



**YOUR FLEXIBLE SPENDING ACCOUNTS  
PROGRAM  
STATE OF GEORGIA  
SUMMARY PLAN DESCRIPTION**

WageWorks, Inc.  
11405 Bluegrass Parkway  
Louisville, KY 40299

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## **THE EMPLOYEE BENEFIT PLAN COUNCIL STATE OF GEORGIA**

The Flexible Spending Accounts Program operates under Regulations set forth by the Employee Benefit Plan Council on behalf of the State of Georgia under rules written and enforced by the Internal Revenue Service (IRS). The Employee Benefit Plan Council reserves the right to amend or terminate the Program at any time, in accordance with certain rules and within the parameters established by federal law and the Internal Revenue Service.

This booklet is issued by the Employee Benefit Plan Council on behalf of the State of Georgia for delivery to employees who elect Spending Account coverage under the Flexible Benefits Program. The contract rights of an eligible employee who elects Spending Account coverage will be governed by the contract between the Employee Benefit Plan Council and the Plan Administrator.

This booklet is a summary plan description of the Flexible Spending Accounts Program. If there should be any conflict between the information contained in this booklet and the provisions of the Program, as set out in the formal Program documents, the latter will govern.

This booklet is provided only when you are entitled to the coverage provided by the group contract as an eligible employee, you elect this coverage, and you retain coverage in accordance with the terms and conditions of the group contract. This booklet supersedes and replaces all booklets previously issued to you for Spending Account coverage under the State of Georgia, Flexible Benefits Program. This booklet describes the coverage in effect as of January 1, 2020.

## **NOTICE**

If you have a disability and need assistance, please notify the Flexible Benefits Program at (404) 656-2730, or for TDD Relay Service only: 1-800-255-0056 (Text-telephone) or 1-800-255-0135 (Voice).

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## INTRODUCTION

### How Spending Accounts Save Your Money

A very important feature of your Flexible Benefits package is the Spending Accounts Program (SAP). This special option allows you to pay health care and dependent care items with pre-tax dollars, thus reducing your taxable income and saving you money on your state and federal income taxes.

The Spending Accounts Program operates as a “salary reduction arrangement,” where pre-tax contributions are taken from your paycheck and applied to one or both spending accounts. This effectively reduces your taxable income by the amount of your contributions for that Plan Year. Money is transferred from your salary without ever being taxed and is reimbursed to you for certain qualifying health care and dependent care expenses.

The Program exists to let you pay qualifying health care and dependent care expenses with untaxed dollars. There are numerous rules that govern SAP, and certain exceptions and exclusions, as explained herein.

Depending on the amount of money earned, your family situation, tax rate, and various other factors, you may save between 26% and 42% on the money you choose to put into a SAP.

Here is a general example of how a spending account saves you money:

	<b>With a Spending Account</b>	<b>Without a Spending Account</b>
-Say your annual State salary is:	\$22,000	\$22,000
-And your spending account deposit is:	\$ 2,000	\$0
-Now deduct for taxes at a 29% rate: -	\$ 5,800	\$ 6,380
And your available annual pay is now:	\$14,200	\$15,620
-Now pay off your family-care bills:	\$0	\$2,000
-So your overall net is:	\$14,200	\$13,620

By channeling your family care expenses through tax-exempt spending accounts, rather than paying with after-tax dollars, you have increased your annual take-home pay by \$580.

### **Program Composition**

The Spending Accounts Program (SAP) is divided into two separate spending accounts: Health Care Spending Account and Dependent Care Spending Account. Each of these are separate and administered independently. Money cannot be transferred from one account to the other. While the underlying principles are similar, the actual operation of the accounts is very different:

**-Health Care Spending Account (HCSA)** lets you set aside pre-tax dollars from your paychecks to cover “excess” health care expenses not reimbursed by any medical, dental, or vision care plan.

**-Dependent (Child) Care Spending Account (DCSA)** lets you set aside pre-tax dollars from your paycheck to cover eligible dependent care expenses incurred so you and/or Spouse may work, look for work, or attend school full time.

### **Forfeiture: “Use it or Lose it”**

The IRS determined that an element of risk must be involved in any kind of benefit protection that provides a substantial tax savings. When you deposit money in a HCSA or DCSA, you must use it or you lose it. There is no refund at the end of the year and anything that is left over in your account is forfeited and goes to help offset the costs of operating the FSA.

Eligible expenses incurred while covered in a Plan Year must be claimed in that Plan Year (January 1 through December 31). You have a 2 ½-month grace period, or until March 15, to incur expenses for that Plan Year and until April 30 to file incurred expenses. Any money remaining after this time will be forfeited.

