Employee Benefit Plans Frequently Asked Questions

2026 Plan Year

Contents

Section I: General Open Enrollment Information

1. Are there any benefit changes for 2026?

Last year, we announced that all employees, with certain exceptions, would experience benefit changes and enhancements to the Anchor, Anchor Plus, and Anchor Choice medical plans and the CVS Caremark prescription drug coverage. The only change these employees will experience in 2026 is an increase to the deductible and employer contribution for the Anchor Choice Plan with HSA as described under "For All State of Rhode Island Employees" below. **However, in 2026, additional employees will transition to the updated benefit plans**, and their medical and prescription drug benefits will include the following changes:

For All State of Rhode Island Employees

The deductible for the Anchor Choice Plan with HSA is increasing, and the State is increasing the amount of its health savings account (HSA) contribution.

The Anchor Choice Plan is an HSA-qualified high-deductible health plan (HDHP), and the Internal Revenue Service (IRS) sets strict rules about certain features of the plan, like deductibles and out-of-pocket maximums. The IRS maintains these rules because of the tax advantages that come with contributing to an HSA.

For 2026 the IRS has changed the minimum allowable annual deductible for HDHPs. For that reason, your deductibles under the plan will increase. The new deductibles are:

- $1,700 if you elect employee-only coverage (a $50 increase)
- $3,400 if you elect family coverage (a $100 increase)

Because of this change, the State is increasing the amount of its annual HSA contributions to match the full annual amount of the new deductibles. Employees enrolling after January 1, 2026, may receive a lower State contribution.[1]

[1] *Contributions are made biannually with half deposited in January and the other half deposited in July. The State's HSA contributions are NOT pro-rated for employees who enroll after January 1 and July 1.*

For employees transitioning to the updated plans

- **No PCP Coordination of Care Required**

  You do not need to receive a referral from your primary care physician (PCP) to pay less for a specialist visit. Beginning January 1, you will pay the same for a specialist visit with or without a referral. Under the Anchor and Anchor Plus plans, there is a $25 copay for all in-network specialist visits. If you are enrolled in Anchor Choice, you pay 10% for an in-network visit.

- **Introducing Hinge Health**

  If you are enrolled in the Anchor, Anchor Plus, or Anchor Choice medical plans, you are now covered for Blue Cross Blue Shield of Rhode Island's virtual musculoskeletal (MSK) benefit through a partnership with Hinge Health. This comprehensive digital MSK care program combines personalized exercise therapy, wearable technology, health coaching, and education to help reduce chronic pain and improve joint and muscle health. You don't need a referral to use it, and there is no cost to you for this coverage.

- **Greater Wellness Incentives**

  If you are enrolled in the Anchor medical plan, your annual maximum incentives under the Rewards for Wellness program are increasing from $500 to $700. See Section IV for more information on the Rewards for Wellness program.

- **PrudentRx for Specialty Drugs (through CVS Caremark)**

  This new benefit is designed to reduce your out-of-pocket cost for certain specialty drugs. When you or a dependent takes a specialty drug on the PrudentRx program list, you would pay 30% coinsurance when receiving the drug from an in-network pharmacy, after meeting any applicable deductible. Under PrudentRx, you are automatically enrolled in the drug manufacturer's copay assistance plan for that medication. When the manufacturer's assistance is applied, you would receive the drug at $0 out-of-pocket cost.

  If you are enrolled in the Anchor Choice plan with HSA, you must fully satisfy your deductible before you are eligible to obtain your specialty drug at no out-of-pocket cost, unless you have been prescribed a medication that is qualified as "preventive care" by the IRS. You may still choose to use available manufacturer copay assistance to help cover your out-of-pocket cost before you have met your deductible, but you will not be eligible for $0 out-of-pocket cost under the program until your deductible has been satisfied.

  If you choose not to participate in PrudentRx, your specialty fills will be subject to the 30% coinsurance with no additional manufacturer assistance.

Please note: If you are a member of certain University of Rhode Island non-classified unions, your benefits are not changing, and these changes do not apply to you. However, you are subject to the increased Anchor Choice plan deductibles and HSA contributions from the State. Visit the OEB website for a listing of the specific groups.

2. When is the deadline to enroll?

The official deadline for completing your enrollment is October 31. However, we want to make sure that all State employees can make informed choices and complete the enrollment process without running out of time. Therefore, please don't wait until the last minute to make your elections. Note that the Office of Employee Benefits will be closing at 4 p.m. on Friday, October 31, and we will not be able to assist with any inquiries after that time. Elections can still be submitted through Workterra (the enrollment platform State employees have used in previous years) until the end of the day (11:59 p.m. ET) on Friday, October 31.

3. Is there an open enrollment grace period?

No. Open enrollment closes at the end of the day (11:59 p.m. ET) on Friday, October 31. We encourage you to enroll early.

4. When do open enrollment changes become effective?

With the exception of some life insurance coverage elections, any changes you make during the open enrollment period—for example, changing medical plans or electing a flexible spending account (FSA) or legal coverage—will take effect at the beginning of the new plan year on January 1, 2026. If your life insurance election is subject to The Hartford's evidence of insurability requirements, your new life insurance coverage will become effective only after you complete the required medical questionnaire provided to you by The Hartford and receive an approval from The Hartford. Payroll deductions for your 2026 benefits, including new elections and new premium (co-share) amounts, begin on January 2, 2026.

5. Am I locked into my elections until the next open enrollment?

Yes. The benefit elections you make during this open enrollment period will stay in effect for all of 2026. The only exception is if you have a qualified status change, for example, gaining or losing a dependent. In that case, you can make a change consistent with the status change, including adding or removing dependents and adding or canceling coverage, but you cannot change plans.

However, this rule does not apply to HSA contributions. You can change or stop your HSA contribution at any time during the year. Visit Workterra to update your HSA contribution amount.

NOTE: Beginning November 2, 2025, qualified status change elections and HSA contribution changes must be made through Workday, the State's new self-service benefits platform.

6. If I take no action during open enrollment, will all my benefits elections carry over to next year?

Yes, most benefit elections will automatically carry over. If you take no action during open enrollment, your current medical, dental, vision, life insurance, and legal coverage elections (including waivers) will carry over to the new plan year. However, if you want an FSA or a dependent care spending account (DCSA) in 2026, you must elect or reelect it during open enrollment. FSA and DCSA elections do not carry over from year to year and must be elected each year during open enrollment.

If you wish to make an FSA or DCSA election for 2026, you must use Workterra, the online enrollment system State employees have used in previous years. You must also use Workterra for medical (including waiving coverage and electing the opt-out payment), dental, vision, life, and legal coverage elections. You can find detailed Workterra guidance on the Benefits Enrollment page of the Office of Employee Benefits website.

If you have a balance remaining in your 2026 health care FSA after the end of the plan year, it will carry over to 2027 at the end of the 90-day claims run-out period, subject to the carryover limit of $680. The carryover limit is set by the IRS and is subject to change.

Any amount left in a DCSA at the end of the 90-day claims run-out period after a plan year ends is forfeited.

