YOUR FLEXIBLE SPENDING ACCOUNTS PROGRAM
STATE OF GEORGIA
SUMMARY PLAN DESCRIPTION

WageWorks, Inc.
11405 Bluegrass Parkway
Louisville, KY 40299

Has issued Group Policy Number 10029/10829
Contract Anniversary: January 1 of each year

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 Flexible Spending Account coverage under the Flexible Benefits Program. The contract rights of an eligible employee who elects Flexible 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 Flexible Spending Account coverage under the State of Georgia, Flexible Benefits Program. This booklet describes the coverage in effect as of January 1, 2023.

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 Flexible Spending Accounts Save Your Money

A very important feature of your Flexible Benefits package is the Flexible 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 Flexible Spending Accounts Program operates as a "salary reduction arrangement," where pre-tax contributions are taken from your paycheck and applied to one or both Flexible 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 Flexible Spending Account saves you money:

	With a Flexible Spending Account	**Without a Flexible Spending Account**
-Say your annual State salary is:	$22,000	$22,000
-And your Flexible 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 Flexible Spending Accounts, rather than paying with after-tax dollars, you have increased your annual take-home pay by $580.

Program Composition

The Flexible Spending Accounts Program (SAP) is divided into two separate spending accounts: Health Care Flexible Spending Account and Dependent Care Flexible 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 Flexible Spending Account (HCFSA)** 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 Flexible Spending Account (DCFSA)** 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 HCFSA or DCFSA, 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 HCFSA. This grace period allows you to use any unused contribution to reimburse eligible expenses (with respect to the applicable Flexible 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, 2022; the grace period begins January 1, 2023, and ends March 15, 2023.

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

- A Participant in the applicable Flexible 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 HCFSA 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 HCFSA at the end of the 2022 Plan Year and further assume that you have elected to allocate $2400 to the Health Care Flexible Spending Account for the upcoming 2023 Plan Year. If you submit for reimbursement an Eligible Medical Expense of $500 that was incurred on

January 15, 2023, $200 of your claim will be paid out of the unused amounts remaining in your HCFSA from the 2022 Plan Year and the remaining $300 will be paid out of amounts allocated to your Health Care Flexible Spending Account for 2023.

- 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 HCFSA amounts to reimburse eligible day care expenses. The grace period is not applicable for the Dependent Care Flexible 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 (HCFSA only)**:

- **Elected Coverage Amount** (HCFSA 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 HCFSA contribution by the number of calendar months in his or her Anticipated Coverage Period.

- **Available Coverage Amount** (HCFSA 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** (HCFSA only): The number of calendar months during any Plan Year for which a participant is expected to make an HCFSA 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** (HCFSA only): The calendar month(s) for which a participant actually makes an HCFSA 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 Flexible Spending Accounts Program of the State of Georgia Flexible Benefits Program.

Enrollment in the Program

You are eligible to participate in the Flexible 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 Flexible 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

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 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 Flexible 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.

HCFSA 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 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. *See "Eligibility for COBRA Coverage"* on page 24.

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 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.

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 DCFSA are not allowed. You may continue premium payments while on a leave of absence without pay for the HCFSA. If you do not contribute to your HCFSA 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 FLEXIBLE SPENDING ACCOUNT (HCFSA)

How the HCFSA works

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

The minimum contribution to an HCFSA is $120.00 a year or $10 a month; the maximum is $2,808.00 a year or $234.00 a month.

You use your HCFSA 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 Arrangement (HRA) credit may be utilized first before an employee's HCFSA dollars. This may affect how much money an employee wishes to contribute to their Flexible Spending Account.

Just one note of caution…Use it or lose it!

