

STATE OF DELAWARE

Health Care Flexible Spending Account

Plan Booklet

(Fiscal Plan Year July 1, 2026 – June 30, 2027)

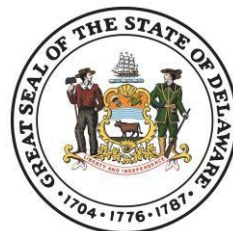


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INTRODUCTION

A Health Care Flexible Spending Account (FSA) is an employer-sponsored plan that lets you deduct dollars from your paycheck before they are taxed and put them into a special account to pay for health, dental and vision care related expenses.

Health Care FSA accounts are exempt from federal income taxes, Social Security (FICA) taxes and, in most cases, state income taxes. FSA participation will impact earnings reported to the Social Security Administration. The more money you put in, the more tax you avoid. When you use the money in your account to pay for out-of-pocket health, dental or vision care expenses, you avoid paying taxes on those dollars. Depending on your tax bracket, you will save as much as 25% on out-of-pocket family care expenses.

Flexible Spending Accounts offer tax savings for your out-of-pocket medical and dependent care expenses. Most people save as much as 25% on each dollar that is set aside.

How does the Health Care FSA work?

When you enroll in the Health Care FSA plan, you estimate the amount of health care expenses you expect to incur during the plan year. You have that amount deducted from your paychecks in equal amounts throughout the year. Although your actual salary remains the same, your taxable salary as reported to the government is reduced by the amount you put into your Health Care FSA.

After you enroll in the Health Care FSA, ASIFlex will send you a confirmation of your enrollment to your home address. As you incur eligible expenses throughout the plan year, you submit a claim along with documentation of the expense to be reimbursed with funds from your Health Care FSA account. You are not taxed on these reimbursements. After each claim, you will receive an account summary.

You can submit claims in a variety of ways, and you do not have to choose only one method. You can use a variety of submission methods during the year. You will have the following options:

- ASIFlex Online – Just go to www.asiflex.com and sign into your account. Scan your documentation and submit the claim.
- ASIFlex Mobile App – Just snap a picture of your itemized statement of services and submit via the mobile app for fast reimbursement! You can do this right from your provider's office!
- Manual Submission – Download a claim form from www.asiflex.com and submit with your documentation by toll-free fax or by USPS mail.

Federal rules state that you will only be able to be reimbursed for expenses you incur during the plan year and the accompanying FSA grace period. **Plan rules also state that if you do not use all of the money in your account, unused funds will be forfeited to the State.**

You can only change your election during the plan year as a result of a qualifying event. Also, your Social Security benefits calculations will be based on your lower taxable earnings figures. (You can check with your local Social Security office to explore any effects this may have on your benefits – which are usually very minor.) **The State of Delaware may require, at any time, employees to amend their Plan Year elections in order to maintain qualified status under the Plan.**

The State of Delaware has contracted with ASIFlex to perform certain administrative functions for the Plan. ASIFlex processes all claims for the Health Care Flexible Spending Account. If you have any questions concerning claims, please contact ASIFlex, P. O. Box 6044, Columbia, MO 65205, 800-659-3035, email: asi@asiflex.com, or on-line at www.asiflex.com.

ENROLLMENT

Enrollment Action Checklist

READ your Health Care FSA Benefits information in this booklet.

PLAN your out-of-pocket health, dental and vision care expenses for July 1, 2026 through June 30, 2027.

ENROLL by visiting de.gov/statewidebenefits.

Important Reminders

- Open Enrollment is the **ONLY** time during the year you can enroll in Flexible Spending, unless you experience a qualifying event (see below).
- Enrollment is **REQUIRED EACH YEAR** during Open Enrollment if you wish to continue your participation in Flexible Spending.
- FSA elections are irrevocable for the Plan Year. You may only change your election during the plan year if you, your spouse, or a dependent experience a qualifying event **AND** your desired election change corresponds with that event.
- Claims must be filed by **October 15th** following the end of the Plan Year. There are no exceptions to this rule. After that, your account will be closed and any balance remaining will be forfeited to the State of Delaware in accordance with federal regulations.