7. Where can I find more information about benefits and enrollment?

You can find everything you need for your enrollment online at the Office of Employee Benefits website (**www.employeebenefits.ri.gov**) and the virtual benefits fair (**www.exploreemployeebenefits.ri.gov**).

The enrollment brochure contains information about how to access these and other enrollment resources. A copy of that brochure is posted to the Office of Employee Benefits website.

Section II: In-Person Open Enrollment Fairs and the Virtual Benefits Fair

1. Will the State hold an in-person open enrollment fair at or near my work location?

No. Instead, you are encouraged to make use of the many online resources you will find on the Office of Employee Benefits website and the virtual benefits fair.

2. What is a virtual benefits fair?

It's an online event that replicates many of the features of a live, in-person benefits fair. When you visit the website, you can:

- Access virtual booths from most of your benefit providers.
- View pre-recorded presentations by many of your benefit plan vendors.
- Download information to help you learn more about your benefits and make informed choices.
- Find information about choosing or updating your beneficiary elections.
- Link to valuable resources, including the State's Office of Employee Benefits website, benefit provider websites, and ALEX, the interactive online decision tool.

3. Do I need a password to access the virtual benefits fair? Do I need to use a computer at a State office location?

No. During the open enrollment period, October 20 to October 31, you and your family can access the virtual benefits fair by visiting **www.exploreemployeebenefits.ri.gov** from your smartphone, tablet, or computer. You do not need any login information, like an ID or password.

4. What are the best ways to contact a benefits provider or learn more about my State of Rhode Island employee benefits?

Speaking with your benefit providers throughout the year is easy—just refer to the contact page of the Office of Employee Benefits website. More information is also available on the Office of Employee Benefits and virtual benefits fair websites. In addition, during open enrollment, you can schedule a virtual one-on-one session with a BCBSRI representative to review your benefit options. See Section III, question 1 for a list of helpful tools.

Section III: Making Your Benefit Elections

1. Are there any tools I can use to help me choose among the Anchor plan options?

Absolutely. The following tools are available to you right now.

- **Visit the virtual benefits fair.** The virtual benefits fair is a special website (www.exploreemployeebenefits.ri.gov) that is dedicated to giving you the experience of attending an in-person benefits fair.
- **Talk to ALEX®.** ALEX—a personalized online decision support tool—can help you understand the plans and choose what's best for you and your family.
- **Get help choosing a medical plan**. Schedule a virtual one-on-one session with a BCBSRI representative to review your options. Sessions are available Monday through Friday, October 20–October 31 from 10 a.m. to noon and 1 p.m. to 2:30 p.m. Eastern time. If you are registered at bluecareconnectRI.com, you will receive an email with a link to schedule your private appointment. Otherwise, you can find the appointment link on the BCBSRI flyer posted to the virtual benefits fair and to the News & Announcements page of the Office of Employee Benefits website.
- **Watch our newest benefit videos** on:
  - Comparing the Anchor, Anchor Plus, and Anchor Choice with HSA medical plans
  - Taking a closer look at the Anchor Choice with HSA medial plan

2. Can I get guidance on making a medical plan decision?

Yes. You can start by talking to ALEX, the personalized online decision support tool. ALEX can help you understand your options and make the best choice for you and your family. If you need additional assistance, you can set up a one-on-one consultation with a member of the BCBSRI State of Rhode Island Employee CARE Center. (See question 3 in this section.)

3. What is the BCBSRI State of Rhode Island Employee CARE Center?

BCBSRI, the State's medical provider, created the State of Rhode Island Employee CARE Center to support people covered under the RI State Employee Anchor plans. It is an all-in-one support center that connects State employees and their families with a local BCBSRI customer service and clinical team that is dedicated to their health needs.

If you need assistance during open enrollment or year-round, including benefit questions, bluecareconnectRI.com website help, or a Workterra password reset, contact the BCBSRI State of Rhode Island Employee CARE Center at **401-429-2104** or **866-987-3705**, Monday through Friday, 8 a.m. to 8 p.m. and Saturday 8 a.m. to noon.

The State of Rhode Island Employee CARE Center is exclusively dedicated to questions about **medical** coverage under the Anchor medical plans. If you have questions about **prescription drug** coverage, visit CVS Caremark online, or call **800-307-5432** to speak with a representative 24 hours a day, seven days a week. If you're looking to get in touch with the State's non-medical benefit providers, visit the Office of Employee Benefits website or see individual provider pages at the virtual benefits fair.

4. How do I change my assigned PCP (or that of a dependent)?

If you want to change your or a dependent's current PCP assignment, just call the BCBSRI State of Rhode Island Employee CARE Center at **401-429-2104** or **866-987-3705**. CARE Center hours are Monday–Friday, 8 a.m. to 8 p.m. and Saturday, 8 a.m. to 12 p.m.

If you are adding coverage for yourself or a dependent for the first time, you will need to wait until you receive your BCBSRI ID card. Your ID card should arrive by mail to your home address by the end of December.

Please note that PCP coordination of care is no longer required for most State of Rhode Island employees (see Section I, question 1 for more information).

5. How much should I contribute to my HSA?

If you're electing the Anchor Choice medical plan and need help deciding how much to contribute to your HSA, talk to ALEX, the State's personalized online decision support tool.

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.

7. Can I make my elections in any other way, or do I have to use Workterra?

The State of Rhode Island open enrollment is conducted entirely online, so all employees are expected to use Workterra, the online enrollment platform State employees have used in previous years. The Workterra interface is intuitive and user friendly, so you should find it easy to make your elections using the system. However, if you need support, please review the Workterra User Guide, and/or seek navigation assistance from the BCBSRI CARE Center. You can call the CARE Center for help with things like finding a provider or resetting your Workterra password. Additionally, if there is a legitimate reason why you cannot use Workterra, for example, an access issue, contact the Office of Employee Benefits for assistance.

Please note that Workterra access will close at 11:59 p.m. on Friday, October 31. Your elections must be completed by that time.

8. What if I have difficulty accessing the open enrollment information on the website or have questions that aren't answered online?

If you need help accessing information or want to ask a question, contact the Office of Employee Benefits by phone at **401-574-8530**, by email, or through our website. Let us know if you have any questions during the open enrollment period. Because of increased call volume during the open enrollment period, **the best way to contact us** is through email at doa.oeb@doa.ri.gov or through our website's feedback tool. If you prefer to call us and you have to leave a voicemail, we greatly appreciate your patience as we strive to return all calls within one business day.

9. What happens if I am on a leave without pay during open enrollment?

If you are on a leave without pay during the open enrollment period, you can still access Workterra to make your elections. However, if you elect an FSA or DCSA, you won't be able to use it for eligible expenses until you return to work and begin making payroll contributions.

10. Are all benefits restricted to changes during the open enrollment period?

No. You can make HSA contribution changes and enroll in or make changes to your deferred compensation plan, short-term disability plan, and other products sold through Aflac and Colonial Life at any time during the year.

