

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

SHPS, Inc.
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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 Program 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, 2011

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).

TABLE OF CONTENTS

INTRODUCTION	PAGE
How Spending Accounts Save you Money	4
How Two Separate Accounts Make Up the Program	5
- Health Care Spending Account	5
- Dependent (Child) Care Spending Account	5
Forfeiture: “Use it or Lose it”	5
Grace Period	6
GENERAL PROVISIONS	
Glossary of Terms	7
Enrollment in the Program	8
Coverage Effective Date	9/10
Coverage Termination Date	10
Leave of Absence	10/11
HEALTH CARE SPENDING ACCOUNT (HCSA)	
How the HCSA Works	12
Who is Covered	12
Eligible Expenses	12/13
Exclusions	14/15
DEPENDENT CARE SPENDING ACCOUNT (DCSA)	
How the DCSA Works	15/16
Who is Covered	16
Eligible Expenses	16/17
Exclusions	17
CLAIM REIMBURSEMENT	
Using the Electronic Payment (Debit) Card	18/19
Filing Claim Forms	20
Electronic Funds Transfer (EFT)	21
INFORMATION ABOUT YOUR SPENDING ACCOUNT(S)	
Call AccountLINK (1-800-893-0763)	22
Internet Web site (http://myspendingaccount.shps.com)	
ADMINISTRATIVE INFORMATION	
Reporting a Change in Status Event	23
How to File an Appeal	23
How the HCSA Can be Extended Under COBRA	24
Eligibility for COBRA Coverage	24/25

INTRODUCTION

How Spending Accounts Save Your Money

A very important feature of your Flexible Benefits Program is the Spending Accounts Program. This special option allows you to pay for certain health care and dependent care items with pre-tax dollars, and thus saves on your state and federal income taxes. The Spending Accounts Program 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 contributions for that Plan Year.

Money is transferred from your salary into the spending accounts without ever being taxed. Then that money is reimbursed to you from the Spending Accounts Program for certain qualifying health care and dependent care expenses incurred by you and your eligible dependents.

The Program exists to let you pay some of your health care and dependent care expenses with untaxed dollars and thereby allows you to save money that you’d otherwise pay out as federal income tax, state income tax, and FICA (Social Security) tax. There are numerous rules that govern the Program, of course. There are exceptions and exclusions, and you’ll find them farther on.

Depending on your earnings, your family situation, your tax rate, and various other factors, you stand to save somewhere between 26% and 42% on the money you choose to put into the Spending Accounts Program. The amount of savings will vary, as you’ll see on the next few pages.

Here’s a general example of how a spending account saves money for you:

	With a Spending Account	Without a Spending Account
Say your annual State salary is	\$22,000	\$22,000
And your spending account deposit is	\$ 2,000	\$0.00
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	\$0.00	\$2,000
So your pay, net of bills and taxes, was	\$14,200	\$13,620

By channeling your family care expenses through the tax-exempt spending account, rather than paying them with after-tax dollars, you have increased your annual take-home pay by \$580! And that's the way each of the two spending accounts is designed to work.

How Two Separate Accounts Make Up the Program

The Spending Accounts Program is divided into two separate spending accounts. The two accounts are totally separate. Each is administered and maintained independently; no money can be moved from one account to the other. While the underlying principles are similar, the actual operation of the accounts is very different.

The **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 you or your dependents may have.

The **Dependent (Child) Care Spending Account (DCSA)** lets you set aside pre-tax dollars from your paychecks to cover eligible dependent care expenses incurred so you can work or, if you are married, so you and your spouse can work, look for work, or your spouse can 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.

The following restrictive requirement was added by the IRS based on their determination. When you deposit money in a Health Care or Dependent (Child) Care Spending Account, you must "use it or lose it." There's no refund at the end of the year; anything that's left over in your account is forfeited and goes to help offset the costs of the Spending Accounts Program.

Eligible expenses that you incur while you are 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, until March 15, to incur expenses for that Plan Year. You have until April 30 to file incurred expenses. Any money remaining in your account(s) after April 30 will be forfeited whether you terminate employment, transfer to another State job, or continue to participate in the Spending Accounts Program.