Eligibility: All active State employees who are benefit eligible*

** NOTE: If an Employee, the spouse of an Employee, or anyone else on behalf of the Employee contributes to a Health Savings Account (HSA) owned by either the Employee or the Employee's spouse, the Employee is not eligible to enroll in the Health Care Flexible Spending Account (FSA), unless it is a limited purpose Flexible Spending Account (FSA) as outlined in IRS Publication 969. The State of Delaware does not offer a Limited Purpose FSA.*

New Employee Enrollment. Benefit eligible employees are eligible to begin FSA coverage effective on the first of the month following the date of hire and can participate for the remainder of that plan year. You may enroll by completing an enrollment form available from your Human Resources Office or online at de.gov/statewidebenefits.

Completed enrollment forms must be submitted within 30 days of the employee's hire date to ensure timely enrollment. If you fail to enroll within the time period described above, then you may not elect to participate in the Plan until the next Open Enrollment Period or until a qualifying event occurs that would justify a mid-year election change.

Enrollment during Open Enrollment. Open enrollment for the Plan Year will be held **May 4, 2026 through May 15, 2026**. You may enroll online during open enrollment each year for the upcoming Plan Year. If you fail to enroll within the time period described above, then you may not elect to participate in the Plan until the next Open Enrollment Period or until a qualifying event occurs that would justify a mid-year election change.

Enrollment during the Plan Year. You may enroll during the plan year **ONLY** if you experience a qualifying event and the enrollment corresponds with a change in eligibility caused by that event. See the **Making a Change Section** for more information. Forms are available from your Human Resources office or online at de.gov/statewidebenefits.

Manage your account

Register your account at ASIFlex.com to see your account statement and balance, submit claims, sign up for email, text alerts and direct deposit.

Check out over-the-counter (OTC) products

Bandages, blood pressure monitors, diabetic supplies, contact lens solution, and sunscreen are just a few of the eligible OTC items. Go to ASIFlex.com and click on the FSA Store link.

Get the ASIFlex app!

Submit claims.
Submit documentation.
Access your balance and account statement.



Search ASIFlex Self Service and download the app today.

ASIFlex Customer Service

ASIFlex.com
asi@asiflex.com
P: 800.659.3035
F: 877.879.9038
P.O. Box 6044
Columbia, MO 65205-6044

MAKING A CHANGE

Except as specified in this section, your election under the Plan is irrevocable for the Plan Year. It is the employee's responsibility to file a change with their agency's Human Resources Office. To file a change, the employee may complete an ELECTION CHANGE FORM. The form is available at de.gov/statewidebenefits.

Navigation: *Select your group > Select Flexible Spending Account > Select Enroll or Make Changes*. The election change request must be filed within 30 days of the date of the qualifying event and becomes effective on the 1st of the month coincident with or following the event or the date the form is signed whichever is later and upon the approval of the request. Requests received after 30 days will not be approved.

You may change your election if you, your spouse, or a dependent experience an event listed below which results in a gain or loss of eligibility for coverage under the State of Delaware Health Care Flexible Spending Account Plan or a similar plan maintained by your spouse's employer or one of your dependent's employer and **your desired election change corresponds with that gain or loss of coverage**. Changes are only allowed if one of the specific events listed below has occurred that caused the needed change in your account. Otherwise, your election is effective through the end of the plan year.

Qualifying changes include:

1. Your legal marital status changes through marriage, divorce, death or annulment.
2. Your number of dependents changes by reason of birth, adoption (or placement for adoption), or death.
3. You, your spouse or any of your dependents have a change in employment status (termination, retirement, new employment, change from part time to full time or vice versa) **that affects eligibility** or the Health Care Flexible Spending Account with the State of Delaware or a plan maintained by your spouse's or any dependent's employer. Please see page 5 for specifics related to termination of employment from the State of Delaware.
4. 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 Flexible Spending Account Plan. 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 Flexible Spending Account Plan.
5. 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 Flexible Spending Account Plan.
6. 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 Flexible Spending Account Plan.