11. I'm locked out of Workterra. How do I get a password reset?

If you incorrectly enter your Workterra login information too many times, the system will automatically lock you out. If this happens, call the BCBSRI State of Rhode Island Employee CARE Center at **401-429-2104** or **866-987-3705**. CARE Center hours are Monday–Friday, 8 a.m. to 8 p.m. and Saturday, 8 a.m. to 12 p.m.

12. Can someone help me make my elections?

Online open enrollment through Workterra is intuitive and user friendly. This is the enrollment platform State employees have been using to enroll for the past several years, so you should find it easy to make elections on your own. If you have trouble, the BCBSRI State of Rhode Island Employee CARE Center can walk you through and help you navigate Workterra. However, representatives are not able to make changes to your record, so you must complete your own enrollment.

13. How do I know my enrollment was successful? How do I know my dependents have the correct benefits?

You'll see an on-screen confirmation statement at the end of your enrollment process, and it is available on your dashboard in Workterra. Just confirm that the confirmation statement reflects your choices and the correct elections for you and your dependents. Please be certain to review and verify your confirmation statement before Workterra closes on October 31.

14. How do I enroll a new dependent who is not reflected on Workterra?

If your dependent is not listed in Workterra, you need to first add that person as a dependent in your Workterra account. Then, you can add the person to the desired coverage plans by checking the box next to that person's name. Remember to upload supporting documentation to Workterra, for example, a birth or marriage certificate, or that person's coverage will be canceled.

15. What happens if I don't upload supporting documentation for a dependent?

If you have added a dependent in Workterra, you must upload supporting documentation—such as a birth or marriage certificate—by October 31 or that person's coverage will be canceled.

16. Are there any special computer requirements for enrolling through Workterra?

No. There are no special computer requirements for completing your open enrollment in Workterra. The site is designed to work with most browsers and devices, including desktop and laptop computers, tablets, and smartphones. However, pop-ups must be enabled to use the site. If pop-ups are disabled in your browser, the site will ask you to enable that functionality.

Section IV: Other Questions

1. Why are there no resources or information about the 2026 wellness program?

The Rewards for Wellness program enters its 19th year in 2026. It offers up to $500 per employee in credits that are automatically applied to your biweekly medical plan premium (co-share) for completing certain wellness activities.[2] All activities must be completed during the 2026 calendar year, and incentives will be delivered in 10 consecutive pay days in the first half of 2027. Look for the Employee Wellness Program brochure, which will be mailed to your home at the end of December.

In 2026, you can earn up to $700 in incentives if you are enrolled in the Anchor plan[3] and up to $500 in incentives if you are enrolled in the Anchor Plus or Anchor Choice plans. These will be applied to your medical plan premiums in 2027.

As in previous years, if you receive a preventive care exam in 2026, you will earn a $250 credit toward your medical premiums (co-shares). If you're married and your spouse also receives a preventive care exam, you will earn an additional $250 credit toward your premiums (co-shares).[4] This credit is in addition to any wellness credits you may receive for completing wellness activities in the Rewards for Wellness program. Credits will be delivered in five consecutive pay days in the second half of 2027.

2. How can I contact a benefit provider directly?

To find contact information for your benefit providers, visit the Office of Employee Benefits website or see individual provider pages at the virtual benefits fair.

3. Do all of the State's benefit plan providers offer mobile apps?

Visit each of your benefit providers at the virtual benefits fair to find information about mobile apps and other online services.

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[2] Only active State of Rhode Island employees who are paying State medical premium payments at the time of the incentive delivery are eligible to receive premium credits.
[3] Up to $500 if you are a member of certain University of Rhode Island non-classified unions.
[4] You and/or your spouse must obtain at least one of the following qualifying preventive exams to earn the $250 credit(s): annual physical exam, annual gynecological exam, or prenatal obstetric exam. To receive $250 in credits for a spouse's annual preventive exam, the spouse must have been covered as a dependent on the employee's family plan both when they received a qualifying annual preventive exam and when the incentives are paid out.

4. Will I get new ID cards for this year?

You will receive a new ID card from BCBSRI for 2026. Please dispose of any older cards you may have and bring this new card with you when you receive care in the new year. Although your coverage has not changed, let your provider know that you have a new ID card.

Your ID card shows applicable copays and other important information. If you have been transitioned to one of the updated plans, your new ID card will not list a PCP and will show the $25 copay for a specialist visit without a referral. If you elect the Anchor Choice with HSA medical plan, your ID card will also reflect your updated annual deductible.

If you are a member of certain University of Rhode Island non-classified unions and are not changing plans, your new ID card will show your current PCP election. **Visit the OEB website** for a listing of the specific groups.

For all employees, your new ID card should arrive by mail to your home address by the end of December.

Your current CVS Caremark ID card does not expire, so you can continue to use your current ID card in 2026. However, if you change medical plans, add or remove a dependent, or are enrolled in an updated plan, you will automatically receive a new CVS Caremark ID card.

5. How can I access the new Workday self-service platform?

Beginning Sunday, November 2, all benefit information and changes will be accessible through Workday, the State's new benefits self-service platform. At that time, you will have access to view your 2025 plan year enrollment, elect any qualified status changes, and make HSA contribution changes for the remaining calendar year. Your 2026 benefit elections will be visible there starting on January 1, 2026.

You will receive more information about the new platform soon.

Flexible Spending Accounts Frequently Asked Questions

2026 Plan Year

Contents

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 the employee is 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"). 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 2025 plan year, the general purpose or limited purpose health care FSA allows a maximum contribution of $3,300.

For the 2026 plan year, the general purpose or limited purpose health care FSA allows a maximum contribution of $3,400.

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 such as recurring expenses for drug copays or 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 $680 are forfeited, as are any carried-over amount not used in the following year. This amount is subject to change as we receive updated guidance from the IRS. 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 is eligible to enroll.

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 online enrollment system State employees have used in previous years. 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. 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 is 21 cents per mile from January 1 to December 31, 2025* The IRS is expected to announce the 2026 mileage reimbursement rate in December 2025.

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.

* *This amount is subject to change based on updated guidance from the IRS.*

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 $5,250 or more, or
    c. You or your spouse, if filing jointly, could be claimed as a dependent on someone else's 2025 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?
The State health care FSAs allow you to carry over up to $660 of unused contributions from the 2025 plan year into the 2026 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 2026 plan year, you will be permitted to carry over up to $680 of unused contributions into the 2027 plan year.

Example: $660 in carryover funds from 2025 plan year + $3,400 maximum election for the 2026 plan year = $4,060 total available for the 2026 plan year. These numbers are subject to change based on updated guidance from the IRS.

20. What about forfeiture?
At the end of the 90-day claims run-out period after the end of the 2025 plan year, up to $660 in unused contributions from your 2025 health care FSA will carry over to 2026, subject to federal guidance extending such a deadline. At the end of the 2026 plan year, you will be permitted to carry over up to $680[†] of unused contributions into the 2027 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 2026 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 fixed-amount 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 requesting that your annual election amount be decreased.

NOTE: Beginning November 2, 2025, election changes must be requested through Workday, the State's new self-service benefits platform.

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 that 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 the vendor. 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 available only 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.