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 of this booklet for details.

To avoid forfeitures, we recommend planning wisely when determining the amount to contribute to your account(s). When you set your contribution amount for the coming year, be realistic. Write down and carefully analyze those recurring expenses each week or each month, and plan for them in the year ahead. You'll find that you can come amazingly close to your actual expenditures if you just "budget." Planning is the key!

Grace Period

The State has adopted a Grace Period for the following account:

Health Care Spending Account

The Employer has established a "grace period" that follows the end of the Plan Year, during which amounts you have allocated to the applicable spending account(s) that are unused at the end of the Plan Year may be used 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, 2010, the grace period begins January 1, 2011 and ends March 15, 2011.

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 Health Care Spending Account 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 Health Care Spending Account at the end of the 2010 Plan Year and further assume that you have elected to allocate \$2400 to the Health Care Spending Account for the upcoming 2011 Plan Year. If you submit for reimbursement an Eligible Medical Expense of \$500 that was

incurred on January 15, 2011, \$200 of your claim will be paid out of the unused amounts remaining in your HCSA from the 2010 Plan Year and the remaining \$300 will be paid out of amounts allocated to your Health Care Spending Account for 2011.

- Expenses incurred during a grace period must be submitted before the end of the Run-out Period, 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 Health Care Spending Account amounts to reimburse Eligible Day Care Expenses. The grace period is not applicable for the Dependent (Child) Care Spending Account.

GENERAL PROVISIONS

Glossary of Terms

Administrator: The Employee Benefit Plan Council and the Commissioner of the State Personnel Administration, SPA, who 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 months for which a participant actually makes an HCSA contribution.

Department: The state entity for which you work. Your Department may be 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 this Program, that 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.

Annual Enrollment Period: A month-long period that occurs each year during October and November when eligible employees may enroll in the Spending Accounts Program, and participants may 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 Annual 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, provided that you are actively at work on that date.

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

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

Enrollment in the Program

If you fully meet any one of the four categories listed below, you are eligible to participate in the Spending Account Program.

- **Active State Employees.** Employees who are actively at work, 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 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 a 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 his compensation in a direct payment from a state department, agency, community service board, authority, or 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 his 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 at work or 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 who meets the work requirements, as follows:
 - Persons 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 who work at least 15 hours per week or 60% of the time normally required for these positions, if that is more than 15 hours per week.

NOTE: The Spending Accounts Program 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 contributions for that Plan Year. You may not change your elections during the Plan Year unless you have a qualifying change in status event.

Coverage Effective Date

Your Spending Account coverage will begin on the first day of the month following one full calendar month of employment provided you are actively at work on that day. Your contribution is deducted from your paycheck in the calendar month before the calendar 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 annual Open Enrollment Period, your coverage will begin on January 1. Your first payroll reduction will be in December for coverage beginning January 1.

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 8 and sign up for 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 year, you may not contribute the maximum allowed under each Account for the remainder of the Plan Year. You may only contribute the maximum per month allowed to each Account.

Coverage Termination Date

Your coverage will terminate at the end of each Plan Year ending December 31. You have a four-month grace period, ending April 30, to file expenses that were incurred during the Plan Year in which you were covered.

If you terminate or retire from State employment during the Plan Year, your health care spending account coverage ends the end of the month following the last full month of employment or contribution. For example, if you terminate employment on June 30, your last contribution to your health care spending account would be taken from your June 30 paycheck. Your coverage would end July 31.

If you have a positive Account balance in your HCSA on the date you experience a qualifying event such as termination or retirement, you may be able to continue to participate in the HCSA for the rest of the Plan Year. See the discussion of COBRA rights at the end of this booklet for more information.

