SUMMARY PLAN DESCRIPTION (SPD)
for the
CAFETERIA PLAN, and ACCOUNT PLANS

The Employer named below also serves as Plan Administrator:
State of Georgia
200 Piedmont Avenue, SE, Suite 1206
West Tower
Atlanta, GA 30334
The Employer accepts service of legal process.

Federal Tax ID: 58-1125844

ERISA Plan Number: 515

Plan Name: The State of Georgia **Cafeteria Plan and Account Plans**

Group Name, if applicable: N/A

Plan Effective Date: 01/01/2026

Plan Year: 01/01 to 12/31

Account Plans included in this Plan: Dependent Care FSA, Healthcare FSA

Run Out - Number of Days: 120 days

Carryover Maximum: N/A

Grace Period: 2 months, 15 days (Healthcare FSA only)

'You' and 'Your' refer to an Employee who has enrolled in at least one Qualified Benefit Plan for the current Plan Year, or has a carryover balance from an existing Account Plan, when a Carryover is allowed as indicated above. 'You' and 'Your' are also referred to as a 'Participant'.

Purpose. Your Employer has adopted this Plan to allow you to pay for benefit options (called Qualified Benefit Plans) for Yourself, Your spouse, and your dependents via pre-taxed salary reduction contributions. You may choose from these "tax-free" Qualified Benefit Plans in lieu of receiving taxable compensation. The Plan is intended to qualify as a "Cafeteria Plan" within the meaning of Section 125(d) of the Internal Revenue Code. This Plan allows you to reduce your taxable income in direct proportion to (a) your contribution to the cost of your elected Qualified Benefit Plans and (b) your contribution to any Account Plan. **Administrative fees are charged to the employee on an after-tax basis.**

Qualified Benefit Plans. A Qualified Benefit Plan is a tax advantaged Plan pursuant to Section 125(f) of the Internal Revenue Code. The list of Account Plan(s) made available for the current Plan Year is provided above. The list of other Qualified Benefit Plans is provided in the Enrollment Materials provided by Your Employer at the time of enrollment, expressly incorporated by reference into this SPD.

Definitions

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.

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

Open Enrollment Period: A period that occurs each year during October and November when eligible employees may enroll in the Flexible Spending Accounts.

Participant. Any person who has been or is an Eligible Employee and who qualifies to participate and enrolls in a Flexible Spending Account plan option.

Plan Year: The period that begins each January and ends on December 31st.

An Employee's right to enroll in and maintain coverage under the Qualified Benefit Plans is described in detail in the Enrollment Materials provided by the Employer, including:

1) Under what circumstances a spouse, dependents, and other persons may be enrolled, including any proof of a relationship needed to meet the eligibility requirements (note that group health Plans are required to cover dependent children placed with a Participant for adoption under the same terms and conditions as apply in the case of dependent children who are Your natural children);
2) The existence of any waiting periods and how they are applied;
3) When enrollment is allowed and a description of the enrollment procedures;
4) When coverage will be effective and when it will end, including the events that can occur that will terminate coverage;
5) Details regarding when special enrollment rights allowing individuals who previously declined health coverage for themselves and their dependents have an opportunity to enroll (regardless of any open enrollment period). The Special Enrollment Notice, a copy of which was previously furnished to each Participant, also contains important information about the potential special enrollment rights, including a 31-day time limit for requesting the enrollment; and,
6) Details regarding when special enrollment rights for an employee who is eligible, but not enrolled for coverage (or a dependent of the employee if the dependent is eligible, but not enrolled) when either:

(a) The employee or dependent was covered under a Medicaid Plan or under a State Child Health Plan (SCHIP) and that coverage is terminated as a result of loss of eligibility; or,
(b) The employee or dependent becomes eligible for premium assistance from Medicaid or SCHIP (including assistance under any waiver or demonstration project conducted under or in relation to Medicaid or SCHIP).

Enrollment in the Program. You are eligible to participate in the Flexible Benefit Program if you fully meet any of the 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 Program.

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.