*NOTE: If you terminate or retire from State employment, your coverage period will stop at the end of the month following your last full month of employment or contribution. You may be able to extend your coverage temporarily under COBRA. See page 24 for details.*

To avoid forfeitures, plan wisely when determining the amount to contribute. Be realistic when setting the contribution amount and carefully analyze your recurring expenses each week or each month to plan for the year ahead. Planning is the key!

### **Grace Period**

The State adopted a grace period for the HCSA. This grace period allows you to use any unused contribution to reimburse eligible expenses (with respect to the applicable spending account) incurred during the grace period.

The grace period will begin on the first day of the next Plan Year and will end two (2) months and fifteen (15) days later.

For example, the Plan Year ends December 31, 2019; the grace period begins January 1, 2020 and ends March 15, 2020.

In order to take advantage of the grace period, you must be:

- A Participant in the applicable spending account(s) on the last day of the Plan Year to which the grace period relates, or
- A Qualified Beneficiary who is receiving COBRA coverage under the HCSA on the last day of the Plan Year to which the grace period relates.

The following additional rules will apply to the grace period:

- Eligible expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the Plan Year to which the grace period relates and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. Claims will be paid in the order in which they are received. This may impact the potential reimbursement of eligible expenses incurred during the Plan Year to which the grace period relates to the extent such expenses have not yet been submitted for reimbursement. However, the Employer reserves the right to reprocess claims to change the order in which they were received so that you can maximize your current and prior year annual election amounts.
  - For example, assume that \$200 remains in your HCSA at the end of the 2019 Plan Year and further assume that you have elected to allocate \$2400 to the Health Care Spending Account for the upcoming 2020 Plan Year. If you submit for reimbursement an Eligible Medical Expense of \$500 that was incurred on

January 15, 2020, \$200 of your claim will be paid out of the unused amounts remaining in your HCSA from the 2019 Plan Year and the remaining \$300 will be paid out of amounts allocated to your Health Care Spending Account for 2020.

- Expenses incurred during a grace period must be submitted before the end of the Run-out Period, or April 30. Any unused amounts from the end of a Plan Year to which the grace period relates that are not used to reimburse eligible expenses incurred either during the Plan Year to which the grace period relates or during the grace period will be forfeited.
- You may not use HCSA amounts to reimburse eligible day care expenses. The grace period is not applicable for the Dependent Care Spending Account.

## GENERAL PROVISIONS

### Glossary of Terms:

**-Administrator:** The Employee Benefit Plan Council and the Commissioner of the Department of Administrative Services (DOAS) are responsible for administering the Plan.

**-Code:** The Internal Revenue Code of 1986, as amended.

### **-Coverage Amounts and Coverage Periods (HCSA only):**

- **Elected Coverage Amount (HCSA only):** The maximum amount of money available for the reimbursement of eligible health-care expenses at the beginning of a Plan Year. It is calculated by multiplying a participant's monthly HCSA contribution by the number of calendar months in his or her Anticipated Coverage Period.
- **Available Coverage Amount (HCSA only):** The maximum amount available for the reimbursement of covered healthcare expenses at any given time after the beginning of a Plan Year. It equals the Elected Coverage Amount less the total of all reimbursements already made to the participant in that Plan Year.
- **Anticipated Coverage Period (HCSA only):** The number of calendar months during any Plan Year for which a participant is expected to make an HCSA contribution. For current employees, the Anticipated Coverage Period is always 12 months, for new employees it is the number of calendar months from Participation Start Date to the end of the Plan Year.
- **Actual Coverage Period (HCSA only):** The calendar month(s) for which a participant actually makes an HCSA contribution.

**-Department:** The state entity for which you work, which may include a State authority, a school system, a county health department, a county department of family and children's services, or the General Assembly. For the purposes of this booklet and SAP, the employing entity will be known as your Department.

**-Employer:** The Employee Benefit Plan Council, on behalf of the State of Georgia and the Department from which a participant receives his or her regular compensation.

**-Expenses Incurred Date:** The date on which a service is rendered, not when it is paid or billed. This applies to all expenses for health care and dependent care.

**-Itemized Receipt:** An explanation of services that includes the name and address of the service provider, the date of service, services provided, the amount charged, and the name of the employee or dependent who received the services.

**-Open Enrollment Period:** A month-long period that occurs each year during October and November when eligible employees may enroll in the SAP and/or make changes in their participation status.