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 go on an unpaid leave of absence, personal premium payments to the Dependent Care Spending Account are not allowed, but personal premium payments for the Health Care Spending Account is allowed. If you continue your Health Care Spending Account but do not make payments to the Health Care Spending Account during your leave of absence and return within the same plan year, 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

You estimate your excess health care expense for the coming Plan Year (January through December). Then you decide on the amount of your HCSA contribution, and authorize your Department to transfer that amount from your paychecks to your HCSA on a regular basis. The minimum contribution is \$120 a year, or \$10 a month; the maximum is \$5,040 a year, or \$420 a month. If you are hired after January 1 or have a qualified change in status during the Plan Year, you may contribute up to \$420 per month for the remainder of the Plan Year.

As you or your tax dependents incur health related expenses, you use your account to be reimbursed with the pre-taxed dollars you have elected to set aside. 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 the section heading “CLAIM REIMBURSEMENT.”

With the State Health Benefit Plan Consumer Driven Health Plan, the 500/1000 annual Health Reimbursement Account (HRA) credit will be utilized first before an employee’s Spending Account dollars. This may impact how much money an employee wishes to contribute to their Spending Account.

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

The IRS says 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 over in your account is forfeited and goes to help offset the cost of the Spending Accounts Program.

Who is Covered Under the HCSA

Eligible dependents for the Health Care Spending Account include your spouse, children, and any other person who is a qualified IRS dependent. You cannot be reimbursed for expenses other than those for eligible persons.

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 at your personnel/payroll office, your local library or IRS office, or online at

http://www.irs.gov/prod/forms_pubs/pubs.html. The administrator has the authority to make the final decision as to whether an expense is eligible under the law and the Program.

The following is a list of potentially eligible expenses for the Health Care Spending Account as defined by the State of Georgia Flexible Benefits Program.

- 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 Health Care Spending Account as defined by the State of Georgia Flexible Benefits Program.

- Cosmetic procedures or drugs
- Electrolysis
- Expenses actually claimed on your income tax
- Expenses that would not be eligible to be claimed as an income tax deduction even if 7.5% threshold and other limits were met
- Expenses reimbursed by other sources, such as insurance companies

- Fees for exercise/athletic/health clubs when there is no specific medical reason 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

You estimate the amount of your dependent care expenses for the coming Plan Year. Then you decide on the amount of your DCSA contribution and authorize your Department to transfer that amount from your paychecks to your DCSA on a regular basis. 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. Be aware there are other federally imposed limitations that may curtail your deposits short of the maximum; they are set out at the end of this section.

When you incur an expense for dependent care, you'll need to pay the bill first. Be sure to have the DCSA form signed by the person who provided the service, or attach to the claim form 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. You then file a claim and receive a reimbursement check for the amount you claimed provided your claim is approved and provided you have enough money in your DCSA to cover the check.

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

The IRS says 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 over in your account is forfeited and goes to help offset the costs of the Spending Accounts Program.

There are limitations on the amount that can be deposited in a DCSA, in addition to the \$5,000 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 \$5,000.
- Either you or your spouse earns less than \$5,000 for the year. When this happens, the maximum deposit drops from \$5,000 to the smaller of your two income figures.
- 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 to \$4,800 if you have two or more.
- You are married but file a separate federal income-tax return. Your DCSA deposit in such a case is limited to \$2,500.
- If you are hired after January 1 or have a qualified change in status during the Plan Year, you may contribute up to \$416 per month for the remainder of the Plan Year.

Who is Covered Under the DCSA

Eligible dependents for a Dependent Care Spending Account include:

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

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

Eligible Expenses for the DCSA

Generally, any dependent care services provided for your eligible dependent(s) while you and your spouse, if you are married, work, look for work, or go to school full time are eligible. The dependent being cared for must be a “qualifying person.” For further information on a qualifying person, see IRS Publication 504.

IRS Publication 503 provides information on tax deductible items that may be eligible for the Dependent Care Spending Account. A copy of Publication 503 and 504 is available at your personnel/payroll office, your local library or IRS office, or online at http://www.irs.gov/prod/forms_pubs/pubs.html. The Administrator has the authority to

make the final decision as to whether an expense is eligible under the law and the Program.

The following is a list of potentially eligible expenses for the Dependent Care Spending Account as defined by the State of Georgia Flexible Benefits Program:

- 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 Dependent Care Spending Account as defined by the State of Georgia Flexible Benefits Program.