Active Educational System Employees. Active Educational System Employees include a member of any local board of education, and public-school teachers and public-school employees. Employees who are not considered temporary or emergency employees, and who are actively working or on approved leave with pay other than personal sickness or disability, 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.
- Any person any person, other than an employee in a professionally certificated capacity or position, employed not less than half time and compensated in a charter school in this state established pursuant to either Article 31 or Article 31A of this chapter if such charter school elects to participate in the flexible benefit plan upon initial approval of its charter or, if such charter school is an existing charter school, upon renewal of its charter.

Administration. Your Employer, acting as the Plan Administrator, has sole discretionary powers and is responsible for the administration of this Plan and the Qualified Benefit Plans. Should you need to see any records or have any questions regarding these Plans, contact Your Employer. Your Employer has sole discretionary authority (a) to interpret the Plan in order to make eligibility and benefit determinations, and (b) to make factual determinations as to whether any individual is eligible and entitled to receive any benefits under the Plan. The Plan Administrator has the right, in its sole discretion, to terminate the Plan or to modify or amend any provision of the Plan at any time.

No Continued Employment. No provisions of the Plan or this SPD grant any Employee any rights of continued employment with the Employer or in any way prohibit changes in the terms of employment of any Employee covered by the Plan.

ACCOUNT PLANS

The Account Plans offered for the current Plan Year are listed above on the first page of this SPD. Your Employer appoints TASC as its Administrator/Service Provider to maintain the Flexible Spending Account (FSA) Plan options and to be responsible for the day-to-day administration. TASC is not a Plan Administrator and has no discretionary authority over the Plan.

The Participant Reference Guide. The Participant Reference Guide, which is incorporated by express reference into this SPD, includes all the information you need to access Flexible Spending Account Plan options and submit requests for reimbursement. By signing into your online Account Plan, You may access information about your enrollment, available funds, annual election, total contributions, and total reimbursements.

Age Requirement. No maximum age requirement may be imposed for participation in an FSA plan.

Re-employment of Former Employees. A former Employee rehired within thirty (30) days of termination will immediately be reinstated into their original FSA Plan elections. A former Employee rehired after thirty (30) days of termination will be allowed to make new FSA elections.

Excess Payments. Upon any benefit payment made to an Accountholder in error under an FSA plan, said Accountholder will be informed and required to repay the errant amount. This includes and is not limited to amounts over the Accountholder's annual election, amounts for services that are determined to be ineligible, or when adequate documentation to substantiate a paid Request for Reimbursement (RFR) upon request is not provided. The Employer may take reasonable steps to recoup the excess payment, including withholding the amount from future salary or wages and subtracting it from future benefit reimbursement(s). You will be allowed to submit valid claims to offset any amount due.

Non-Assignment of Benefits. No Accountholder or beneficiary may transfer, assign, or pledge any FSA plan benefits except as may be required pursuant to a "Qualified Medical Child Support Order" (which provides for Plan coverage for an alternate recipient), other applicable law, or payment made directly to a healthcare provider.

Termination Of Participation. Accountholders are enrolled in the FSA plan option(s) for the entire Plan Year or the portion of the Plan Year remaining after enrollment. You will automatically cease to be an Accountholder due to the following events:

1) Your death, resignation or termination of employment with the Employer;
2) This Plan terminates;
3) You fail to pay any required premium (including payment by salary reduction) under the Plan;
4) You no longer meet the requirements for eligibility in the Plan; or,
5) You revoke your election under a qualifying change in status event.

Change In Status Events. The laws governing FSA plans generally do not allow you to change your benefit and contribution elections during a Plan Year (except for Health Savings Accounts; see below). Your elections are irrevocable and any balance in your account at the close of the Plan Year is forfeited and becomes the property of Your Employer (refer to the first page of this SPD to see if there is a Grace Period or Carryover). This irrevocable election rule does not apply if you experience a qualifying change in status event. The election change request must be based on and consistent with the change in status event.