Your Salary Reduction amount for a pay period is, an amount equal to your annual contribution for your Health Care FSA election, divided by the number of pay periods in the Plan Year following your effective date. If you increase an election under the Health Care Flexible Spending Account Plan, your salary reductions per pay period will be an amount equal to your new contribution limit elected less the salary reductions made prior to such election change, divided by the number of pay periods remaining in the Plan Year beginning with the election change effective date.

Any increase in your election may include only those expenses that are incurred during the period of coverage on or after the effective date of the increase. Your coverage for the remaining period of the year shall be calculated by adding the amount of contributions made prior to the change to the expected contributions after the effective date of the change and subtracting prior reimbursements.

TERMINATION/RETIREMENT

Termination of participation. Your participation will end on the date in which you cease to be an Active Employee because of Retirement, Termination of Employment, Layoff, Reduction in Hours, or any other reason. Except as specified in the section on Coverage Continuation (COBRA), **Health Care expenses incurred while you are not a participant will not qualify for reimbursement.** Participation in the Health Care Flexible Spending Account ends on the day of termination or retirement, or on the date of your last paycheck with an FSA deduction.

Should you return to work as an eligible employee within 30 days during the same Plan Year, your participation will be reinstated as it was. If you return after 30 days during the same plan year, you will have the option of reinstating your coverage at the same annual level you had prior to your termination or reinstating your coverage at the same per pay period amount with a reduced annual amount. Should you choose the same annual amount, your per pay period contributions will be adjusted so that your total contributions for the year will equal your annual coverage amount. You have 30 days after you return to work during the same Plan Year to make a new election for the remainder of the Plan Year (not to exceed the annual plan maximum).

Your participation will also end at the end of the expiration of the Period of Coverage, if the Plan is terminated, or if you a file false or fraudulent claim for benefits.

Coverage Continuation (COBRA). To the extent required by COBRA, a participant or his/her spouse or dependent may elect to continue the coverage elected under the Health Care Flexible Spending Account Plan even though the participant's or his/her spouse's or dependent's election to receive benefits expired or was terminated, under the following circumstances:

- 1) Death of the participant;
- 2) Termination (other than for gross misconduct) or a reduction in hours;
- 3) After retirement;
- 4) Divorce of the participant; or
- 5) A dependent child ceases to be a dependent under the terms of this plan.

When the Plan is notified that one of the above events has occurred, the right to choose **continuation coverage** will be provided to each eligible person(s) if, **on the date of the qualifying event, the participant's remaining benefits for the current Plan Year are greater than the participant's remaining contribution payments.** The right to elect to continue ends **60 days** from the date the notice of the right to continue coverage is provided by the Administrator. It is the responsibility of the participant or a responsible family member to inform their Human Resources Office of the occurrence of an event described in bullet points 4 or 5 above.

Continuation coverage will not extend beyond the end of the current Plan Year but may terminate earlier if the premiums are not paid within 30 days of their due dates. **Payments for expenses incurred during any period of continuation shall not be made until the contributions for that period are received by the Administrator.** An administrative charge of 2% is assessed for each premium paid for continuation coverage.

Participants on Leave. If you are going on a leave of absence, you may need to complete required paperwork with your Human Resources Office. You may also be eligible to make adjustments to your annual Health Care FSA election.

If you are on a paid leave of absence and contributing to your Health Care FSA, you may continue your participation in the Plan.

If you are on an unpaid leave of absence **less than 30 days**, you will continue your Health Care FSA election. Upon returning to a paid status, coverage will be reinstated at the same annual election amount as you had prior to going unpaid. The deductions taken from your paycheck will be recalculated based on any contributions owed and the remaining paychecks in the plan year, which ends June 30.

To maintain Health Care FSA coverage while on an unpaid leave of absence of more than 30 days, you are required to complete a **LEAVE OF ABSENCE FORM** PRIOR to going on leave. The form is available online at de.gov/statewidebenefits. Navigation: *Select your group > Select Flexible Spending Account > Select the Leave of Absence form located under the FORM column.* By completing the LEAVE OF ABSENCE FORM you will have the option to either pay for coverage upon returning from unpaid leave* or revoke coverage during your leave of absence. If you do not elect to catch-up contributions when you return, the election and corresponding coverage will be revoked, effective the first day of the unpaid leave of absence or the date of your last paycheck with a Health Care FSA deduction, whichever is later. Once Health Care FSA coverage is revoked, the ASIFlex Debit Card will immediately be suspended.