**-Participation Start Date:** The day your coverage under the Program goes into effect. If you sign up during an Open Enrollment Period, then your Participation Start Date will be the first day of the upcoming Plan Year (January 1), provided that you are actively at work on that date. If you sign up at any other time, your Participation Start Date will be the first day of the calendar month after you complete one full calendar month of employment, if you are actively at work on that date.

**-Plan Year:** The one-year period which begins each January 1 and ends December 31.

**-The Program:** The Spending Accounts Program of the State of Georgia Flexible Benefits Program.

### **Enrollment in the Program**

You are eligible to participate in the Spending Account Program (SAP) if you fully meet any of following categories:

- Active State Employees. Employees who are actively working, on approved leave with pay (other than personal sickness or disability), or on suspension with pay, may participate in the Flexible Benefits Program if the employee is a regular full-time employee who works a minimum of thirty (30) hours per week and whose duties are expected to require at least nine (9) months of continuous service. Contingent workers of the Labor Department, employees who are working on a temporary, seasonal, or intermittent basis, and employees working in a sheltered workshop operated by county family and children services, mental health subdivisions or other employing entities are not eligible to participate in the SAP.

Eligible employees are as follows:

- A member of the General Assembly or a full-time employee of the General Assembly;
  - A person who works full time and receives compensation in a direct payment from a state department, agency, community service board, authority, or other institution of State government, exclusive of the Board of Regents of the University System of Georgia; or
  - A person who works full time and receives compensation from a county department of family and children services or a county department of health which receives funds through the grant program of the Department of Human Resources.
- Active Educational System Employees. Employees who are not considered temporary or emergency employees, and who are actively working, on approved leave with pay (other than personal sickness or disability), or on suspension with pay, may participate in the Flexible Benefits Program if the employee receives pay from one of the educational institutions that has elected to participate in the Program and meets the following requirements:
    - Employees serving in a certificated position and who work at least 17.5 hours per week;
    - Employees who work at least 17.5 hours per week for a county or regional library;
    - Persons serving in a non-certificated position and who work at least 20 hours per week or 60% of the time normally required for these positions if that's more than 20 hours per week; and
    - Persons eligible for the Public School Employees Retirement System and work at least 15 hours per week or 60% of the time normally required for these positions if more than 15 hours per week.

*NOTE: The SAP operates as a "salary reduction arrangement." When you instruct your Department to transfer contributions from your paycheck to one or both spending accounts, you effectively reduce your taxable compensation by the amount of your contribute for that Plan Year. You may not change your elections during the Plan Year unless you have a qualifying event.*

### **Coverage Effective Date**

Spending Account coverage begins on the first day of the month following one full calendar month of employment provided you are actively working. The contribution is deducted from your paycheck in the calendar month before the actual month in which your coverage becomes effective and in each calendar month thereafter through the end of the Plan Year.

If you are a current employee who enrolled during the Open Enrollment Period, your coverage will begin on January 1. Your first payroll reduction will be in the preceding December.

If you are a new employee, your coverage will begin on the first day of the month after you complete one full calendar month of employment. For example, if you are hired on July 16 and select to contribute to a spending account, your first payroll reduction will be made in August for coverage beginning September 1.

If you are hired mid-year or have a qualifying change in status during the plan year, you may not contribute the maximum allowed under either SAP for the remainder of the Plan Year. In this case, you may only contribute the maximum per month allowed by each account.

### **Coverage Termination Date**

Your coverage will terminate at the end of each Plan Year, or December 31. You have a grace period, which typically ends on April 30 to file expenses that were incurred during the Plan Year you had coverage.

If you terminate or retire from State employment during the Plan Year, your HCSA ends at the end of the month following the last full month of employment or contribution.

For example, if you terminate employment on June 30, the last contribution towards your HCSA would be deducted from the June 30 paycheck. Therefore, your HCSA would end July 31, or the month following the last full month, you were employed.

If you have any remaining funds in your HCSA on the date you were terminated, resigned or retired you may be able to continue to participate in the HCSA for the rest of the Plan Year. See "*Eligibility for COBRA Coverage*" on page 24.

### **Leave of Absence**

If you go on a paid leave of absence, your regular payroll reductions will be continued during your leave, with no change in your coverage.

If you have an unpaid leave of absence or an absence without pay, premium payments to the DCSA are not allowed. You may continue premium payments while on a leave of absence without pay for the HCSA. If you do not contribute to your HCSA while on leave without pay, your elected coverage amount and coverage period will be adjusted accordingly.

*NOTE: An unpaid leave of absence for the purposes of Military or Family Medical Leave Act (FMLA) qualifies as a Change in Status Event. See page 23 for more information.*

## **HEALTH CARE SPENDING ACCOUNT (HCSA)**

### **How the HCSA works**

First, estimate your excess health care expense for the coming Plan Year (January through December) and decide on the amount of your HCSA contribution. You will make your election during Open Enrollment and authorize your Department to transfer that amount from your paycheck to your HCSA.