Dependent Care Spending Accounts Frequently Asked Questions

2026 Plan Year

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Section I: Introduction to the Dependent Care Spending Account

1. What is a dependent care spending account (DCSA)?
The DCSA 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 DCSA does for dependent care expenses what the health care FSA does for health care expenses. Contributions are made pretax through payroll deductions and are not subject to federal and state income taxes or Social Security and Medicare withholdings. The IRS sets pretax contribution limits for DCSAs and enforces rules related to plan administration, enrollment, and status changes.

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 flexible spending accounts (FSAs) also offered by the State, 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.

2. What are the contribution limits for the DCSA?
For the 2026 plan year, the maximum amounts that an employee can contribute to the DCSA have increased to $7,500 if single or married filing jointly or $3,750 if married and filing separately. *(Please note that it is the employee's responsibility to ensure that a dependent care spending account election is appropriate for his or her tax filing status.)*

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

Section II: ASIFlex, Our DCSA Administrator

1. Why are dependent flexible spending accounts now called dependent care spending accounts?
The Office of Employee Benefits previously referred to dependent care spending accounts (DCSAs) as "dependent flexible spending accounts" (DFSAs). While DCSAs are similar to FSAs, they are not the same. This naming change is intended to reduce employee confusion among general health flexible spending accounts (FSAs), limited health flexible spending accounts (LFSAs), and dependent care spending accounts (DCSAs). Additionally, please note that ASIFlex, the State's spending account administrator, refers to DCSAs as "dependent day care flexible spending accounts."

2. Who is the State's partner for administering the DCSA program?
The State has partnered with ASIFlex to administer your DCSA. 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, and mail.
- Educational website at **www.ASIFlex.com**. Learn about eligible expenses, 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; manage your personal settings for email, text alerts, and direct deposit; and chat with an ASIFlex representative.

3. How do I register my account on the ASIFlex website?
When you first enroll in a DCSA, 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.

4. 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 can also 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 DCSA via **Workterra**, the online enrollment system State employees have used in previous years. 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 from ASIFlex with their confirmation of enrollment.

5. What is a status change?
DCSA 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, where you are allowed to adjust your benefits election within 31 days of the event date.

The most common qualifying events applicable to DCSAs are:

- *Change in legal marital status.*
- *Change in number of dependents.* 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 any other plans.
- *Change in employment status.* You may make a corresponding change to your DCSA and your future contribution amount if you, your spouse, or a dependent experience an employment status change that affects eligibility under the State's benefits programs or under your spouse's or any dependent's employer.
- *Change in provider.* You may make a corresponding change to your DCSA and your future contribution amount if you change dependent care providers.

- *Change in cost.* You may make a corresponding change to your DCSA and your future contribution amounts if your dependent care provider who is not your relative changes your costs significantly.

If you experience a qualifying status change, you can change your DCSA election. Supporting documentation showing evidence of the occurrence of the status change is required and must be provided when applying for a 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.

Section IV: Using Your Dependent Care Spending Account

1. Whose expenses qualify under my DCSA?
Your work-related expenses must be for the care of one or more members of your home who are qualifying persons. You must provide over half of the qualifying person's support. The qualifying person cannot have income in excess of the federal exemption amount. A qualifying dependent is:

- Your qualifying child under the age of 13 who shares the same residence with you, or
- Your spouse or qualifying child or qualifying relative who is physically or mentally unable to care for himself or herself, who shares the same residence with you and has income less than the federal exemption amount.

If you are divorced, you must have physical custody of your child for over half of the year to be eligible for reimbursements through your DCSA. If custody is exactly equal, then neither parent can use the child care expenses. The parent who has more than 50% custody is eligible for the dependent care spending account regardless of who claims the tax exemption.

Physical or mental incapacity must be disabling. Persons who are not able to dress, clean, or feed themselves because of a physically or mentally disabling condition are considered unable to care for themselves. Persons with disabling conditions who require constant attention to prevent them from injuring themselves or others are considered unable to care for themselves.

2. Where can I find a list of eligible expenses?
A list of eligible expenses is available on the ASIFlex website under the **Resources** tab. Please note that the list is updated frequently, as required by changing regulations. Also see IRS Publication 503, "Child and Dependent Care Expenses," on **www.ASIFlex.com**.

3. Does my dependent care provider have to be a licensed day care center?
No. The provider does not have to be licensed, unless the provider cares for enough individuals to require licensing in your state. The provider must furnish you with the company's tax ID number or his or her Social Security number, as this will be required when filing your federal income tax returns.

Additionally, the care provider can be a relative of yours (even if the provider lives in your home) as long as the provider is not a dependent. However, do not count any amounts you pay to:

- A dependent whom you (or your spouse, if filing jointly) can claim as an exemption;
- Your child who was under age 19 at the end of the year, even if he or she was not your dependent;
- A person who was your spouse any time during the year; or
- The parent of your qualifying person if your qualifying person is your child and under age 13.

4. Do kindergarten charges qualify for my DCSA?
No. Expenses for education do not qualify for your DCSA. However, if you are charged for "after-care" for the portion of the day that your child attends the school that is charged for care and well-being, this charge does qualify for the DCSA. Your provider must provide you with support for the charges for the portion that is specifically for care and well-being.

5. Can I claim dependent care expenses under my DCSA after my child turns 13 years old?
Expenses for dependent care no longer qualify for the DCSA on the day your child turns age 13 unless your child has a physically or mentally disabling condition and is incapable of self-care. Persons who are not able to dress, clean, or feed themselves because of physically or mentally disabling condition are considered unable to care for themselves. Persons with mental health challenges who require constant attention to prevent them from injuring themselves or others are considered unable to care for themselves. Care for dependents who are incapable of self-care qualifies for any age, as long as it is for care and well-being while you are working or looking for work.

6. Do charges for food, transportation, activity fees, etc., qualify for reimbursement from my DCSA?
No. Only charges for care and well-being in order for you to work or look for work qualify for your DCSA. Separately billed charges for food, transportation, activity fees, etc., do not qualify.

7. If I pay my dependent care provider in advance of the services, can I file my claim when I pay?
Yes and no. The earliest you may file claims for services provided in advance is within the month in which the expenses will be incurred. For example, beginning July 1, you can submit a claim for day care services that will be incurred in the month of July. However, under that example, you would have to wait until August 1 to file a claim for reimbursement of expenses incurred in the month of August.

8. Do summer camps that include an overnight stay qualify for my DCSA?
No. The Internal Revenue Code disqualifies expenses that include overnight care. The charges cannot be prorated to include the portion that was for care during the day while you were working.

9. Does summer school tuition qualify for my DCSA?
No. The Internal Revenue Code does not allow the tax exemption on expenses incurred for a child's education.

10. Do soccer, baseball, football, gymnastics, ballet, etc., day camps qualify for my DCSA?
If the primary purpose of these camps is for care and well-being for you (or you and your spouse if married) to be gainfully employed, they may qualify. If ASIFlex cannot independently verify the primary purpose of the camp, ASIFlex will request a statement that the primary purpose is for care and well-being and not for educational or instructional purposes. Summer school is considered educational and not eligible for reimbursement. Overnight camps are not eligible for reimbursement.