Any request to change your election must be submitted to the SOG's eligibility and enrollment administrator via the enrollment portal or by contacting the Benefits Center within 31 days of the occurrence of a change in status event. The

new benefit elections start on the first of the month following the event. This Plan is intended to allow any change in status event that is allowed by the IRS. The following change in status events are applicable:

1) A change in legal marital status (marriage, death of spouse, divorce, legal separation, and annulment).
2) The adoption, birth, or death of a child or dependent.
3) Dependent satisfies or ceases to satisfy dependent eligibility requirements.
4) The change in employment status of You, your spouse or dependent.
5) Change in your residence. *
6) Beginning or ending adoption proceedings.
7) Automatic changes upon cost increases or decreases. *
8) Significant cost increases. *
9) Significant curtailment of coverage. *
10) Addition or elimination of similar benefits package option. *
11) Change in coverage of a spouse or dependent under an employer Plan. *
12) FMLA.
13) HIPAA special enrollment rights. *
14) COBRA qualifying event.
15) Loss of group health coverage sponsored by a governmental or educational institution. *
16) A judgment, decree, or order requiring coverage for a spouse or child.
17) Medicare or Medicaid entitlement.
18) Termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage. *
19) Eligibility for Employment Assistance under Medicaid or SCHIP. *
20) Exchange Event – A loss of eligibility under the terms of the Plan due to a reduction in hours (less than 30) – even when the Employer allows the coverage to continue in effect during the 'Stabilization Period' to satisfy the Affordable Care Act coverage requirements. *
21) Exchange Event – Exchange enrollment during an Exchange open enrollment period or special enrollment period. *
22) Exchange Event – Exchange enrollment by one or more of the participant's dependents and/or spouse who are enrolled in the Employer-provided group health insurance plan during an Exchange special enrollment period or open enrollment period. (Effective January 1, 2023) *

**These qualifying changes in status events do not apply to the Health Care FSA.*

Notes:

1) For the termination of Medicaid or SCHIP coverage and eligibility for employment assistance under Medicaid or SCHIP, the Employee must request the group health benefit change no later than 60 days after the date of termination or after the date eligibility is determined under Medicaid or SCHIP.

Grace Period or Carryover. As a terminated Accountholder, You are not eligible for the Grace Period or Carryover (when offered by Your Employer) unless you are an active Accountholder in the Plan and Your Paid Coverage Period continues through the last day of the Plan Year.

The Family and Medical Leave Act ('THE FMLA') and Unpaid Leave. The FMLA requires employers with 50 or more employees to provide unpaid leave for eligible employees under circumstances prescribed by applicable federal law, including the Family and Medical Leave Act of 1993 (29 U.S.C. § 2611), as amended.

The payment option(s) for coverage while on unpaid Family Medical Leave Act leave and for unpaid leave for Health Care Flexible Spending Account Plans are:

1) Pay-as-you-go. Under this option, you will pay your share of your election amounts to the eligibility and enrollment administrator through their direct bill process. If you fail to make payments under this Pay-as-you-go option, Your Employer is not required to continue coverage. Your coverage will be terminated.

If a Participant's coverage under the Plan ceased while on FMLA leave, the Participant will be entitled to resume coverage upon return from leave on the same participation basis in effect prior to the leave, or as otherwise required under the FMLA. The Participant will be entitled to elect reinstatement in the Plan at the coverage level that was in effect before the FMLA leave, with increased contributions if necessary to reach their annual election. Or, the Participant can continue with the amount withheld from the Participant's compensation on a payroll-by-payroll basis equal to the amount withheld before the FMLA leave.

Important Note: The Health Care FSA and Dependent Care FSA contributions do not automatically roll over to the next plan year. Participants must re-enroll during Open Enrollment for the next plan year.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA). The first page of this SPD indicates that this Plan includes a Health Care Flexible Spending Account. All healthcare expenses must be (a) for medical care as defined in Code Section 213(d) which is rendered or received during the Plan Year, (b) incurred by an Accountholder, Accountholder's spouse, or dependent, (c) not otherwise taken as a medical deduction by a taxpayer and (d) not covered under any other benefit plan or account. Services and supplies must be for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Services and supplies that are beneficial" to an individual's general health" are not covered unless they are determined by a physician to be necessary to treat or alleviate a specific physical or mental illness. Amounts paid for menstrual care products shall be treated as paid for medical care. Over-the-counter (OTC) products no longer require a prescription and can be reimbursed under the Health Care FSA Plan.

Coverage Effective Date

Flexible Spending Account coverage begins on the first day of the month following one full calendar month of employment, provided you are actively working. The contributions are deducted from your paychecks in the calendar month preceding the actual month in which your coverage becomes effective, and in each subsequent calendar month 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 following the completion of one full calendar month of employment. For example, if you are hired on July 16 and choose to contribute to a Flexible Spending Account, your first payroll deduction will be made in August for coverage to begin on September 1.