The minimum contribution to an HCSA is \$120.00 a year or \$10 a month; the maximum is \$2,652.00 a year or \$221.00 a month.

You use your HCSA as you or your dependents incur health related expenses. Reimbursement from your account can be made by using the Electronic Payment (Debit) Card or by filing a claim. Both processes are outlined later in this booklet under “Claim Reimbursement” on page 18.

Please note that with the State Health Benefit Plan (SHBP) Consumer Driven Health Plan, the Health Reimbursement Account (HRA) credit will be utilized first before an employee’s HCSA dollars. This may affect how much money an employee wishes to contribute to their Spending Account.

### **Just one note of caution...Use it or lose it!**

The IRS provides that when you deposit money in a spending account, you must “use it or lose it.” There is no refund at the end of the year. Any remaining money left in your account is forfeited and helps offset the cost of the SAP.

### **Who is Covered Under the HCSA**

Eligible individuals for the HCSA include you, your spouse, children, and any other person who is a qualified IRS dependent. Reimbursement for expenses under the HCSA is made only for those who are eligible.

### **Eligible Expenses for the HCSA**

Eligible health care related expenses are any expenses incurred for medical care, including amounts paid for the diagnosis, care, mitigation, treatment, or prevention of disease or illness and for treatments affecting any part or function of the body. IRS Publication 502 provides a detailed listing of tax-deductible items that may be eligible for the Health Care Spending Account. A copy of Publication 502 is available by contacting your HR/payroll office, visiting a local library, by contacting the IRS at 1-800-829-1040 or online at [www.irs.gov](http://www.irs.gov).

The administrator has the authority to make the final decision as to whether an expense is eligible.

The following is a list of potentially eligible expenses for the HCSA:

- Acupuncture\*
- Abdominal supports\*
- Air conditioners\* (to the extent in excess of value enhancements to the property, if not detachable)
- Automobile equipment to assist the physically disabled
- Back supports\*
- Bereavement and grief counseling
- Birth control pills
- Bone marrow transplants
- Braille books and magazines (above cost of regular printed material)
- Certain special schooling for disable persons
- Child birth preparation classes (to the extent instruction relates to birth and not child-rearing)
- Chiropractic expenses
- Computer storage of medical records
- Contact lenses and contact lens solutions
- Co-payments
- Coinsurance
- Crutches\*
- Deductible amounts
- Dental cleanings and fillings
- Detoxification or drug abuse centers
- Diathermy
- Diabetic supplies
- Elevators (in home) for disabled (to the extent in excess of value enhancement to property)
- Expenses in excess of medical, dental, or vision plan limits
- Expenses for services connected with donating an organ
- Eye exams
- Fee to use swimming pool for exercises prescribed by physician to alleviate specific medical conditions\* (used exclusively to treat medical condition)
- Fertility Enhancement
- Guide or guide dogs for persons who are visually or hearing impaired
- Hearing aids
- Household visual alert system for hearing impaired person
- Kidney transplants
- Lasik Eye Surgery

- Legal fees directly related to mental commitment of mentally-ill person
- Medically necessary mattresses and boards\*
- Note-taker for a hearing impaired child in school
- Orthodontia
- Orthopedic shoes
- Over the counter drugs (antacids, allergy medications, pain relievers and cold medicines)
- Physical therapy (required for a specific medical condition)
- Prescription drugs
- Psychotherapy/psychoanalysis
- Radial Keratotomy
- Radiation treatments
- Remedial reading\*
- Respirators
- Routine physical exams
- Smoking cessation programs\*
- Specialized equipment for disabled persons
- Speech therapy
- Sterilization surgery
- Support hose\*
- Water fluoride devices\*
- Weight loss programs\* (prescribed by a physician to treat a specific medical condition, such as diabetes)
- Well baby visits
- Wheelchairs
- Whirlpool baths\*
- Wigs for hair loss due to any disease\*
- X-rays

\*Expenses must be accompanied by a doctor's certification indicating the specific medical disorder, the specific treatment needed, and how this treatment will alleviate the medical condition.