11. How do I access my DCSA funds to pay for claims?
You can 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 by mail. If you want to initiate a manual reimbursement request or you receive an email requesting that you substantiate an expense, you will need to provide ASIFlex 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 12 below), as well as email and text alerts.

12. 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.

13. What is ASIFlex automatic reimbursement, and how does it work?
Automatic reimbursement is a paperless reimbursement option. When you file a claim, ASIFlex will automatically reimburse the expense from your DCSA. Choose this option if you have a regular expense on a recurring basis, for example, a day care provider who bills the same amount at regular intervals.

To take advantage of this feature, download and complete a claim form for each provider with recurring charges. Have the provider sign the form. Then submit the form to start or stop automatic claims. You need to submit the form only once per year (one for each provider) to receive automatic reimbursements during the plan year. ASIFlex will automatically enter a claim for each month during the plan year or until you request to stop the automatic claims.

The benefit of this option is that you do not need to submit recurring claims for the same amount each month. Simply submit the form once, and the reimbursement will be made to you at the end of each month as though you had submitted a claim. Claims are paid up to the amount of the monthly cost or the

balance remaining in your DCSA. The funds will be paid by check or direct deposited if you have enrolled in that option (see question 12).

14. What is ASIFlex recurring direct payment, and how does it work?
ASIFlex recurring direct payment allows you to pay a provider without submitting a claim for every payment. This is a free service with a one-time initial setup between you, your provider, and ASIFlex. After setup, ASIFlex will pay your dependent care provider directly from your ASIFlex account on the schedule set by you and your dependent care provider. This option is best if you do not want to submit claims or wait for reimbursement of your dependent care services. ASIFlex will pay your provider(s) directly out of your DCSA up to the amount of the charge or the available balance in your account.

To set up a recurring direct payment, log in to your account at **www.ASIFlex.com**. Under **Participant Services**, click on **Schedule a Recurring Direct Payment** and follow the instructions for each provider.

15. 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 documentation or claims you incurred during the plan year for reimbursement. This period of time is referred to as the "90-day claims run-out period."

16. What about forfeiture?
All money contributed to a DCSA must be used to reimburse qualified expenses incurred during that plan year. Any amount left in a dependent care spending account at the end of the 90-day claims run-out period after a plan year ends is forfeited. The unused portion of your DCSA may not be paid to you in cash or other benefits, including transferring money to an FSA. To reduce the risk of forfeiture, it is critical for you to be conservative when choosing your annual election amount.

17. Are there any fees associated with a DCSA?
There are no fees to open and contribute to a DCSA.

18. How will a wage garnishment affect my DCSA?
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. DCSAs exist only as a pretax benefit. Therefore, because you are not making any contributions, you will be able to access DCSA funds only up to the amount you had already contributed before the garnishment was applied. When the garnishment is completed and DCSA contributions resume in the same plan year, you will be able to reimburse yourself for eligible expenses out of those newly contributed funds (in addition to any funds in your DCSA that had not already been reimbursed to you).

If a fixed-amount garnishment (e.g., $100 per pay period) is placed on your account, pretax deductions remain as long as there is enough pay to support the DCSA deduction. If there is not enough pay, then you will be able to access DCSA funds only up to the amount you had already contributed before the garnishment was applied. When the garnishment is completed and DCSA contributions resume in the same plan year, you will be able to reimburse yourself for eligible expenses out of those newly contributed funds (in addition to any funds in your DCSA that had not already been reimbursed to you).

19. What happens to my DCSA if I go on an unpaid leave of absence from the workplace?
When you go on an unpaid leave of absence, you will be able to access DCSA funds only up to the amount you had already contributed before your leave period began. When the leave period is completed and DCSA contributions resume in the same plan year, you will be able to reimburse yourself for eligible expenses out of those newly contributed funds (in addition to any funds in your DCSA that had not already been reimbursed to you). 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 DCSA election amount unless you initiate a qualifying event requesting that your annual election amount be decreased.

NOTE: Beginning November 2, 2025, election changes must be requested through Workday, the State's new self-service benefits platform.

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

21. Does a DCSA affect the child care tax credit on my income tax return?
You cannot claim a child care tax credit for amounts contributed to your DCSA. However, you may be able to claim a child care tax credit for any additional day care costs above the amount you contributed to the DCSA.

Section V: Dependent Care Spending Accounts and Retirement or Employment Termination

1. After I leave State service, will I be able to access funds I contributed to my DCSA prior to my retirement or employment termination?
Yes and no. As a rule, DCSAs are available only for active employees, and your DCSA will be deactivated when your employment terminates. This means that you will no longer have access to the funds which you contributed prior to your employment termination to reimburse yourself for eligible expenses incurred after your employment termination. However, you would be able to access the funds which you contributed prior to your employment termination to reimburse yourself for eligible expenses incurred before 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.

2. I'm enrolling in State-sponsored pre-65 retiree health coverage. Can I enroll in a DCSA for use in conjunction with my retiree coverage?
No. DCSAs are only available for active employees.

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2026 Plan Year

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Section I: Learning About Health Savings Accounts (HSAs)

1. What is a health savings account (HSA)?

An HSA is a tax-advantaged personal savings account that can be used to pay for medical, dental, vision, and other qualified expenses now or later in life.

2. Are all State employees eligible to enroll in the Anchor Choice Plan with HSA?

All State employees are eligible to enroll in the Anchor Choice Plan with HSA. However, IRS rules apply to HSA contributions and withdrawals.

3. What are the requirements for opening an HSA through the State of Rhode Island?

To open and contribute to an HSA, you must meet the following conditions:

- You must be enrolled in the Anchor Choice Plan, which is an HSA-eligible high-deductible health plan (HDHP);
- You must not be covered by any other health plan that is not an HDHP (this includes a general purpose health care flexible spending account);
- You must not be enrolled in Medicare (including premium-free Part A, in which most people are automatically enrolled at age 65), TRICARE, or TRICARE For Life;
- You must not be claimed as a dependent on someone else's tax return; and
- You must not have received VA benefits within the past three months, except for preventive care (this exclusion does not apply if you are a veteran with a disability rating from the VA).

4. Will the State contribute any money to my HSA?

Yes. The State's contribution to your HSA will be $1,700 if you have individual coverage or $3,400 if you have family coverage. This contribution is enough to cover the entire annual deductible for the Anchor Choice Plan.

These contributions are made biannually, with half deposited in January and the other half deposited in July.[1] Contributions post to the account approximately one to two business days after the funds are received by UMB Bank. The State's HSA contributions are not prorated for employees who enroll after those dates.

5. How does an HSA help me save?

An HSA is a great way to save money. Not only are you able to receive an annual contribution from the State, but you can contribute, too. As long as you maintain a balance of at least $1,000 in your HSA, you can invest the money in your account for even greater earnings potential.[2] Even without all of that, you save on taxes.