If you are hired mid-year or have a qualifying change in status during the plan year, you can contribute the maximum allowed under either FSA for the remainder of the Plan Year. The annual maximum allowed limits are not prorated for mid-year enrollments or qualified status changes.

The minimum contribution to an HCFSA is $120.00 per year, or $10 per month; the maximum is $3,252.00 per year, or $271.00 per month.

HCFSA Coverage Termination Date

Your coverage will terminate at the end of each Plan Year, or December 31. You have a grace period of March 15th to incur costs for unused funds from the prior year. Claims must be filed by April 30 to be eligible for reimbursement.

If you terminate or retire from State employment during the Plan Year, your HCFSA 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 HCFSA would be deducted from the June 30 paycheck. Therefore, your HCFSA would end July 31, or the month following the last full month you were employed.

If you have any remaining funds in your HCFSA on the date you were terminated, resigned, or retired, you may be able to continue to participate in the HCFSA for the rest of the Plan Year by enrolling in COBRA.

Eligible Expenses. The following is a list of eligible expenses for the HCFSA.

- Acupuncture
- Artificial limbs
- Bandages and dressings
- Birth control, contraceptive devices
- Birthing classes/Lamaze (only the mother's portion, not the coach/spouse; class must be only for birthing instruction, not child rearing)
- Blood pressure monitor
- Chiropractic therapy/exams/adjustments
- Contact lenses and contact lens solution
- Copayments
- Crutches (purchased or rented)
- Deductibles and coinsurance
- Dental cleanings and fillings
- Diabetic care and supplies, including insulin
- Expenses in excess of medical, dental, or vision plan limits
- Eye exams
- Eyeglasses or safety glasses (prescription)
- Feminine care products (pads, tampons, etc.)
- First aid kits and supplies
- Hearing aids and hearing aid batteries
- Heating pads
- Incontinence supplies
- Infertility treatments
- Lactation expenses (breast pump, etc.)
- Laser eye surgery, LASIK
- Legal sterilization
- Medical supplies to treat injury or illness
- Mileage to and from doctor appointments
- Kidney transplants
- Lasik Eye Surgery
- Over-the-counter drugs (antacids, allergy medications, pain relievers, and cold medicines)
- Orthopedic inserts
- Personal protective equipment (for the purpose of preventing the spread of coronavirus; includes face mask, hand sanitizer, sanitizing wipes, etc.)
- Physical exams
- Physical therapy (as medical treatment)
- Physician's fees and hospital services
- Pregnancy test
- Prescription drugs and medications
- Psychiatric care, psychotherapy (as medical treatment)

Certain medical expenses must be accompanied by a doctor's certification that indicates the specific disorder, the specific treatment required, and how this treatment will alleviate the medical condition.

Exclusions for HCFSA. The following is a list of items excluded from the HCFSA:

- Cosmetic procedures or drugs
- Electrolysis
- Hair transplants
- Herbal supplements
- Insurance premiums
- Nutritional Supplements
- Teeth whitening/bonding
- Vitamins
- Weight reduction programs for general well-being

The link for additional eligible medical expenses is https://www.tasconline.com/wp-content/uploads/2024/05/FX-4248-042425-FSA-Eligible-Expenses.pdf.

Uniform Coverage Rule. The entire amount of your annual Health Care FSA election is available to you for services rendered on any day of the Plan Year that you are covered by the Health Care FSA.

Limitations and Exclusions. The following examples—even those recommended by a doctor—do not qualify as expenses eligible for reimbursement under the Health Care FSA: insurance premiums; expenses for cosmetic procedures or cosmetic items; items that are for an Accountholder's general wellbeing; items the Accountholder would have purchased even if the Accountholder had no medical condition (for example, a toothbrush); vacation and travel expenses even if for rehabilitation or prescribed by a doctor; long-term care expenses that are not for actual medical care; expenses incurred in stockpiling over-the-counter items in quantities that could not reasonably be used during the current Plan Year.

