Flexible Spending Accounts Frequently Asked Questions

2024 Plan Year

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Section I: Introduction to Flexible Spending Accounts

1. What is a flexible spending account (FSA)?
An FSA is a tax-advantaged financial account that allows you to set aside a portion of earnings on a **pretax** basis to pay for qualified expenses incurred during the plan year. The IRS sets pretax contribution limits for FSAs and enforces rules related to plan administration, enrollment, and status changes.

2. What kinds of FSAs does the State offer?
The State offers two kinds of FSAs to eligible employees:

General purpose health care FSA covers a wide range of health-related expenses, including, but not limited to:

- Copays
- Coinsurance
- Deductibles
- Prescriptions
- Dental expenses
- Vision expenses
- Orthodontia

Limited purpose health care FSA covers dental and vision expenses only, including, but not limited to:

- Dental expenses
- Vision expenses
- Orthodontia

For both general purpose and limited purpose health care FSAs, your FSA debit card is loaded with your full annual election amount at the start of the plan year and can be used to pay for eligible expenses. When the card is used, funds will be pulled directly from your health care FSA and are paid to the provider.

In addition to the health care FSAs, the State also offers a dependent care spending account (DCSA). The DCSA covers any day care or dependent care expenses that allow you (and your spouse) to work, look for work, or be a full-time student. This includes expenses like:

- Before- and after-school care
- Day care
- Preschool
- Day camps
- Elder care

The DCSA requires that the dependent must live with you and be 12 years old or younger. Dependents age 13 or older may be eligible if they cannot physically or mentally care for themselves and require care while you're working.

Unlike the health care FSAs, the DCSA is a pay-as-you-go plan—the entire annual election amount is NOT available on the first day of the plan year.

For more information about the DCSA, refer to the Dependent Care Spending Account FAQ.

3. Why are there two kinds of health care FSAs?

The general purpose health care FSA ("FSA" in Workterra) is the standard health care FSA available to any eligible State employee, as long as they are not covered by an HSA-qualified high-deductible health plan (HDHP) like the State's Anchor Choice Plan with HSA. Generally, individuals who are not covered by an HDHP should enroll in the general purpose health care FSA. Individuals who are covered by an HDHP, or individuals whose spouse is covered by an HDHP, should enroll in the limited purpose health care FSA ("LFSA" in Workterra). Please note that while the Office of Employee Benefits can ensure that Anchor Choice Plan participants are not participating in a general purpose health care FSA, it cannot see whether an employee's *spouse* is covered by an HDHP. Accordingly, **it is the employee's responsibility to choose which health care FSA is appropriate for them**. Individuals may not maintain both a general purpose health care FSA and a limited purpose health care FSA at the same time.

4. What are the contribution limits for each FSA?

For the 2024 plan year, the general purpose or limited purpose health care FSA allows a maximum contribution of $3,050.

FSA contribution limits shown in this FAQ are set by the IRS and may change. Verify current maximums by visiting **www.employeebenefits.ri.gov**.

5. How much should I contribute to my FSA?
When deciding how much to contribute to your FSA, consider how much you expect to spend on health care for the coming year and what qualified expenses will not be covered by your health plans. Review your out-of-pocket health care spending in previous years. Also take into consideration any planned health care expenditures for the coming year, for example, recurring expenses like drug copays or any elective surgeries.

However, please plan carefully, as FSAs have a use-it-or-lose-it rule. If you contribute too much, unused amounts beyond the allowed carryover of $610 are forfeited, as are any carried-over amount not used in the following year. For more information about carryovers and forfeitures, see Section IV.

6. Can I get guidance on making an FSA election?
If you need help deciding how much to contribute to your FSA, first talk to ALEX, the State's personalized online decision support tool. You should also visit the ASIFlex tax savings calculator to see how much an election could save you in taxes.

Section II: ASIFlex, Our FSA Administrator

1. Who is the State's partner for administering the FSA program?
The State has partnered with ASIFlex to administer your FSA. ASIFlex offers:

- Live help: You can speak with an experienced customer service representative every time you call.
- Extended servicing hours Monday through Saturday.
- Secure communications via email and text alerts, and reimbursements via direct deposit to your bank account.
- Multiple claim and reimbursement options, including mobile app, online, toll-free fax, mail, debit cards for health care FSAs, and exclusive FSA Store cardless pay service.
- Educational website at **www.ASIFlex.com**. Learn about eligible expenses and debit card information; estimate expenses and calculate tax savings; and watch videos and link to IRS publications.
- Secure employee portal through which you can view your account statement and balance; submit claims; read messages; shop the FSA Store; manage your personal settings for email, text alerts, and direct deposit; and chat with an ASIFlex representative.