- The State contributes to your HSA *up to the deductible* of your coverage. You can use the State's contribution to pay for current expenses, which saves you money right from the start.
- Your direct payroll contributions are made on a pretax basis, which reduces your taxable income.
- Money that is withdrawn from an HSA to pay for qualified medical expenses is income tax free.
- Accounts earn interest, and this growth, as well as any investment-based growth, is not taxable.
- HSA funds not spent during the plan year carry over to subsequent plan years.

6. Who administers the HSA account?

UMB Bank is the custodian of the Blue Cross & Blue Shield of Rhode Island (BCBSRI) HSA, but you will be able to log in and manage your account (check your balance, change your contribution amount) through the Blue Cross & Blue Shield of Rhode Island website.

7. Is there a limit on how much I can put into my HSA each year?

Yes, the IRS puts annual limits on how much can be contributed to an HSA. For 2026, the contribution limits are $4,400 for individual coverage and $8,750 if you are enrolled in family coverage. These limits include contributions from your employer and any contributions you choose to make. If you are 55 years of age or older but not yet enrolled in Medicare benefits, you can deposit an additional $1,000 per year as a catch-up contribution.

8. Can I increase, decrease, or stop my HSA payroll contribution anytime?

Yes, you can change or stop your HSA contribution at any time during the year. Visit Workterra

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[1] *Contributions are made biannually with half deposited in January and the other half deposited in July. The State's HSA contributions are NOT pro-rated for employees who enroll after January 1 and July 1.*

[2] *UMB Bank investment accounts are subject to an additional fee, are not FDIC insured, are not bank guaranteed, and may lose value.*

to update your HSA contribution amount through October 31, 2025. Beginning November 2, 2025, HSA contribution changes must be made through Workday, the State's new self-service benefits platform.

9. Can I participate in the Anchor Choice Plan without opening an HSA?

No. It's a benefit you receive automatically. When you enroll in the Anchor Choice Plan, an HSA will automatically be opened for you, and the State will make contributions to the account. You do not have to make other contributions to the HSA.

10. Can I stay in the Anchor Plan or the Anchor Plus Plan and open an HSA?

No. Only employees who enroll in the Anchor Choice Plan are eligible to open an HSA account.

11. If my spouse has his or her own health coverage, how would that affect our ability to make HSA contributions?

It depends on the exact health coverage that you and your spouse have. See the table on pages 4 through 6 for details.

12. What can I use my HSA for?

You can use your HSA funds:

- To pay for qualified medical, dental, vision, and prescription drug expenses, including over-the-counter drugs that have been prescribed by a doctor, as defined in IRS Publication 502, "Medical and Dental Expenses."
- As supplemental income after age 65. Once you are 65, you can withdraw funds for any reason without paying a penalty, but they will be subject to ordinary income tax.
- For any reason, but if you are under age 65 and use your HSA funds for nonqualified expenses, you will need to pay taxes on the money you withdraw, as well as an additional 20% penalty.

13. What are HSA-eligible expenses?

Below is a sampling of qualified medical expenses that you can pay for with your HSA. See IRS Publication 502, "Medical and Dental Expenses," for a complete list of qualified expenses. (See question 15 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
Long-term care
Machine tests
Medicare Part D premiums
Mental health
Neurologist services
Nursing home
Optometrist services
Prescription drugs
Psychiatric care
Psychologist services
Smoking-cessation programs
Surgeon fees
Transplants
Transportation for health care
Vision expenses
X-ray fees

HSA contributions by employee and spouse					
	Spouse has no health plan coverage	**Spouse has self-only non-HDHP coverage**	**Spouse has self-only HDHP coverage**	**Spouse has family non-HDHP coverage**	**Spouse has family HDHP coverage**
Married employee with self-only non-HDHP coverage	*Employee and spouse*: no contributions	*Employee and spouse*: no contributions	*Employee*: no contributions *Spouse*: may contribute up to individual annual limit	*Employee and spouse*: no contributions	*Employee*: no contributions *Spouse*: may contribute up to family annual limit

HSA contributions by employee and spouse					
Married employee with self-only HDHP coverage	*Employee*: may contribute up to individual annual limit *Spouse*: no contributions	*Employee*: may contribute up to individual annual limit *Spouse*: no contributions	*Both employee and spouse:* eligible for contributions. Each may contribute up to the individual annual limit to their respective HSAs.	*Employee*: no contributions if employee is covered under spouse's coverage. If not covered, employee may contribute up to individual annual limit. *Spouse*: no contributions	*Both employee and spouse:* eligible for HSA contributions and are treated as having only the family coverage. Total contribution (employee and spouse combined) may not exceed the family annual limit.
Married employee with family non-HDHP coverage	*Employee and spouse:* no contributions	*Employee and spouse*: no contributions	*Employee*: no contributions *Spouse*: no contributions if spouse is covered under employee's coverage. If not covered, spouse may contribute up to individual annual limit.	*Employee and spouse*: no contributions	*Employee*: no contributions *Spouse*: no contributions if spouse is covered under employee's coverage. If not covered, spouse may contribute up to family annual limit.

HSA contributions by employee and spouse					
Married employee with family HDHP coverage	*Employee*: may contribute up to family annual limit *Spouse*: no contributions	*Employee*: may contribute up to family annual limit *Spouse*: no contributions	*Both employee and spouse:* eligible for HSA contributions and are treated as having only the family coverage. Total contribution (employee and spouse combined) may not exceed the family annual limit.	*Employee*: no contributions if employee is covered under spouse's coverage. If not covered, employee may contribute up to family annual limit. *Spouse*: no contributions	*Both employee and spouse:* eligible for HSA contributions and are treated as having only the family coverage. Total contribution (employee and spouse combined) may not exceed the family annual limit.

14. Can my HSA be used to pay insurance premiums?

Insurance premiums are generally not considered qualified medical expenses and would be subject to taxes and penalty. However, the following types of insurance premiums typically do qualify:

- COBRA continuation coverage
- Qualified long-term care insurance contract
- Any health plan maintained while an individual is receiving unemployment compensation
- For account holders age 65 and over (i.e., those eligible for Medicare), premiums for any health insurance (including Medicare and Medicare Part D premiums) other than a Medicare supplemental policy

See IRS Publication 502, "Medical and Dental Expenses," for more details.

15. What happens if I use my HSA to pay for ineligible expenses?

Any funds you withdraw for nonqualified expenses will be taxed at your income tax rate plus 20% tax penalty if you're under 65. For example, if the expense was $100, the $100 would be considered taxable income, and you would also pay an additional $20 tax penalty. The 20% tax penalty does not apply if the account holder is age 65 and older.

16. Can I use the HSA for my spouse or dependents if they're not covered under my plan?

You can use the HSA to pay for qualified expenses of any family member if that person is claimed as a spouse or dependent on your taxes. If a tax dependent is not covered under your plan and you use your HSA to pay for the dependent's expenses, those expenses will not go toward your deductible.

17. Do I have to spend all my contributions by the end of the plan year?

No. HSA money is yours to keep. Unlike a flexible spending account (FSA), unused money in your HSA isn't forfeited at the end of the year. It continues to carry over from year to year and grow, tax deferred.