Qualified Medical Child Support Order (QMCSO). The Plan will provide benefits in accordance with a QMCSO and adhere to the terms of any judgment, decree, or court order which (1) relates to the provision of child support related to health benefits for a child of an Accountholder in a group health Plan; (2) is made pursuant to a state domestic relations law; and (3) which creates or recognizes the right of an alternate recipient—or assigns to an alternate recipient the right—to receive benefits under the group health Plan under which an Accountholder or other beneficiary is entitled to receive benefits. Accountholders may obtain, without charge, a copy of the Plan's procedures from the Plan Administrator.

Family and Medical Leave Act (FMLA). If you go on a qualifying leave under FMLA, to the extent required by the FMLA, You may continue to maintain your Health Care FSA option by paying your contribution after tax to the Program's eligibility and enrollment administrator via their direct bill process through the end of the current plan year. Your Employer may require you to continue coverage while you are on paid leave (as long as Accountholders on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave.

If your coverage ceases while on FMLA leave, you will be permitted to re-enter the Plan upon return from such leave, and to participate in the Plan on the same basis as you had been prior to the leave or as otherwise required by the FMLA. You may elect reinstatement in the Plan at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a reduced pro-rata coverage level for the period of FMLA leave during which you did not make contributions.

Unpaid FMLA Leave**.** If you are going on unpaid FMLA leave and you opt to continue Your Health Care FSA plan option, then you may pay your share of the contributions by:

(1) Paying-as-You-go. Your share of contributions will be paid to the eligibility and enrollment administrator through their direct bill process. Per the Department of Labor regulations, if you fail to make payments under this option, Your Employer is not required to continue coverage. Your coverage will be terminated.

Non-FMLA Leave**.** If you go on an unpaid leave of absence that does not affect eligibility, then you may continue to participate in the Health Care FSA, and the after-tax contributions will be directly billed to you by the eligibility and enrollment administrator while you are on leave. If you go on unpaid leave that affects your eligibility, the Change in Status rules will apply.

Military Leave**.** If You take a leave of absence due to military service, You may continue coverage under this Plan as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Health Savings Account (HSA): If you contribute to a Health Savings Account (HSA), then you may only enroll in a ***Limited Purpose Health Care FSA*** **(LPFSA**). Qualified Expenses under an LPFSA are limited to dental and vision services or supplies excluded from coverage under Your High Deductible Health Plan (HDHP), or unpaid amounts incurred after the HDHP statutory annual deductible has been satisfied. The LPFSA will not provide reimbursement for any other service or supply, regardless of whether that service or supply is considered a medical expense by the IRS or is allowed under a General-Purpose Health Care FSA.

Health Care FSA Continuation Coverage Rights Under COBRA. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, ("COBRA") continuation shall not apply to any group health Plan of the Employer for any calendar year if all employers maintaining such Plan normally employed fewer than twenty (20) Employees on a typical business day during the preceding calendar year. Government entities are subject to the same continuation coverage under the Public Health Services Act. This Summary Plan Description describes your rights for the Health Care FSA. Your rights under any of the other Qualified Benefits Plans offered by Your Employer are described in the Summary Plan Description(s) for that Plan and may be obtained from Your Plan Administrator.

If you elect to participate under the Health Care FSA and are considered an Accountholder on the day before experiencing a qualifying event, COBRA continuation ends on the last day of the Plan Year in which the qualifying event occurred. Further, COBRA continuation coverage will not be offered if on the day of your qualifying event, the amount of your annual election, less any reimbursed payments, is less than the amount of premium required to continue the Health Care FSA Plan until the end of the Plan Year. COBRA continuation under an excepted Health Care FSA Plan is available until the end of the Plan Year in which the qualifying event occurs.

An Accountholder who experiences a qualifying event is considered a qualified beneficiary. When a qualified beneficiary experiences a qualifying event, they will be sent a notification explaining their rights to elect COBRA continuation coverage. Your Employer has 44 days from the date of the loss of coverage in which to send the COBRA Election Notice. A qualified beneficiary who wishes to continue coverage must notify the Eligibility and Enrollment Administrator of their desire to continue coverage within sixty days of either the date of notification or the date of loss of coverage, whichever is later. If the Eligibility and Enrollment Administrator does not receive notification within this time period, You will lose Your right to elect continuation coverage. Finally, qualified beneficiaries who elect continuation coverage are responsible for premiums from the date of termination from the Plan, had it not been for the election of continuation coverage.