- 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

CLAIM REIMBURSEMENT

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 to you. Or, you can pay for eligible expenses out of your own pocket and then fax or mail a reimbursement request form with the appropriate documentation. Both processes are outlined in this section.

Reimbursement Notes:

- *For the Dependent Care Spending Account, the Card is not available; therefore, a claim form must always be filed.*
- *With the State Health Benefit Plan Consumer Driven Health Plan, the 500/1000 annual Health Reimbursement Account (HRA) credit will be utilized first before an employee's Spending Account dollars. This may impact 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 the Electronic Payment Card 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 as set forth herein and in the Electronic Payment Cardholder Agreement (the “Cardholder Agreement”) including any fees applicable to participate in the Program, 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 your tax dependents) that 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.

- **Health Care Spending Account 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 swipe the card at the health care provider like 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 like 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).
 - What has changed: 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”. An electronic or written order that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual authorized to issue a prescription in that state.
 - The date the expense was incurred.
 - The amount of the expense.

You must retain this 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 is required to be submitted (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: You should still obtain the third party receipt when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Claims Administrator does request it.

- **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, your usage of the card may be terminated by the Employer.

Filing Claim Forms

When you choose not to use the Card and elect to file a claim for reimbursement, you should:

1. Pay your bills and gather documentation.
For the HCSA, expenses should be submitted to carrier(s) of any insurance coverage(s) your family has. This applies even if you have not met your deductible. Your insurer(s) will then pay none, some, or your entire claim. 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, available in your personnel/payroll office or online at <http://myspendingaccount.shps.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 SHPS 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 the information to SHPS at 1- 866-643-2219.

Note: When you file a claim and are not enrolled in Electronic Funds Transfer (EFT), you will receive a paper check. Checks totaling \$25 or more are issued daily to the employee only and not the provider of services. Checks totaling less than \$25 are issued at the end of each quarter.

Important Reminder: Your HCSA Available Coverage Amount is your annual Elected Coverage Amount less any reimbursements to date and the DCSA balance is the actual balance of contributions that have posted to your account. For the Dependent Care Spending Account, 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.shps.com> and complete the Flexible Spending Account Authorization Agreement for EFT and provide the necessary documentation. The EFT process will reduce the amount of time it takes to receive your reimbursement to approximately three (3) days.

The SPA maintains and transmits participant banking information to SHPS daily. SHPS will retrieve this information and establish a pre-notification to your banking institution. The pre-notification process takes approximately fourteen (14) days, during which time your banking institution will confirm the account and routing information is correct. 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, you will need to know your social security number and password. Once you have this information, call 1-800-893-0763 and the system will walk you through the rest.

AccountLINK can provide participants with:

- 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 Eastern Time, Monday through Saturday. Benefit Counselors are available between 8:00 AM and 8:00 PM Eastern Time, Monday through Friday, should you need assistance.

Internet Web-site

Spending Account participants may visit the SHPS Internet Website to access their Account information at <https://myspendingaccount.shps.com> . When accessing Account information, you will need to know your social security number and password. With SHPS 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: SHPS 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 Internal Revenue Service limits changes you can make to your Spending Accounts outside the Annual 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 change in status event, you must contact GaBreeze of the change on a timely basis. “Timely” means 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’ll get 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.

If you wish, you may appeal the denial with a written request for reconsideration. You must file your appeal 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:

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

SHPS, 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 if you do so

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 given a copy of the decision, written in understandable terms and including specific reference(s) to any pertinent provision(s) of the Spending Account Program. 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 federal statute called 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." It 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 and you must pay it on a timely basis.

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.

- 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. However, COBRA coverage will end 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. But if you are about to be divorced from your spouse, or if one of your covered dependent children is about to reach the limiting age, you must take action and notify GaBreeze directly within 60 days after the event occurs. Once you have provided information of the change, you'll be notified of your eligibility for the coverage under COBRA and provided an election form. You will have 60 days from the date you receive the form to enroll in COBRA coverage. Then you will have 45 days from the date you enroll to pay your initial contribution.