18. What happens if I leave my current employer, change health plans, or retire?

The money in your HSA is yours to keep. If you leave State service, change health plans, or retire, you take your HSA with you. If you switch to a health plan that makes you ineligible to continue contributing to your HSA, you may continue to use the money in your account for qualified medical expenses, but you can no longer make contributions. If you switch from Anchor Choice to a different medical plan option, payroll contributions to your account will stop automatically. Otherwise, if you want to stop your HSA contribution on or before October 31, 2025, visit Workterra to change your election. Beginning November 2, 2025, HSA contribution changes must be made through Workday, the State's new self-service benefits platform. Changes must be made electronically.

19. I want my HSA dollars to go as far as possible. How can I find out how much a treatment or procedure is going to cost?

After you enroll, you can use the **Find a Cost** in the **Self Service** menu in your BCBSRI online account. You can compare costs for procedures at different facilities, based on your health plan.

20. How do I pay with an HSA?

Your HSA is similar to a checking account. Payments can be made with your HSA debit card, online from your HSA account, or with an HSA check. You also can pay out of pocket and then reimburse yourself from your HSA (as long as the HSA was open at the time you made the purchase).

21. Is there a monthly maintenance fee for the BCBSRI HSA account with UMB Bank?

You will pay no fee as long as you remain enrolled in the Anchor Choice Plan. However, if there is a balance in your account, you are responsible for a maintenance fee of $2.50 per month if you disenroll from the Anchor Choice Plan for any reason. If there is no balance, your account will be closed.

22. Is there a fee for the HSA debit card? Can I request additional cards?

There is no fee for the debit card. You can request additional cards for dependents at no cost.

23. If I paid a health care bill with my credit card, can I pay myself back from my HSA?

Yes, as long as the service is a qualified expense incurred while you were enrolled in Anchor Choice with an active health savings account. You can take money out of your HSA to pay yourself back with no penalty.

24. Can I use any bank for my HSA?

No. An HSA account will automatically be opened for you at UMB Bank, and the State will make contributions to that account only. Also, any payroll contributions you make will go into that account. You could then transfer those funds into another bank's HSA, subject to any applicable transfer fees.

25. Does the HSA account earn interest?

Yes! You earn interest on the money in your account. As long as you maintain a balance of at least $1,000 in your HSA, you can elect to begin investing the balance in mutual funds for the potential of even greater growth.* Log in to your BCBSRI account to get started.

Section II: Managing Your HSA

1. What are the HSA deposit options?

- Pretax payroll deduction, provided that you elected the Anchor Choice Plan during open enrollment or when you attained eligibility and your account is active; you may start, stop, or change the amount of your payroll deductions at any time.
- A paper check (deposit additional dollars into your account by April 15 of the current year in order to realize tax savings for the prior year)
- Online (arrange a one-time or regular electronic transfer from an account at another financial institution)

2. Are HSA funds available immediately?

Only deposited funds in the account are available for immediate use. Employee HSA payroll contributions will be available within one business day of the payroll check date.

3. How do I make contributions to my HSA outside of payroll deductions?

You can do this electronically or with a paper check:

- **Electronically:** You can process electronic deposits through your BCBSRI account online. After logging in to **https://bluecareconnectri.com/**, click **Your HSA,** and you will see your HSA dashboard.
  - — Click on the HSA balance.
  - — Then click on the **Contributions** tab.
  - — The first time you do this, you will need to **Add Bank Account**.
  - — When you've done that, click on **Add Contributions** to start an electronic deposit.
- **Paper check:** First, you will need to complete a UMB HSA Deposit Form. You'll find this in your BCBSRI account online. After logging in to **https://bluecareconnectri.com/**, click **Your HSA**, and you will see your HSA dashboard.
  - — Choose **Document & Forms**.

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* *UMB Bank investment accounts are subject to an additional fee, are not FDIC insured, are not bank guaranteed, and may lose value.*

- Choose the form titled "HSA Member Contribution Form – Personal Deposits Only."
- Mail the form and check made payable to UMB Bank to:

  UMB Bank Contributions
  P.O. Box 874264
  Kansas City, MO 64187-4264

4. Do I need to save my receipts?

Yes, you should save your receipts in case of an IRS audit. You can load them into your BCBSRI HSA account if you wish.

5. Can I control how the funds are invested?

Yes. Once your HSA cash account balance reaches $1,000, you can transfer funds to an HSA investment account. If you maintain a balance of at least $1,000 in your HSA, you can choose from a selection of mutual funds and set up an allocation model for future transfers. You can transfer money between your HSA cash and HSA investment account at any time.

6. What tools are available for managing my HSA account online?

- Check your balance.
- Arrange deposits from another bank account.
- Pay bills to health care providers.
- Use the convenient online claims submission.
- Reimburse yourself for qualified medical expenses paid out of pocket.
- Use HSA calculators.
- Check the contribution tracker for year-to-date contribution amounts.
- Manage investment activities for your HSA.

7. Is there an app for the BCBSRI HSA?

Yes. You can download the BlueSolutions Spending on the Go app to manage your HSA. You can view your account balances, update your profile, and submit a claim.

Section III: Making Changes Once You Have an HSA

1. What if I want to switch plans at the next open enrollment?

If you enroll in the Anchor Choice Plan, you are committed to the plan for the entire plan year. At the next open enrollment period, you can make a new health plan election for coverage effective January 1 of the following year.

2. If I enroll in the Anchor Choice Plan and decide to change plans at the *next* open enrollment, what happens to the money in my HSA?

The money in your existing HSA is yours to keep. You can still use it to pay qualified medical expenses, but you will not be able to make contributions to it. You will be responsible for a maintenance fee of $2.50 per month as long as there is a balance in the account. If there is no balance, your account will be closed.

3. Will the State's contribution be prorated if I enroll in the Anchor Choice Plan during the year due to a status change or if I'm newly hired?

No. The State's contribution is made in two deposits. These contributions are made biannually, with half deposited in January and the other half deposited in July. You must be enrolled on the date the deposit is scheduled (generally the first banking day of January and July) to receive the State's contribution.

For example, an employee who was hired and enrolled effective after the first banking day of January will receive the State's contribution in July if his or her employment continues. An employee hired and enrolled effective after the first banking day of July will not receive any State contribution for the plan year.

4. I have an existing HSA from a previous employer. Can I roll over my existing HSA balance into a BCBSRI account?

Yes. If you enroll in the Anchor Choice Plan and an account is opened for you, you can roll over your existing HSA balance into your BCBSRI HSA account. You can do this at any time after your enrollment takes effect. There are a few things to consider:

- It is recommended that you wait about a month after your BCBSRI HSA is opened to do this. That way, you will have made some HSA contributions, and you'll have HSA funds to use while your money is being moved.
- Use the form in your BCBSRI online account to request the transfer. Check with your existing institution to see if you must also use its transfer form.
- Your current HSA bank may charge a fee to transfer funds (roll over) from your existing account to your new BCBSRI HSA account. Contact your current HSA bank for information.

5. How long does a rollover take?

The transfer process can take up to two weeks. During that time, you will not be able to access funds from your existing account.