COBRA continuation is available until the end of the Plan Year in which the qualifying event occurs. The premium charged for the continuation coverage will be 102% of your monthly contribution. The Employer may require the COBRA payments to be apportioned for the remainder of the Plan Year.

Listed below are qualifying events.

(1) Termination of employment (for a reason other than "gross misconduct"); and

(2) Reduction of employees' work hours.

If you have questions about Your COBRA continuation coverage, you should contact Your Employer, or you may contact The nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA); addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa**.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA). The first page of this SPD indicates that this Plan includes a Dependent Care Flexible Spending Account. This account provides employees with tax-free dependent care assistance only when the assistance is necessary for the Accountholder to leave the home to engage in an activity directly related to his/her employment. Qualified expenses under the Dependent Care FSA include any expenses that you could take as a credit against tax on your income tax form for the care of a Qualified Person. Benefits are provided only to the extent of your payroll deduction on the date the request for reimbursement (RFR) is processed. The tax laws further limit how much you may contribute to this account.

Under the law and the terms of the Plan, You may defer no more than the lesser of your actual income for the year (or, if you are married and it is less, your spouse's actual income) or $5000 per year to this Program. A married Accountholder who files separate tax returns is limited to $2500 per year. A married Accountholder who files joint returns can split this limit as they see fit.

The minimum contribution is $120 per year or $10 per month; the maximum is $4,956 for Plan Year 2026, or $413 per month. If you and your spouse both work for the State, you cannot exceed the $4,956 per year family limitation.

There are limitations on the amount that can be deposited in a DCFSA, in addition to the overall $4,956 annual 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 $4,956.
- Your spouse works for any employer (other than the State) that offers a similar plan. In such a case, combined deposits to both plans would be limited to the maximum.
- Either you or your spouse earns 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 only one eligible dependent or $4,800 if you have two or more.
- You are married but file a separate federal income-tax return. Your DCFSA deposit is limited to $2,500.

Who is covered under the DCFSA. Eligible dependents for a DCFSA 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 who 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 DCFSA. 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 Flexible

Spending Account. Publication 503 and 504 provide a detailed listing of tax-deductible items that may be eligible for the DCFSA. The link for eligible dependent care expenses and exclusions is https://www.tasconline.com/wp-content/uploads/2024/05/FX-6561-101420-DCFSA-Eligible-Expenses.pdf.

The following is a list of eligible expenses for the DCFSA:

- Childcare 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 childcare (these expenses must be kept separate from any tuition expenses)
- Housekeeper who cares for the child (only portion of payment attributable to work-related childcare)

Exclusions for the DCFSA. The following is a list of items excluded from the DCFSA:

- Activity Fee (piano lessons, dance Classes)
- Babysitting while you or your spouse are NOT working, looking for work or attending school
- Childcare supplies (diapers, formula, clothing)
- Field trips
- Household services (housekeeping, maid, cook, etc.)
- Kindergarten tuition
- Late payment fees
- Meals, food or snacks
- Medical care
- Private school tuition for kindergarten and up
- School tuition
- Tutoring

DCFSA Coverage Termination Date

Your coverage will terminate at the end of each Plan Year or December 31. If you terminate or retire during the Plan Year, your DCFSA ends at the end of the month following the last full month of employment or contribution.

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

If you terminate during the Plan Year and have any remaining funds in your DCFSA, you will still have access to your funds through the end of the Plan Year. Eligible dependent care expenses can be incurred before and after your termination date through the end of the current Plan Year. You must file your dependent care expenses by April 30 of the following year.

You must incur eligible dependent care expenses during the Plan Year in which you are enrolled. There is no grace period for the DCFSA. Unused contributions will be forfeited.

Accountholder Certification and Debit Card Use. The Plan requires the Accountholder/Participant to certify that each expense submitted for reimbursement has actually been incurred and has not previously been reimbursed (i.e., there is no "double-dipping"), and reimbursement will not be sought from any other source, such as another health plan for medical tax advantaged account services. The Plan requires the Accountholder/Participant to certify that upon enrollment in a TASC Subscription Service that includes the use of a TASC Debit Card, for the immediate service year and any service year thereafter, that the card will only be used for legitimate eligible expenses, limited to persons eligible for reimbursement. This Certification is printed on the back of the TASC Debit Card and reaffirmed each time the TASC Debit Card is used. The TASC Debit Card will be shut off and should not be used after the Accountholder's termination of employment, except for spending down MyCash that has been accumulated.