**NOTE: If your unpaid leave of absence will extend beyond the end of the plan year, you are not eligible to catch-up contributions.*

If you are returning from a paid or unpaid leave of absence of **more than 30 days** you are eligible to adjust your Health Care FSA election, not less than your current contributions. An **ELECTION CHANGE FORM** may be completed and submitted to the Statewide Benefits Office within 30 days of returning to work. The form is available online at de.gov/statewidebenefits. Navigation: *Select your group > Select Flexible Spending Account > Select Enroll or Make Changes.* Coverage will be effective the 1st of the month coincident with or following the event or the date the form is signed, whichever is later.

Health Care FSA Participants called to Active Duty in the middle of the plan year. If you are a military reservist who is called to active duty for at least 180 days and are a Health Care FSA participant, you may request a Qualified Reservist Distribution (QRD) to access funds that might otherwise be forfeited. Requesting a QRD will allow you to access funds you have set aside in your Health Care FSA without incurring eligible expenses to seek reimbursement. If you request a QRD, the Plan will pay you the amount contributed to the Health Care FSA, as of the date of the QRD request, minus any reimbursements received as of the date of the request. QRDs are subject to employment taxes and will be included in your gross income and wages. A QRD will be reported as wages on your W-2 for the year in which the QRD is paid.

Once you request a QRD, you will forego the right to claim any additional expenses incurred while you were an active State employee. However, if you return from your military leave and re-enroll in the State of Delaware's FSA program during the same plan year, you may claim expenses incurred during your NEW period of coverage. All requests for a QRD must be submitted by the end of the FSA grace period (September 15th) following the close of the previous plan year. **For example**, if you would like to submit a request for a QRD for the FY27 plan year, you must submit this request no later than September 15th, 2027.

If you have questions about electing to receive a QRD, please contact your benefit representative for additional details.

ESTABLISHING AND USING YOUR HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Estimate your family's annual out-of-pocket health care expenses. You may include expenses for anyone who is a qualified dependent for tax purposes. (There are exceptions for the expenses of children of divorced parents. Please review IRS Publication 502 at www.asiflex.com, or consult with your personal tax advisor for further information.) When calculating your annual election, include predictable expenses only.

Plan Year Maximum \$3,400.00 FY26 Plan Year Minimum \$50.00

The Affordable Care Act states that an individual is not allowed to have more than the federal maximum per plan year allocated to a Health Care FSA. If you have a spouse who has access to a Health Care FSA through his/her employer, you may each set aside up to the \$3,400 calendar year maximum through your respective employers.

Qualifying Health Care Expenses include all medical, dental and vision expenses not covered or not reimbursed by insurance which are **incurred by you or your eligible dependent (definition available at www.asiflex.com) during the Plan Year or Grace Period** for health care as defined in Section 213(d) of the Internal Revenue Code. Please refer to the following list, or the Eligible Expenses Listing and IRS Publication 502 (available at www.asiflex.com) for further details on qualifying expenses.

Expenses qualify for the health care FSA based on when they are incurred, not when they are paid. Federal regulations do not allow any insurance premiums or long-term care expenses to be included under the FSA. Please review the eligible expense listing at www.asiflex.com, or contact ASIFlex at asi@asiflex.com or (800) 659-3035 if you have any questions regarding particular expenses.

Below is a partial listing of qualified health care expenses. Expenses can only be claimed based on the date incurred regardless of the date you are billed or pay for the expense.

- Deductibles
- Co-pays
- Doctor's fees
- Dental expenses
- Vision care expenses
- Prescription glasses
- Contact lenses and solutions
- Corrective eye surgery
- Prescription and over-the-counter drugs
- Chiropractor's fees
- Medical equipment
- Over-the-Counter health care products such as bandages, sunscreen, first aid kits, diagnostic tests/monitors, etc.
- Insulin
- Orthodontia/braces (See details on page 8)
- Routine physicals
- Hearing aids including batteries
- Transportation expenses related to seek health care

Non-Qualifying Health Care Expenses

This is a **partial** list of related items that **do not** qualify under the Plan. There may be other items that do not qualify that are not listed here.