6. What happens to my HSA if I die?

You should assign a beneficiary to your account (online or via paper form) as soon as your HSA is opened.

- If no beneficiary is elected, your estate will be deemed to be the beneficiary.
- If your spouse is designated as a beneficiary, it will become your spouse's HSA with all the associated tax benefits.

- If anyone other than your spouse is designated as the beneficiary:
  - Your account ceases to be an HSA.
  - The fair market value of your HSA will be treated as taxable income to the beneficiary.
  - The account can be used for the decedent's expenses on a tax-free basis if used within one year after death.

For more information about designating a beneficiary for your HSA, visit the Naming Your Beneficiaries page of the virtual benefits fair (www.exploreemployeebenefits.ri.gov).

7. Can I still have a health care flexible spending account (FSA) if I have an HSA?

The limited purpose health care FSA ("LFSA" in Workterra) is available to employees who have elected the Anchor Choice Plan. Because the Anchor Choice Plan has a health savings account component attached to it, the IRS prohibits combining it with a general purpose health care FSA. An LFSA is allowed because it is limited to eligible dental and vision expenses. For the 2026 plan year, the limited purpose health care FSA allows a maximum contribution of $3,400. At the end of the 2026 plan year, you will be permitted to carry over up to $680 of unused LFSA contributions into the 2027 plan year.

Some examples of LFSA eligible expenses are:

- Copays, deductibles, and coinsurance for dental or vision expenses
- Dental exams, X-rays, fillings, orthodontia, crowns, bridges, implants, and dentures not reimbursed under the dental plan
- Vision exams, eyeglasses, prescription sunglasses, and contact lenses and solution not reimbursed under the vision plan

For more specific information about HSA and FSA, see Section 5: HSA and Flexible Spending Accounts below.

Section IV: HSA and Medicare

Note: Many people are automatically enrolled in Medicare Part A when they turn 65. **If you are enrolled in Part A, you are enrolled in Medicare.**

1. Can I continue contributing to my HSA if I am Medicare-eligible (but have not signed up for Medicare)?

Maybe, depending on your situation:

- If you're eligible for Medicare *but have not filed an application for either Social Security retirement benefits or Medicare*, you don't need to do anything. You have the right to postpone applying for Social Security and Medicare—and, therefore, can continue to contribute to your HSA—until you stop working. There is no penalty for this delay, and when your employment ends, you will be entitled to a special enrollment period to sign up for Medicare.

- If you're entitled to Medicare because you signed up for Part A at age 65 or later (perhaps not realizing that it could affect the use of your HSA) *but have not yet applied for Social Security retirement benefits*, you can withdraw your application for Part A. To do so, contact the Social Security Administration at **800-772-1213**. There are no penalties or repercussions, and you are free to reapply for Part A at any future date.
- *If you have applied for, or are receiving, Social Security benefits—which automatically entitles you to Part A*—you cannot continue to contribute to your HSA. In these circumstances, the only way you could opt out of Part A would be to pay back to the government all the money you've received in Social Security payments, plus everything Medicare has spent on your medical claims. You must repay these amounts before your application to drop out of Part A can be processed. If you take this action, you're no longer entitled to Social Security or Medicare, but you can reapply for both at any time in the future (for example, if you end or lose your HSA coverage).

2. When I enroll in Medicare, can I continue contributing to my HSA?

You cannot contribute to an HSA in any month that you are enrolled in Medicare. In the year you enroll in Medicare, your total contribution (your contribution plus the State's) must be prorated. For example, if you enroll in Medicare in July, your HSA contribution must reflect the fact that you were eligible to contribute to your HSA for only half of the year (January through June).

3. I'm enrolled in Medicare. Can I still be covered under my spouse's HSA-eligible plan through his or her employer?

Yes, and you can continue to use funds from your working spouse's HSA for qualified expenses.

4. If my spouse or dependent is enrolled in Medicare, can I open and contribute to an HSA?

Yes, if a spouse or dependent will be or is already covered by Medicare, you can still sign up for the Anchor Choice Plan and open and contribute to an HSA if you are eligible (see question 3). If you file taxes jointly with your spouse, you can use your HSA to help pay for your spouse's qualified expenses, such as Medicare premiums.

5. I'm 65 or older and not enrolled in Medicare. What happens to my HSA when I decide to retire?

When you retire and enroll in Medicare, you may no longer *contribute* to your HSA. However, you may *withdraw* money from your HSA for medical and non-medical purposes without penalty. When your Medicare coverage starts, you can use your HSA to pay your Medicare premiums, deductibles, and copayments.

Important: You need to stop contributing to your HSA six months before you apply for Social Security retirement benefits to avoid tax penalties. If you're already at least six months beyond your full retirement age (currently 66) when you finally sign up for Social Security retirement benefits, Social Security will give you six months of back pay in retirement benefits. This means that your enrollment in Part A (and, therefore, in Medicare) will also be backdated by six months. Under IRS rules, you cannot contribute to an HSA in any month that you are enrolled in Medicare, so you will be liable to pay six months of taxes on any HSA contributions made up to that point.

6. I enrolled in Medicare under age 65 due to a disability. Can I participate in the Anchor Choice Plan?

Yes, but as long as you are enrolled in Medicare, you will not be able to contribute to an HSA. You also will not receive any HSA contributions from the State.

Section V: HSA and Flexible Spending Accounts

1. Can I have an HSA and a health care flexible spending account (FSA)?

Yes and no. Per IRS rules, you cannot maintain both a *general purpose* health care FSA (shown as "FSA" in Workterra) and an HSA. An FSA counts as other health coverage that renders you ineligible for an HSA. However, the law *does* permit an HSA holder to contribute to and maintain a *limited purpose* health care FSA ("LFSA" in Workterra). An LFSA can only be used to pay for eligible dental and vision expenses, as well as preventive health care expenses.

2. If my spouse has an FSA through another employer, can I open an HSA?

Probably not. Unless your spouse's FSA is an "employee-only" or "employee plus children only" FSA, you would be covered by your spouse's FSA and would be ineligible to open an HSA.

3. If I am covered under a high-deductible health plan through my spouse's employer, can I contribute to a State-sponsored FSA?

Yes. However, you should consider electing an LFSA, so your spouse can remain eligible for HSA contributions. If you elect an FSA, your spouse will lose his or her eligibility to contribute to an HSA because your FSA automatically covers your spouse and is considered disqualifying health coverage for HSA eligibility purposes.

4. If I am currently enrolled in an FSA and want to enroll in the Anchor Choice Plan during open enrollment, what happens to remaining funds in my FSA as of the end of the current plan year?

If you are enrolling in the Anchor Choice Plan during open enrollment and you have a balance left in your 2025 FSA after the claims run-out period ends on March 31, 2026, your entire remaining balance will be rolled over to an LFSA for 2026—regardless of whether you elect to open an LFSA. However, if you do not elect an LFSA for 2026, your carryover-only balance will be subject to a $2.25 per month administrative fee. For further details about FSA carryover and fees, please see the FSA FAQ.