The IRS provides that when you deposit money in a Flexible 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 HCFSA

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

Eligible Expenses for the HCFSA

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 Flexible Spending Account. A full list of eligible expenses is accessible at https://healthequity.com/qme, obtainable by visiting a local library, by contacting the IRS at 1-800-829-1040 or online at 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 HCFSA:

- 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 disabled persons
- Childbirth 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)
- Feminine hygiene products
- 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 HCFSA

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

- 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
- Nutritional Supplements
- Postage/Handling fees
- Teeth whitening/bonding
- Vitamins
- Weight reduction programs for general well-being

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA)

How the DCFSA works

First, estimate the amount of your dependent care expenses for the coming Plan Year and decide on the amount of your DCFSA contribution. You will make your election during Open Enrollment and authorize your Department to transfer that amount from your paycheck to your DCFSA. 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 DCFSA 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 DCFSA to cover the check.

Just one note of caution…Use it or lose it!

The IRS provides that when you deposit money in a Flexible 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 DCFSA, 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 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 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 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 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. To obtain a copy of 503 and/or 504, A full list of eligible expenses is accessible at https://www2.healthequity.com/learn/dependent-care-expenses, obtainable by visiting a local library, by contacting the IRS at 1-800-829-1040 or online at www.irs.gov.
The Administrator has the authority to make final decisions as to whether an expense is eligible.

The following is a list of potentially 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)
- Cost of a housekeeper whose duties include the care of a qualifying dependent

Exclusions for the DCFSA

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

- 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

CLAIMS REIMBURSEMENT

Once you enroll in the HCFSA, 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 DCFSA; 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 Flexible Spending Account dollars. This may affect how much money an employee wishes to contribute to their Flexible 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 HCFSA 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.

- **HCFSA 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 as if you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amountavailable under the HCFSA (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 thatthe expense for which payment under the HCFSA is being made is an Eligible Medical Expense and that you have not been reimbursed from any other source norwill 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 wasprovided).
    - 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 HCFSA, 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 DCFSA, 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 Flexible Spending Account Claim Form. https://www.wageworks.com . Read the instructions on 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 1-877-353-9236.

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

Important Reminder: Your HCFSA available coverage amount is your annual Elected Coverage Amount less any reimbursements to date. The DCFSA balance is the actual balance of contributions that have posted to your account. For the DCFSA, 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 Flexible 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://www.wageworks.com and access your Account Profile to setup your EFT reimbursement method. The EFT process will reduce the amount of time it takes to receive your reimbursement by approximately three (3) days.

Upon confirmation, your Flexible 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 FLEXIBLE SPENDING ACCOUNT(S)

HealthEquity Member Services

Member Services Support for FSA related questions is accessible by phone 24/7/365 days a year. You can contact Member Services @ (877)924-3967.

Internet Website

Flexible Spending Account participants may visit the WageWorks website to access their Account information at https://www.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
- File a claim online or download a Flexible Spending Account claim form
- Setup your account for ACH reimbursements by accessing your Account Profile
- Calculate your optimal Flexible Spending Account contribution and determine your potential tax savings
- Find general information about Flexible Spending Accounts, such as eligible expenses for reimbursement
- Receive immediate help by reading the answers to common Flexible 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 Flexible Spending Accounts outside the Open Enrollment Period. You may be able to enroll or make a change to your Flexible Spending Accounts based on a "qualifying" change in status event.

When you have a qualifying event, you must contact GaBreeze of the change within 31 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 the event.

NOTE: If you are requesting a decrease or cessation of the Health Care Flexible Spending Account (HCFSA), 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.

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.

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 Board
PO Box 14034
Lexington, KY 40232-4700
FAX# 877-220-3248

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 Flexible 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 HCFSA Coverage Can Be Extended Under COBRA

The Consolidated Omnibus Budget Reconciliation Act, or COBRA, provides that an active worker participating in a Health Care Flexible Spending Account (and each of that person's covered dependents) may be entitled to a temporary extension of coverage under that Flexible 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 HCFSA coverage by direct paying its cost for a limited period 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 HCFSA balance on the day, you experience a "qualifying event" you have the right to continue to participate in the HCFSA 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 Flexible Spending Account program, by reason of employment or re-marriage; eligibility for Medicare; or termination of the Flexible 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 31 days via the website www.GaBreeze.ga.gov or by calling the GaBreeze Benefits Center 1-877-342-7339. Once the changed information is provided, you will receive notification of eligibility for the coverage under COBRA alone 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.