### **Exclusions for the HCSA**

The following is a list of items excluded from the HCSA:

- Cosmetic procedures or drugs
- Electrolysis
- Expenses actually claimed on your income tax
- Expenses reimbursed by other sources, such as insurance companies

- Fees for exercise/athletic/health clubs when there is no specific medical reason or justification for membership
- Hair transplants
- Herbal Supplements
- Illegal treatments, operations, or drugs
- Insurance premiums
- Nicotine patches and gum
- Nutritional Supplements
- Postage/Handling fees
- Teeth whitening/bonding
- Vitamins
- Weight reduction programs for general well-being

## **DEPENDENT CARE SPENDING ACCOUNT (DCSA)**

### **How the DCSA works**

First, estimate the amount of your dependent care expenses for the coming Plan Year and decide on the amount of your DCSA contribution. You will make your election during Open Enrollment and authorize your Department to transfer that amount from your paycheck to your DCSA. The minimum contribution is \$120 a year or \$10 a month; the maximum is \$4,992 a year or \$416 a month. If you and your spouse both work for the State, you cannot exceed the \$4,992 per year family limitation. As discussed below, other federally imposed limitations may curtail your deposits short of the maximum.

When you incur an expense for dependent care, pay the bill first. Complete the DCSA form and have it signed by the person or facility that provided the service. You can also attach to the claim form to a signed, itemized receipt from the provider of the service which includes the type(s) of service rendered, the actual date(s) on which they were received, the total amount charged, the name(s) of the child (ren) or others who were cared for, and the complete name, address, and telephone number of the service provider. After the claim has been filed, you will receive a reimbursement check provided the claim is approved and have enough money in your DCSA to cover the check.

### **Just one note of caution...Use it or lose it!**

The IRS provides that when you deposit money in a spending account, you must “use it or lose it.” There is no refund at the end of the year. Any remaining money left in your account is forfeited and helps offset the cost of the SAP.

There are limitations on the amount that can be deposited in a DCSA, in addition to the \$4,992 per year overall limit for married taxpayers who file jointly. You may not be able to deposit the full amount if:

- Your spouse works for the State and the total of your family's contributions is \$4,992.
- Your spouse works for any employer (other than the State) which offers a similar plan. In such a case, combined deposits to both of the plans would be limited to the maximum.
- Either you or your spouse earn less than \$5,000 per year, if so the maximum deposit drops to the smaller of your two incomes.
- Your spouse is a full-time student or is incapable of self-care. When this happens, your deposit is limited to \$2,400 if you have just one eligible dependent or \$4,800 if you have two or more.
- You are married but file a separate federal income-tax return. Your DCSA deposit is limited to \$2,500.

### **Who is Covered Under the DCSA**

Eligible dependents for a DCSA include:

- A dependent child under the age of 13;
- A dependent of any age who is incapable of self-care because of a physical or mental handicap. *Please note that a person qualifying as a dependent for this type of care must spend at least eight hours a day in your home.*

The IRS defines those that are mentally or physically incapable of self-care as individuals who cannot dress, clean, or feed themselves because of a physical or mental handicap or persons who need constant attention to prevent them from injuring themselves or others.

### **Eligible Expenses for the DCSA**

Generally, any dependent care service provided for an eligible dependent(s) while you and your spouse if married, work, look for work, or go to school full time is eligible. The dependent being cared for must be a "qualifying person." For further information on what constitutes a 'qualifying person', please see IRS Publication 504.

IRS Publication 503 provides information on tax-deductible items that may be eligible for the Dependent Care Spending Account. Publication 503 and 504 provide a detailed listing of tax-deductible items that may be eligible for the HCSA. To obtain a copy of 503 and/or 504, please contact your HR/payroll office, visit a local library, or contact the IRS at 1-800-829-1040 or online at [www.irs.gov](http://www.irs.gov). The Administrator has the authority to

make the final decision as to whether an expense is eligible.

The following is a list of potentially eligible expenses for the DCSA:

- Child care at a day camp or nursery school, or by a private sitter
- Elder care for an incapacitated adult who lives with you at least 8 hours a day
- Expenses for pre-school and after-school child care (these expenses must be kept separate from any tuition expenses)
- Cost of a housekeeper whose duties include the care of a qualifying dependent

### **Exclusions for the DCSA**

The following is a list of items excluded from the DCSA:

- Activity and book fees
- Child support payments
- Cleaning and cooking services not provided by the care provider
- Custodial nursing care
- Expenses for overnight camps
- Kindergarten
- Field trips
- Food, clothing, entertainment
- Late payment fees
- Long-term care premiums
- Overnight camps
- Placement fees for finding a dependent care provider
- Sports lessons
- Transportation
- Tuition to private school

Once you enroll in the HCSA, you will receive an Electronic Payment Card, or Debit Card, to pay for eligible health care purchases. Using the card allows you to access your account immediately, with no out-of-pocket cost. You can also pay for eligible expenses out of your own pocket and submit a reimbursement request form with the appropriate documentation.