2. How do I register my account on the ASIFlex website?
When you first enroll in an FSA, you will receive a welcome letter from ASIFlex. When you have received the letter, go to **www.ASIFlex.com**, and click on the **Employee Login** tab. Click **Create an account**, and follow the online instructions. After you register, you can see your account statement and balance, submit claims, and sign up for email, text alerts, and direct deposit.

3. How do I contact ASIFlex for customer service assistance?
By phone at **800-659-3035**, Monday–Friday, 8 a.m. to 8 p.m. ET, and 10 a.m. to 2 p.m. ET on Saturday, or by email at asi@asiflex.com. Additional contact information is available on **www.ASIFlex.com**. Once registered online, you also can chat with customer service.

Section III: Eligibility and Enrollment

1. What is the plan year?
The annual plan year runs from January 1 to December 31.

2. Who is eligible to enroll?
Any State employee who is in a nonseasonal position and is scheduled to work at least 20 hours per week.

3. When can I enroll?
Eligible employees can enroll within 31 days of employment start date, during open enrollment, or if they have a qualified status change during the plan year.

4. How do I enroll?

- You must enroll for your FSA(s) via Workterra, the State's online enrollment system. Visit **www.employeebenefits.ri.gov/enrollment** for detailed instructions.
- Enrollments for new hires are processed after employees receive their first paycheck. Your per-pay-period deduction may be adjusted due to the timing of payroll processing.
- All enrollees will receive a welcome letter and a separate debit card mailer (with two cards) from ASIFlex with their confirmation of enrollment.

5. Do I have to reenroll every year to participate in the FSA benefit?
Yes. You will have to reenroll every year, and at that time you can either increase or decrease your tax deferred amount. Your annual election will go into effect on January 1 of each year.

6. What is a status change?
Health care FSA elections are fixed for the entire year unless you experience a qualifying status change event. A status change is usually a life-changing event, such as marriage or birth of a child, when you are allowed to adjust your benefits election within 31 days of the event date.
The most common qualifying events applicable to health care FSAs are:

- Your legal marital status changes through marriage, divorce, death, or annulment.
- Your number of dependents changes by reason of birth, adoption (or placement for adoption), or death. (If your child no longer qualifies for dependent care because the child turned 13, then that is a loss of a dependent under the DCSA but not under the health care FSA).

- You, your spouse, or any of your dependents has a change in employment status that affects eligibility under an employer's FSA benefit program. If you terminate or take a leave of absence from your employer, then you must be gone at least 31 days for termination or leave of absence to qualify.

The following events apply to the health care FSA but not to the DCSA:

- You are served with a judgment, decree, or court order, including a qualified medical child support order, regarding coverage for a dependent. If the order requires you to pay for medical expenses not paid by insurance for a dependent child, then you may add or increase coverage under the health care FSA. If the order requires that another person pay for medical expenses not paid by insurance for the dependent child, then you may drop or reduce coverage under the health care FSA.
- If you, your spouse, or a dependent becomes entitled to and covered under Medicare or Medicaid, you may drop or reduce coverage under the health care FSA.
- If you, your spouse, or a dependent loses eligibility and coverage under Medicare or Medicaid, you may add or increase coverage under the health care FSA.

For a list of qualifying status change events that apply to the DCSA, see the DCSA FAQ.
If you experience a qualifying status change, you can change your FSA election via Workterra. Supporting documentation showing evidence of the occurrence of the status change is required and must be attached along with your new election. Upon approval of the status change, your election will be changed for the remainder of the plan year, beginning with the next pay period. Please see **www.employeebenefits.ri.gov/enrollment/status-change.php** for more information.

7. Can I contribute to a health care FSA if I am covered under an HDHP through my spouse's employer?

You can, but you should consider electing a limited purpose health care FSA ("LFSA" in Workterra) instead, so your spouse can remain eligible for HSA contributions. If you elect the general purpose health care FSA, your spouse will lose his or her eligibility to contribute to an HSA, since your general purpose health care FSA automatically covers your spouse and is considered disqualifying health coverage for HSA purposes. Individuals who are covered by an HDHP, including participants in the HSA Plan, may not maintain general purpose health care FSAs, but they are eligible to contribute to limited purpose health care FSAs. Qualifying dental and vision expenses can be paid under limited purpose health care FSAs, but general medical expenses that can be paid under general purpose health care FSAs cannot be paid under limited purpose health care FSAs.