- Cosmetic procedures; e.g. face-lifts, skin peeling, teeth whitening, veneers, hair replacement, removal of spider veins
- Clip-on or non-prescription sunglasses
- Warranties & insurance premiums
- Toiletries
- Long-term care expenses
- Medicines, drugs, herbs, or vitamins for general health and not used to treat a medical condition
- Expenses that are merely beneficial to your general health (e.g., vacations)
- Health club dues

NOTICE - Important Information Regarding Over-the-Counter Medicines and Health Care Products

Over-the-counter (OTC) drugs and medicines no longer require a prescription in order to be reimbursed by a flexible spending account (FSA). There are many OTC medicines as well as health care products, and none of these require a prescription! That's right! Take a look at what you can get without a prescription!

OTC MEDICINES & PRODUCTS - NO PRESCRIPTION REQUIRED
Allergy & Sinus medicines
Bandages, Band-Aids
Breast pumps, nose saline spray/drops, nasal aspirator, medicine dropper, ear syringe, etc.
Cold/cough/flu medicines
Cold sore medicines
Diabetic supplies, insulin, glucose monitor, testing strips, syringes, sharps containers, diabetic cases/coolers
Denture adhesives
Eye care, reading glasses, contact lens cleaners/storage kits, eye patches
Family planning, condoms, contraceptive creams, fertility monitors, ovulation prediction kits
First aid kits, first aid supplies
Feminine hygiene products
Glucosamine, arthritis formula
Hearing aids, batteries
Incontinence supplies, adult diapers, pads, absorbent underpads
Joint support bandages/braces, wrist, hand, neck, elbow, knee, ankle, etc.
Laxatives
Medic-alert bracelets or necklaces
Medical equipment and repair; crutches, canes, walkers, wheelchairs
Medical monitoring/testing devices, blood pressure monitors, blood glucose testing kits, cholesterol test kits, colorectal cancer test kits, etc.
Orthopedic and surgical supports, aqua casts, splints
Ostomy products, catheters
Pain Relievers (Aspirin, Ibuprofen, etc.)
Pill holders, pill splitters
Prenatal vitamins
Sleep aids
Smoking cessation patches & gum
Sunscreen & Lip Balm, SPF 15 and higher
Vaporizers, humidifiers, thermometers

Orthodontia Expenses (Braces). Participants may use their Health Care FSA for orthodontia expenses (braces), **however there are specific rules and guidelines.** The State of Delaware allows employees to be reimbursed for a *reasonable* down payment (at the time this payment is made), and a monthly contracted amount. **Claims submitted for upfront payments paid in full will not be eligible for reimbursement under the State of Delaware’s Health Care FSA.**

In order to receive reimbursement for orthodontia expenses (braces), **a copy of the original contract must be submitted to ASIFlex showing the total dollar amount the participant is responsible for,** less any down payment amount as well as the estimated length of time the treatment will last. **Orthodontia expenses (braces) are incurred at the time a monthly payment is due and paid.** These monthly payments **must** be spread out evenly over the expected period of treatment. **If you have questions about using your Health Care FSA dollars for orthodontia expenses, visit www.asiflex.com or email asi@asiflex.com.**

Health Care FSA Eligible Dependents - Expenses for you and your spouse are automatically eligible for reimbursement through the Health Care FSA. Federal rules stipulate that expenses for your children or tax dependents will qualify for reimbursement through the program if one of the following criteria are met:

- 1) The individual must qualify as a tax dependent, as either a Qualifying Child or a Qualifying Relative:
 - a. **Qualifying Child** – in order for someone to qualify as a **tax dependent** as a Qualifying Child, the individual must:
 - Be the taxpayer’s child (including an adopted child, stepchild or eligible foster child), brother, sister, stepbrother, stepsister or a descendant of one of these relatives;
 - Be under the age of 19 (age 24 if a full-time student); and
 - Live with the taxpayer for more than half of the year; and **NOT** have provided over half of his or her own support during the year and cannot be claimed as a “qualifying child” by any other taxpayer.