Grace Period. The Grace Period extends two and one-half months after the last day of your Plan Year. The last day of the Grace Period is the fifteenth day of the third month following the end of the Plan Year. Services that are rendered after the last day of this Grace Period will not be considered for reimbursement under the prior Plan Year. An Accountholder must be enrolled through the end of the last day of the Plan Year in order for this Grace Period to apply. Services that qualify for reimbursement and are rendered during the Grace Period will be reimbursed using any balance in the prior Plan Year annual election, first, and then reimbursed from any new Plan Year annual election. If an Accountholder terminates coverage for any reason prior to the end of the last day of the Plan Year, then the Accountholder may not submit any claims for services that were rendered after your date of termination.

Forfeiture (Use-it-or-lose-it Rule). An Accountholder/Participant forfeits any amount of his/her annual election that exceeds the reimbursement during any Plan Year. An Accountholder who terminates coverage during the Plan Year has a run-out period in which to submit eligible claims. An Accountholder who is covered through the end of the Plan Year will have a runout period in which to submit eligible claims. Participants have until April 30th of the following plan year to submit claims for reimbursement. Upon such forfeiture, an Accountholder's accrual will be reduced to zero. Forfeited funds will be retained by the Employer. Forfeitures of benefits also may be applied towards the cost of administering the FSA plan options. Forfeitures of benefits will become the sole property of the Employer.

REIMBURSEMENT DENIALS FOR ACCOUNT PLANS

Reimbursements under the Health Care FSA or Dependent Care FSA. The RFR procedure described below will apply if (a) a RFR under the Health Care FSA or the Dependent Care FSA components of the salary reduction Plan is wholly or partially denied, or (b) You are denied a benefit under the salary reduction Plan due to an issue relevant to your coverage under the Plan.

If Your RFR is denied in whole or in part, you will be notified in writing by TASC within 30 days after the date TASC received your request. (This time period may be extended for an additional 15 days for matters beyond the control of the TASC, including in cases where an RFR is incomplete.) TASC will provide written notice of any extension, including the reasons for the extension and the date by which a decision is expected from TASC. When an RFR is incomplete, the extension notice will also specifically describe the required information, will allow You 45 days from receipt of the notice in which to provide the specified information, and will effectively suspend the time for a decision on Your RFR until the specified information is provided.)

Notification of a denied RFR will detail:

- specific reason(s) for the denial;
- specific Plan provision(s) on which the denial is based;
- a description of any additional material or information necessary for You to validate the RFR and an explanation of why such material or information is necessary;

- appropriate information on the steps to be taken if You wish to appeal TASC's decision, including Your right to submit written comments and have them considered, Your right to review (upon request and at no charge) relevant documents and other information.

Appeals. If Your RFR is denied in whole or in part, then you (or your authorized representative) may request review upon written application to the TASC, the Administrator/Service Provider. Your appeal must be made in writing within 180 days after your receipt of the notice that the RFR was denied. If you do not appeal on time, you will lose the right to appeal the denial. Your written appeal should state the reasons why you believe Your RFR should not have been denied. It should include any additional facts and/or documents that you feel support Your RFR. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal. The address to use when filing an appeal will be included in the benefit or enrollment denial letter.

Decision on Review. Your appeal will be reviewed, and a determination made within a reasonable time, defined as not later than 60 days after receipt of your appeal. If the decision on review affirms the initial denial of Your RFR, You will be furnished with a Notice of Adverse Benefits Determination on Review, which shall set forth the following:

- specific reason(s) for the decision on review;
- specific Plan provision(s) on which the decision is based;
- a statement of Your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to You upon request; and

Administrative Errors. Modifications of plan participants' elections due to administrative errors that may have occurred during plan enrollments or the processing of a qualifying status change will be allowed.

Assistance with Your Questions. If you have any questions about Your Flexible Spending Account plan option(s), you should contact TASC's Customer Service at 877-586-1702.

Flexible Spending Account participants may visit TASC's website to access their account information at georgiafsatasc.com.