Section IV: Using Your Flexible Spending Account

1. Whose expenses qualify under my FSA?
Qualifying expenses are those for medical care for yourself (the participant), your spouse, your qualified child, or qualified relative. You may also claim medical expenses that you incur and pay to medical providers of a child for whom you don't get the tax exemption due to a divorce decree, as long as one parent claims the child as a tax dependent. (The tax exemption may switch from year to year between parents. As long as one parent gets the tax exemption, the medical expenses you pay on behalf of the child to the medical provider qualify under the FSA.)

2. Where can I find a list of eligible expenses?
A list of eligible expenses is available on the home page of the ASIFlex website under the **Resources** tab. Please note that the list is updated frequently, as required by changing regulations. Also see IRS Publication 502, "Medical and Dental Expenses" on **www.ASIFlex.com**.

3. What are FSA-eligible expenses?
Below is a sampling of qualified medical expenses that you can pay for with your FSA. See IRS Publication 502, "Medical and Dental Expenses," for a complete list of qualified expenses. (See question 8 for rules regarding ineligible expenses.)

Acupuncture
Ambulance
Birth control pills
Braces
Cancer treatment
Chemical dependency treatment
Childbirth and delivery
Chiropractor services
Contact lenses
Deductibles
Dental treatment
Diagnostic tests
Durable medical equipment
Eyeglasses
Eye surgery
Hearing aids
Hospital services
Insulin treatment
Laboratory fees
Machine tests
Mental health
Neurologist services
Nursing home
Optometrist services
Over-the-counter medicine
Prescription drugs
Psychiatric care
Psychologist services
Smoking-cessation programs
Surgeon fees
Transplants
Transportation for health care
Vision correction
X-ray fees

4. Do all prescription medications (drugs available only by prescription from a physician) qualify for the FSA?
Generally, yes, if they are prescription drugs and are legal under federal and state law. However, prescriptions that are purchased solely for cosmetic purposes, which are not treating an existing medical condition, do not qualify for reimbursement.

Additionally, federal law does not allow reimbursement through your flexible spending account for importation of drugs from foreign countries. The only exception to this rule is if you purchase and consume the drug while you are in the foreign country.

5. What are the requirements for reimbursements for over-the-counter (OTC) medicines and drugs?
OTC drugs and medicines purchased on or after January 1, 2020, do not require a prescription and are eligible for reimbursement. Just submit a claim with a copy of the merchant's itemized store receipt showing the store name, date of purchase, a description of each item, and dollar amount. Note: If OTC drugs and medicines were purchased prior to January 1, 2020, a physician prescription is required.

Items such as vitamins, herbs, or nutritional supplements are typically not eligible for reimbursement. In order to claim these items, you must have:

- An existing or imminent medical condition,
- A preprinted receipt from the provider documenting the purchase, and
- A physician's diagnosis and prescription for the specific item(s).

6. Can I use my FSA to pay for health insurance premiums?
No. FSAs cannot be used to pay for insurance premiums. You can, however, use FSA funds to pay for deductibles and copayments, certain medical expenses, prescription drugs, and to cover the costs of certain medical equipment.

7. Can I use my FSA to pay for prior-year expenses?
No. You must incur expenses during the current plan year. To be eligible for payment, the date of service must fall within your coverage period.

8. Do health club dues, massages, vitamins, herbs and nutritional supplements, and exercise equipment qualify for reimbursement under my FSA?
Generally, no. Items such as those listed above are typically considered to be utilized for general good health purposes and, as such, typically do not qualify for reimbursement under the FSA. However, these items may qualify for reimbursement if you have been diagnosed with a medical condition that necessitates the purchase of these items, and you would not have purchased them if it were not for the medical condition. To claim these items, you must have a letter of diagnosis and recommendation or prescription for these items to qualify under your FSA. This letter is valid for 12 months from issue date.

Please review the Sample Letter of Medical Necessity (use the **Resources** tab on the ASIFlex home page and then click on **Forms**) for all information that is needed for approval on these items.