OR

- b. **Qualifying Relative** – in order for someone to qualify as a **tax dependent** as a Qualifying Relative, the individual must:
 - Be a blood relative or reside with the taxpayer if not a blood relative;
 - Receive over half of his/her support from the taxpayer; and
 - Be a US citizen.

OR

- 2) Under the health care FSA, you may also include qualified expenses for your adult child(ren), even if they are not considered a tax dependent, until the end of the calendar year in which your child(ren) reaches age 26. In order to be eligible, the individual must be a “child” of the taxpayer (son, daughter, stepson, or stepdaughter) and be age 26 or younger for the entire plan year in which medical expenses are claimed. Your child does not need to live with you in order for you to claim his/her health expenses that you have incurred on his/her behalf. Please see IRS Notice 2010-38 for further information.

Receive health care services. A health care expense is **incurred** when the services are provided that create the expense. You must receive the services before you file a claim for those services.

File claims. After you have received the health care services and know the amount of your responsibility for the bill, you may submit a claim for those expenses to ASIFlex. See **Flexible Spending Account Claims** for details on claims filing. Extra claim forms are available at www.asiflex.com or de.gov/statewidebenefits.

Grace Period. If you are a participant as of June 30th of a Plan Year, you may continue to incur expenses through September 15th of the following Plan Year to use any remaining funds in the Plan Year that just ended. Claims for expenses incurred during this Grace Period are paid from the oldest year's funds first unless you request otherwise.

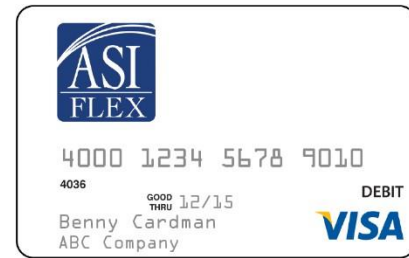
Example: *If you have \$50 remaining in your FY27 health flexible spending account as of July 1, 2027 and incur an expense for \$100 on August 10, 2027, this claim will be paid using \$50 from your FY27 FSA and the remaining \$50 from your FY28 FSA. If you do not want a claim for services provided July 1st through September 15th paid out of the old plan year, please write a note and enclose it with your claim form.*

Receive reimbursements. ASIFlex will review your claim, and if approved will reimburse you for the medical expenses within one to three business days of their receipt of the claim.

Payment from your Health Care Flexible Spending Account will be made up to the approved amount of your claim or your remaining annual election, whichever is less. Payment is not limited to the amount in your account at the time of your claim. Your per pay contributions will continue for the remainder of the Plan year.

THE ASIFLEX DEBIT CARD FOR YOUR HEALTH CARE EXPENSES

The ASIFlex Debit Card provides a convenient method to pay for out-of-pocket health care expenses for you, your spouse and/or any qualified dependents. The IRS has stringent regulations regarding appropriate use of the ASIFlex Card, such as **where the card can be used, and when follow-up documentation is required. Use of the ASIFlex Debit Card is not paperless and DOES NOT eliminate paperwork.** The ASIFlex Debit Card is a great benefit, but it is important that you take a moment and understand how it works.



Where can the ASIFlex Debit Card be used?

Per IRS regulations, the ASIFlex Debit Card can only be used at Health Care Providers (based upon the Merchant Category Code) and at stores that have implemented an Inventory Information Approval System (IIAS).

- 1) **Health Care Merchant Category Codes (MCC):** Every merchant that accepts credit cards has an MCC, which is a general category that is assigned when the merchant applies for the right to accept credit cards. The ASIFlex Card will work to pay providers that have an MCC that indicates the merchant is a health care provider (hospital, doctor, dentist, optometrist, chiropractor, etc.).
- 2) **Inventory Information Approval System (IIAS):** The IRS also allows the ASIFlex Card to be used at retail stores that have IIAS in place. IIAS restricts purchases with your ASIFlex Card to eligible expenses, and you will never be prompted for follow-up documentation for purchases at these stores. Please note that if you have a medical condition that allows you to claim expenses that are not normally eligible, the ASIFlex Card will not be able to pay for these expenses at these stores. You will have to pay with a separate form of payment and submit a claim. The ASIFlex Card will work at these stores, even if the MCC does not indicate it is a health care provider.

