make someone incapable of self-support. The onset of a disease before age 22 that doesn't result in incapability for self-support until age 22 or after doesn't qualify a child for continued coverage as a family member.

Your child incapable of self-support because of mental or physical disability that existed before age 22 must also be dependent upon you to qualify them for health benefits coverage. In addition, your stepchild or foster child incapable of self-support must live with you in a regular parent-child relationship to qualify.

Your dependent child is incapable of self-support when:

- He/she is certified by a state or Federal rehabilitation agency as unemployable; he/she is receiving: (a) benefits from Social Security as a disabled child; (b) survivor benefits from CSRS or FERS as a disabled child; or (C) benefits from OWCP as a disabled child;
- A medical certificate documents that: (a) your child is confined to an institution because of an impairment due to a medical condition; (b) your child requires total supervisory, physical assistance, or custodial care; or (c) treatment, rehabilitation, education training, or occupational accommodation has not and will not result in a self-supporting individual;
- A medical certificate describes a disability that appears on the list of medication conditions; or
- You submit acceptable documentation that the medical condition is not compatible with employment, that there is a medical reason to restrict your child from working, or that he/she may suffer injury or harm by working.

If your child earns some income (generally no more than the equivalent of the GS-5, step 1), it doesn't necessarily mean that he/she is capable of self-support. The Office of Human Resources, Benefits Office is responsible for determining whether your dependent child age 22 or over is incapable of self-support because of mental or physical disability that began before age 22 and for notifying the carrier of your plan of its determination. The Office of Personnel Management maintains a list of qualifying conditions. The list is available through the Benefits Office. If your child's medical condition is listed, the carrier may also approve coverage. Your child's doctor must complete a medical certificate to document the conditions.

Contact the Benefits Office at extension 3-2027, 3-2507, or 3-8550.

## Long-Term Care Insurance

The Office of Personnel Management (OPM) will sponsor a high-quality, Long-Term Care Insurance Program effective in October 2002. As part of its education effort, OPM asks you to consider the following questions?

### **What is Long-Term Care (LTC) Insurance?**

It's insurance to help pay for long-term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimers.

LTC Insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. It can supplement care provided by family members, reducing the burden you place on them.

### **I'm healthy. I won't need long-term care. Or, will I?**

Welcome to the club! Seventy-six percent of Americans believe they will never need long-term care, but the facts are that about half of them will. And its' not just the old folk. About 40 percent of people needed long-term care under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc. We hope you will never need long-term care, but everyone should have a plan just in case. Many people now consider long-term care insurance to be vital to their financial and retirement planning.

### **Is long-term care expensive?**

Yes, it can be very expensive. A year in a nursing home can exceed \$50,000. Home care for only three 8-hour shifts a week can exceed \$20,000 a year. And that's before inflation! Long-term care can easily exhaust your savings. Long-Term Care Insurance can protect your savings.

### **But won't my FEHB plan, Medicare, or Medicaid cover my long-term care?**

Not FEHB. Look at the "Not Covered" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care, a stay in an assisted living facility, or a continuing need for a home health aide to help you with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.

Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older, or fully disabled. It also has a 100-day limit.

Medicaid covers long-term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. Long-term care insurance can provide choices of care and preserve your independence.

### **When will I get more information on how to apply for this new insurance coverage?**

Employees will get more information during the LTC open enrollment period in the late summer/early fall of 2002. Retirees will receive information at home.

### **How can I find our more about the program now?**

The toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on the Web site at [www.opm.gov/insure/ltc](http://www.opm.gov/insure/ltc)

The Office of Personnel Management expects the Long-Term Care to be effective in October 2002. An open season is expected to be held in the late summer/early fall 2002, following an extensive education and marketing. There is a possibility that there may be an opportunity for an early enrollment opportunity in February or March 2002. This means that eligible individuals, who already know about long-term care insurance and do not need extensive educational materials, can apply for the insurance early. The NASA Personnel Payroll System cannot be modified to provide payroll deduction in the event of the early enrollment opportunity. Early LTC enrollees will not be able to pay their premiums through payroll deduction. An arrangement for direct premiums will probably be made.

## Telecommuting

Telecommuting is working in an environment outside of the traditional workplace—normally from an employee's home.

There are three types of telecommuting. It is important to understand the difference so that your telecommuting request can be processed and approved in a timely manner.

**Ongoing Telecommuting** – Working at alternate worksite on an ongoing basis, without a specified ending date, 1 or more days per week. In general, ongoing telecommuting should not be done on a full-time basis.

**Temporary Telecommuting** – Working at an alternate worksite 1 or more days per week for a limited period of time (normally less than 1 year in length) for a specific reason. Such positions are normally established to meet specific employee or organization needs; i.e., to accommodate an employee recovering from an injury of illness (if medically able to work), to meet special project demands, etc.

**As-Needed Telecommuting** – Working at an alternate worksite on an as-needed basis for a very short period of time (generally in 1-day increments). As-needed telecommuting can be used when quiet time is needed to write a paper, complete a project, write performance appraisal evaluations, etc., and the supervisor believes that an employee will be more productive at home where there may be fewer distractions. This type of telecommuting can be approved by the immediate supervisor, without additional approval requirements.

The following forms are used to apply for telecommuting:

### **NASA C-88 (Rev. 4-00) Telecommuting Agreement**

This form is used for employees requesting **as needed** telecommuting only **and** for those requesting **on-going and temporary** telecommuting. This form outlines the work assignments that will be performed and the Government equipment that will be used; and requires the signature of the employee and immediate supervisor.

### **NASA C-89 (Rev 06-2001) Telecommuting Application for Ongoing or Temporary Telecommuting**

This form indicates which type of telecommuting is being applied for and the beginning and ending dates; documents justification for work to be done outside the workplace; and requires the approval of first and second-level supervision. The form is then authorized/approved by the Office of Human Resources.

If you are unsure which form is required for your situation, please contact Carol Mehallick in the Benefits Office at extension 3-2507.

### TSP 2001 Year End Rates of Return As of 01/03/02

G Fund – 5.39%  
F Fund – 8.61%  
C Fund – (11.94%)  
S Fund – (7.32%)  
I Fund – (21.86%)

Percentages in ( )  
are negative



Detailed information can be found at the following the  
TSP Web Site: [www.tsp.gov/rates/index.html](http://www.tsp.gov/rates/index.html).

## Thrift Savings Plan (TSP)

If you are thinking about taking a loan from your TSP account, you might want to visit the Calculator section of the TSP Web site (<http://www.tsp.gov>). The new Loan Calculator can help you determine the amount of your loan payments and the length of time it would take you to repay the loan. The calculator automatically uses the current loan interest rate.

If you already have a loan, you can refer to the new Outstanding Loan Balance and Prepayment information page in the Account Access section of the TSP Web site to determine your outstanding balance and the amount required to repay your loan in full. You will need your Social Security number and your TSP PIN to enter the Account Access Section.

Taking a loan from your TSP account will affect the amount of money available to you for retirement. Before you apply for a loan, be sure to read the TSP Loan Program booklet, so that you understand the rules before borrowing and the effect of a loan on your account. The booklet and the loan application form are available on the TSP Web site.