9. What transportation expenses qualify for the FSA?

You may claim transportation expenses that were primarily for, and essential to, your or your qualifying dependents receiving medical care or services. These transportation expenses could include round-trip mileage, mass transit expenses, or ambulance service, as well as other expenses. See IRS Publication 502 for further detailed information. You cannot include mileage for going to and from work, travel for purely personal reasons to another city for an operation or medical care, or travel merely for general health improvement.

10. What is the mileage reimbursement rate?

The standard mileage rate for use of an automobile to obtain health care during the following time periods is as follows:

- 22 cents per mile from January 1 to December 31, 2023
- 22 cents per mile from July 1 to December 31, 2022
- 18 cents per mile from January 1 to June 30, 2022
- 16 cents per mile from January 1 to December 31, 2021

11. What do I need to submit to support mileage with my claim form?

You can submit claims:

- Via the ASIFlex mobile app
- Through your online account at **www.ASIFlex.com**
- Manual claim form

Just list the date(s) of service and total number of miles traveled. No supporting documentation is required.

12. Can I use my FSA to cover medical expenses for my qualified domestic partner?

The IRS does not recognize a qualified domestic partner for tax purposes. Qualified domestic partners may not file a joint tax return, and expenses of a qualified domestic partner do not generally qualify as those of a dependent under the definition of a "qualifying relative" under Internal Revenue Code Section 152. If you are unsure, you may confirm eligibility by using the Internal Revenue Code worksheet for determining dependent status found on page 20 of IRS Publication 501.

13. Can my family members use my health care FSA funds?
Per IRS Publication 969, the following persons are eligible to use your health care FSA funds for qualified expenses regardless of whether they are covered under your medical plan:

1. You and your spouse
2. All dependents you claim on your tax return
3. Any person you could have claimed as a dependent on your return except that:
   a. The person filed a joint return,
   b. The person had gross income of $4,150 or more, or
   c. You or your spouse, if filing jointly, could be claimed as a dependent on someone else's 2022 return.
4. Your child under age 27 at the end of your tax year

14. How do I access my FSA funds to pay for claims?
The primary way you will access your health care FSA funds is through the FSA debit card that is provided to health care FSA participants automatically upon enrollment. Health care FSA debit cards are loaded with the full annual election amount on the first day of the plan year. Information about how to use the card can be found on **www.ASIFlex.com/debitcards**.

You can also access funds by submitting claims via your online account at **www.ASIFlex.com**, by using the ASIFlex mobile app, or by toll-free fax or mail. If you want to initiate a manual reimbursement request or you receive an email requesting that you substantiate a debit card swipe, you will need to provide ASIFlex a copy of the insurance plan Explanation of Benefits (EOB) or an itemized statement from the provider for verification. You can scan and upload a copy of the documentation to your online account or directly through the ASIFlex mobile app. If you prefer to complete paper reimbursement request forms and mail or fax them to ASIFlex, you can download a claim form from the Office of Employee Benefits website or directly from the ASIFlex website.

Reimbursements will be made to you within three business days following receipt of a complete claim, provided you have available funds in your account. Log in to your ASIFlex account to sign up for direct deposit (see question 17 below), as well as email and text alerts.

15. Can I withdraw money from my FSA at an ATM?
Your ASIFlex debit card cannot be used to withdraw FSA funds from an ATM. Your ASIFlex debit card can only be used directly on qualifying medical services and products.

16. What is document substantiation?
Substantiation is the requirement for you to submit documentation that charges paid for with your ASIFlex debit card are eligible expenses. Documentation should include an itemized invoice, participant's name, date of service, provider or merchant name, service or item received, amount paid by insurance, and amount you owe. Register receipts alone may not include all the required information and may not satisfy the requirement for substantiation. An Explanation of Benefits (EOB) from your insurance carrier is one of the best ways to substantiate a claim.

17. How does the ASIFlex direct deposit feature work?
When registering your account at **www.ASIFlex.com**, you should provide ASIFlex with your bank account information (ABA routing number and account number), and ASIFlex will direct deposit your reimbursement instead of sending you a check. Keep in mind that if you are using your FSA debit card, claim reimbursement is automatic, not manual, and so direct deposit will not play a role. However, you may be required to submit documentation to substantiate card transactions.

18. How long do I have to submit claims for the prior year?
At the end of each plan year you have 90 days to submit debit card documentation or claims you incurred during the plan year for reimbursement, subject to federal guidance extending such a deadline. After the 90-day claims run-out period, carryover amounts are credited to accounts.