### *Reimbursement Notes:*

- *There is no debit or electronic payment card available for the DCSA; thus, a claim form must always be completed.*
- *With the State Health Benefit Plan Consumer Driven Health Plan, Health Reimbursement Account (HRA) credit will be utilized before an employee's Spending Account dollars. This may affect how much money an employee wishes to contribute to their Spending Account.*

### **Using the Electronic Payment (Debit) Card**

The Electronic Payment Card allows you to pay for Eligible Medical Expenses at the time that you incur the expense. Here is how it works:

- **You must make an election to use the card.** In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Program and in the Electronic Payment Cardholder Agreement (the “Cardholder Agreement”) including any applicable fees, limitations as to card usage, the Plan’s right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Program both during the initial election period and during each annual election period. A Cardholder Agreement will be provided to you. The card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Program during the preceding Annual Election Period. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.
- **The card will be turned off when employment or coverage terminates.** The card will be turned off when you terminate employment or coverage under the Plan. You may not use the card during any applicable COBRA continuation coverage period.
- **You must certify proper use of the card.** As specified in the Cardholder Agreement, you certify during the applicable Election Period that the amounts in your HCSA will only be used for Eligible Medical Expenses (i.e. medical care expenses incurred by you, your spouse, and/or your dependents), you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

- **HCSA reimbursement under the card is limited to health care providers (including pharmacies).** Use of the card for health care related expenses is limited to merchants who are health care providers (doctors, pharmacies, etc.). As set forth in the Cardholder Agreement, you will not be able to use the card at certain retail stores.
- **You use the card at the health care provider as if you do any other credit or debit card.** When you incur an Eligible Medical Expense at a doctor's office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider's office much as if you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under the HCSA (or as otherwise limited by the Program) at the time that you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment under the HCSA is being made is an Eligible Medical Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.
- **You must obtain and retain a receipt/third-party statement each time you swipe the card.** You must obtain a third party statement from the health care provider (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the card:
  - The nature of the expense (e.g. what type of service or treatment was provided).
    - Expenses for OTC drugs or medicines (other than insulin) incurred on or after January 1, 2011 will only be considered "medical care" for, IRS purposes if they are "prescribed".
  - The date the expense was incurred.
  - The amount of the expense.

You must retain a receipt for one year following the close of the Plan year in which the expense is incurred. Even though payment is made under the card arrangement, a written third party statement may be required (except as otherwise provided in the Cardholder Agreement). You will receive a notification from the Claims Administrator if a third party statement is needed. You must provide the third party statement to the Claims Administrator within 7 days (or such longer period provided in the notification from the Claims Administrator) of the request.

- **There are situations where the third party statement will not be required to be provided to the Claims Administrator.** There may be situations in which you will not be required to provide the written statement to the claims administrator.

More detail as to which situations apply under your Plan can be obtained by contacting the Plan Administrator or Third Party Administrator:

*NOTE: It is a good idea to keep the third party receipt when you use the card just in it is required by the Claims Administrator.*

- **You must pay back any improperly paid claims.** If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator, you must repay the Plan for the unsubstantiated expense as set forth below. In addition, the Employer may terminate your usage of the card.

### **Filing Claim Forms**

When you elect to file a claim for reimbursement, you should:

1. Pay your bills and gather documentation.

For the HCSA, submit the claim to your insurance carrier(s). This applies even if you have not met your deductible. Your carrier will then determine how much of the claim they will pay. You will receive an explanation of benefits (EOB) indicating what was paid, if anything, or what was not paid and why. In some cases, your insurance company will not cover an expense and you should include an itemized bill from your health care provider(s).

For the DCSA, you should have the provider sign a copy of the claim form or provide an itemized receipt which includes the type(s) of services provided, the actual dates on which they were received, the total amount charged, the name(s) of the child (ren) or others who were cared for, and the complete name, address, and telephone number of the dependent care provider.

*NOTE: For the purposes of this Program, the IRS says that you “incur” an expense on the day the service is rendered; not when the expense is billed or paid.*

2. Complete a Spending Account Claim Form.  
<http://myspendingaccount.wageworks.com> Read the instructions on the back of the claim form carefully and attach all required documentation.
3. Send the completed claim form to the Wage Works processing center. Your claim will be processed within five business days from the date of receipt. You may send your completed claim form and documentation to the address shown on the form by mail or by faxing to 1- 866-643-2219.

Alternatively, you may upload your claim form and supporting documentation via the Spending Account Management website, using the secure online claims submission feature.

**Important Reminder:** Your HCSA available coverage amount is your annual Elected Coverage Amount less any reimbursements to date. The DCSA balance is the actual balance of contributions that have posted to your account. For the DCSA, you can only be reimbursed up to the amount available in your account. Claims for expenses exceeding that amount will be reimbursed as funds of \$25 or more accumulate in your account.

### **Electronic Funds Transfer (EFT)**

You may have your Spending Account reimbursements directly deposited into your checking or savings account by Electronic Funds Transfer (EFT). If you elect to have your reimbursement direct deposited, you must log onto <https://myspendingaccount.wageworks.com> and complete the Flexible Spending Account Authorization Agreement for EFT. The EFT process will reduce the amount of time it takes to receive your reimbursement by approximately three (3) days.

Upon confirmation, your Spending Account reimbursements will be electronically transmitted to your account. You will continue to receive your reimbursements in the form of a paper check until the pre-notification process has been completed after the initial transmission.

## INFORMATION ABOUT YOUR SPENDING ACCOUNT(S)

### Call AccountLINK

AccountLINK is the Spending Accounts Program Interactive Customer Assistance System. The system allows Program participants to directly access their account information using a touch-tone telephone. When accessing AccountLINK, have your social security number and password ready. Once you have this information, call 1-800-893-0763 and the system will walk you through the rest.

AccountLINK can provide participants:

- Access to current and previous year account(s)
- Account balance(s)
- Claims(s) awaiting payment
- Last payment information

A Benefits Counselor is always a keystroke away. Press the POUND (#) key at any time during the call if you need help.

AccountLINK is available between 8:00 AM and 2:00 AM EST, Monday to Saturday. Benefit Counselors are available between 8:00 AM and 8:00 PM EST, Monday to Friday.

### Internet Web-site

Spending Account participants may visit the Wageworks Internet Website to access their Account information at <https://myspendingaccount.wageworks.com> when accessing Account information; you will need to know your social security number and password. With Wage Works on-line services, you can:

- Update your email address to receive correspondence via email
- View your Account balance and claim information
- Download a Spending Account claim form
- Download an Electronic Funds Transfer (EFT) form
- Calculate your optimal Spending Account contribution and determine your potential tax savings
- Find general information about Spending Accounts, such as eligible expenses for reimbursement
- Receive immediate help by reading the answers to common Spending Account questions

*NOTE: Wage Works utilizes Secure Sockets Layer (SSL) protocol to encrypt the data you send and receive to protect the confidentiality of your Account information from unauthorized users.*

## **ADMINISTRATIVE INFORMATION**

### **Reporting a Change in Status Event**

The IRS limits changes you can make to your Spending Accounts outside the Open Enrollment Period. You may be able to enroll or make a change to your spending accounts based on a “qualifying” change in status event.

When you have a qualifying event, you must contact GaBreeze of the change on a timely basis or within 30 days after the event occurs. Any change made to your account(s) must be because of and corresponding with the change in status event. Your coverage will be effective the first of the month following your request.

*NOTE: If you are requesting a decrease or cessation of the Health Care Spending Account (HCSA), you must certify that all expenses incurred prior to your election change request have been filed and affirm that you do not, or will not, have a negative account balance after reimbursement of those expenses.*

### **How to File an Appeal**

If part or all of a claim is denied, you can appeal the decision and ask for reconsideration of the claim.

When a claim is denied, you will receive a written notice of the denial indicating the reason(s) your claim was not paid. Specifically, the notification will include the reasons for the denial, with reference to the specific provisions of the Program on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure.

You may appeal the denial by filing a written request for reconsideration within 30 days after you receive the notice of denial. You may prepare and submit the appeal yourself or have it done by your authorized representative.

Your appeal should be supported by accompanying documents or records. Mail your appeal to the address listed below:

WageWorks, Appeal for #10029  
FSA Processing Center  
P.O. Box 34700  
Louisville, KY 40232-4700

WageWorks, the claims processor, will conduct a full and fair review of your claim, generally within 60 days and not longer than 120 days after receiving your appeal. You will be given a copy of the decision written in understandable terms and including specific reference(s) to any pertinent provisions of the Spending Account Program.

If your claim is denied on appeal, you may file a secondary appeal to the Administrator within 30 days after you receive notice of the denial. The Administrator will conduct a full and fair review of your claim, generally within 60 days and not longer than 120 days after receiving your appeal. You will be provided a written copy of the decision in understandable terms and including specific reference(s) to any pertinent provision(s) of the SAP. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

### **How HCSA Coverage Can Be Extended Under COBRA**

The Consolidated Omnibus Budget Reconciliation Act, or COBRA, provides that an active worker participating in a health care spending account (and each of that person's covered dependents) may be entitled to a temporary extension of coverage under that spending account program whenever the employee's participation is about to end because of loss of eligibility.