19. How does a carryover work?
For 2024, the State health care FSAs allow you to carry over up to $610 of unused contributions from the 2023 plan year. Carryover amounts will be credited to your ASIFlex account after March 31. The amount you carry over does not affect your ability to elect the maximum annual election allowed each plan year for the health care FSA. At the end of the 2024 plan year, you will be permitted to carry over up to $610 of unused contributions into the 2025 plan year.

Example: $610 in carryover funds from 2023 plan year + $3,050 maximum election for the 2024 plan year = $3,660 total available for the 2024 plan year.

20. What about forfeiture?
At the end of the 90-day claims run-out period after the end of the 2023 plan year, up to $610 in unused contributions from your 2023 health care FSA will carry over to 2024, subject to federal guidance extending such a deadline. At the end of the 2024 plan year, you will be permitted to carry over up to $610 of unused contributions into the 2025 plan year.

21. Are there any fees associated with a health care FSA?
If you elect a health care FSA during open enrollment, there are no fees associated with using your account. However, if you do not actively elect a health care FSA and have a carryover balance, ASIFlex will deduct an administrative fee of $2.25 per month from your account. To avoid this administrative fee, you can elect an FSA for 2024 and continue to use your carryover balance.

22. How will a wage garnishment affect my FSA?
If a writ garnishment (i.e., attachment as a percentage of disposable wages) is placed on your account, all benefits deductions are transferred to *post*-tax. Any deductions that are pretax only are stopped until the garnishment is fulfilled. FSAs only exist as a pretax benefit. Therefore, because you are not making any contributions, the FSA is suspended until the garnishment is completed and contributions resume.

If a <u>fixed-amount</u> garnishment (e.g., $100 per pay period) is placed on your account, pretax deductions remain, so long as there is enough pay to support the FSA deduction. If there is not enough pay, then your FSA will be suspended until FSA contributions resume.

In both cases (writ garnishment and fixed-amount garnishment), when the FSA contributions resume, the FSA is reactivated, and, if the FSA is *underspent*, the annual election amount is automatically lowered by the amount of the missed contributions. If the FSA is *overspent*, the annual election amount may be adjusted, and the per-pay-period deduction amount is increased to make up for the missed contributions. Either way, you would be able to submit manual claims for reimbursement for eligible expenses incurred while the garnishment was in place.

23. What happens to my FSA if I go on an unpaid leave of absence from the workplace?
When you go on an unpaid leave of absence, your FSA account(s), including your FSA debit card, will be suspended until you return to work and payroll deductions resume. Expenses incurred during an unpaid leave of absence from the workplace are eligible for reimbursement. Upon your return to work, your payroll contributions will be adjusted to reflect your annual FSA election amount, unless your FSA is underspent (more contributions than reimbursements) and you initiate a qualifying event in Workterra requesting that your annual election amount be decreased.

24. Can I enroll in an FSA if I am on an unpaid leave of absence from the workplace?
Employees on leave without pay are not eligible to enroll.

Section V: Flexible Spending Accounts and Retirement or Employment Termination

1. After I leave State service, will I be able to access funds I contributed to my FSA prior to my retirement or employment termination?
Yes and no. As a rule, FSAs are available only for active employees, and your FSA will be deactivated when your employment terminates. This means that you will no longer have access to the funds to which you contributed prior to your employment termination. Therefore, you should be careful about the amount you elect to contribute for the year if you are thinking about retiring or otherwise leaving State service during the year.

If you do retire or otherwise leave State service, you may be able to continue your FSA participation under COBRA (Consolidated Omnibus Budget Reconciliation Act). This option will be available to you only if you have contributed more money to your FSA than you have withdrawn from it.

2. How can I access funds I have contributed to my FSA if I have enrolled in COBRA continuation coverage?
If you elect to continue the health care FSA under COBRA, the biweekly contributions that were formerly deducted from your paychecks become “monthly premiums” paid directly to Workterra. Your FSA debit card will be reactivated, and all other aspects of your FSA participation will continue.

3. I'm enrolling in State-sponsored pre-65 retiree health coverage. Can I enroll in an FSA for use in conjunction with my retiree coverage?
No. FSAs are only available for active employees.

4. If I have enrolled in COBRA continuation coverage, can I use my health care FSA funds to pay my COBRA premiums?
No. COBRA premiums cannot be paid with traditional or limited purpose health care FSA funds.