This feature is popularly known as "temporary extended coverage" and may allow you to maintain your HCSA coverage by directly paying its cost for a limited period of time after termination. You must pay the full cost of your participation, plus 2% for administrative expenses.

### **Eligibility for COBRA Coverage**

If you have a positive HCSA balance on the day, you experience a "qualifying event" you have the right to continue to participate in the HCSA for the rest of the Plan Year if you make all required payments.

These are the qualifying events that may trigger eligibility for temporary extended coverage through the end of the Plan Year, including:

- If a participant resigns, retires, or otherwise terminates employment (except for reasons of gross misconduct), or loses eligibility status because of reduced work hours.
- If a participant dies or divorces. *NOTE: A dependent child cannot be covered under both the spouse's temporary extended coverage provision and the participant's contract.*

In general, temporary extended coverage under COBRA will end at the end of the Plan Year in which the qualifying event occurred, or at the earliest of these events: non-payment of contributions within the specified time limits; coverage under another spending account program, by reason of employment or re-marriage; eligibility for Medicare; or termination of the Spending Accounts Program.

Your Department will know if you are about to become eligible for temporary extended coverage under COBRA and will relay that fact to the Program.

If you divorce, or you are covered dependent child (ren) reach the age limit for participation (with the exception of disabled dependents), you must notify GaBreeze directly within 30 days via the website [www.GaBreeze.ga.gov](http://www.GaBreeze.ga.gov) or by calling the GaBreeze Benefits Center 1-877-3427339. Once the changed information is provided, you will receive notification of eligibility for the coverage under COBRA along with a COBRA Election Form. You will have 60 days from the date Notice is received to enroll in COBRA coverage. After enrollment in COBRA, you will have 45 days to pay your initial contribution.

**AMENDMENT TO THE  
STATE OF GEORGIA  
FLEXIBLE BENEFITS PLAN**

THE EMPLOYEE BENEFIT PLAN COUNCIL STATE OF GEORGIA

The Flexible Spending Accounts Program operates under Regulations set forth by the Employee Benefit Plan Council on behalf of the STATE of GEORGIA under rules written and enforced by the Internal Revenue Service (IRS).

This Amendment to the **Flexible Spending Accounts** Benefits Plan is adopted by the STATE OF GEORGIA (the "Employer"), effective as of the date set forth herein.

**WHEREAS** the Employer desires to amend the Plan's Flexible Spending Account information as set forth.

**NOW, THEREFORE**, effective August 18, 2020, the STATE OF GEORGIA has amended their Plan to temporarily adopt the selected election changes outlined below through December 31, 2020:

**a. Healthcare Flexible Spending Account (HFSA)**

Revoke an election, make a new election, or increase or decrease an election to an HFSA

**b. Dependent Care Flexible Spending Account (DCFSA)**

Revoke an election, make a new election, or increase or decrease an election to a DCFSA

**Note: HFSA and DCFSA mid-year election changes will be limited to amounts no less than amounts already reimbursed or year-to-date contributions.**

NOW, THEREFORE, effective August 18, 2020, the STATE of GEORGIA has amended their Plan to permanently adopt the change outlined below:

**a. Administrative Errors**

Allow a modification of a plan participant's election due to an administrative error that may have occurred during plan enrollment or due to qualifying status events. .

**Note: HFSA and DCFSA changes including any necessary refunds will be limited to amounts no less than amounts already reimbursed or year-to-date contributions.**

**IN WITNESS WHEREOF**, and as evidence of the adoption of the Amendment set forth herein, the undersigned officer of the Employee Benefit Plan Council on behalf of the State of Georgia has executed this Amendment to the Plan, this 18th day of August 2020.

By: STATE OF GEORGIA

Employee Benefit Plan Council

Title: **Vice-Chair**

The undersigned, being an authorized representative of (the "Employer"), hereby adopt the following Resolution by unanimous consent and direct that this Consent Resolution be entered in the minutes of the Employee Benefit Plan Council.

RESOLVED, that the Amendment to the Flexible Spending Account Benefits Plan (name of the Plan) (the Amendment) is hereby approved and adopted, and that an authorized representative of the Employer is hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Amendment.

The undersigned further certifies that attached hereto is a copy of the Amendment approved and adopted in the foregoing resolution.

Date: August 18, 2020

Signed: Monirah Womack

Monirah Womack, Vice Chair

(print name/title)