A list of stores with this system in place now (and some expected in the future) is available online, at www.asiflex.com/debitcards. **Purchases at these stores will never require follow-up documentation provided the merchant has identified the product as FSA eligible!**

Do I have to turn in documentation when paying with the ASIFlex Card?

If you use the ASIFlex card, you are only required to submit backup documentation if the transaction is unable to be electronically substantiated. ASIFlex will notify you if documentation is required for a card transaction. **You should check your secure messages through your account at asiflex.com.** Also, be sure to ask for an itemized statement of service each time you use the card, and keep copies of all insurance plan explanation of benefit statements.

Which claims can be electronically substantiated?

ASIFlex Debit Card transactions can be accepted by the FSA administrator without any follow up if the merchant is an acceptable merchant type such as a physician's office or hospital and at least one of three other criteria are met. Transactions are electronically substantiated if:

- ✓ The dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment or any combination of any known co-pays up to five times the highest known co-pay, for the **state-sponsored** health, vision or dental plan that participant has elected;
- ✓ The expense is a recurring expense that matches expenses previously approved as to amount, provider, and time period (e.g., for an employee who pays a monthly fee for orthodontia at the same provider for the same amount); or
- ✓ The merchant maintains a compliant Inventory Information Approval System (IIAS) for over-the-counter supplies (e.g., Band-Aids, contact lens solution, etc.) and medication (this system restricts purchases with the ASIFlex Card to FSA-eligible expenses).

Any transaction that does not meet the above criteria will prompt a request for follow-up documentation.

What happens if I don't submit requested documentation?

As detailed above, there are times when you may use the ASIFlex Debit Card to purchase FSA eligible items or services and additional documentation will be required to substantiate the transaction, in accordance with IRS Regulations. When follow up documentation, or a statement of services is required, ASIFlex will send you an e-mail or letter requesting this documentation. The requested information should include the following information: name of provider, name of member (or member's spouse or dependent), date the service was provided, brief description of the service(s) provided, and the amount that was your responsibility. You can request an itemized statement from the provider, or you can submit your insurance plan explanation of benefits to substantiate the transaction.

ASIFlex will send the initial request for follow up documentation within a few days of the ASIFlex Card transaction. Should you not comply with the request, ASIFlex will make a second request in approximately three weeks. Should you not comply with the second request, a third notice will be sent to you stating that the ASIFlex Card has been "suspended" because the requested documentation was not received by ASIFlex.

When you use the ASIFlex Card for a transaction requiring documentation, those dollars are identified as "overpaid" within your FSA account until the transaction is substantiated.

If you submit a manual claim before the ASIFlex Card transaction is substantiated, the dollars associated with the manual claim will be used to offset the overpaid dollars from the ASIFlex Card transaction. This will prevent the manual claim from being reimbursed in part, or in full, depending upon the dollar amount of the manual claim. Once the ASIFlex Card transaction is substantiated, the manual claim used to offset the ASIFlex Card transaction will be reimbursed in full. See the following examples for further explanation:

Example 1: John goes to the dentist and pays \$200 for a root canal with his ASIFlex Card. He then receives a notice from ASIFlex requesting follow up documentation. John submits the statement of services from his dentist along with the notice received from ASIFlex. ASIFlex reviews and processes the follow up documentation to substantiate the claim. John's FSA account will no longer be showing as "overpaid" since all follow up documentation was submitted.

Example 2: Lisa pays her eye doctor \$250 for contacts using her ASIFlex Card. ASIFlex sends Lisa a notice asking for follow-up documentation for the \$250 purchase. Prior to submitting the detailed statement from her eye doctor, Lisa submits a manual claim to ASIFlex for a \$100 prescription which she paid for out-of-pocket. ASIFlex will process the \$100 claim but no payment will be issued that day. Instead, the amount of the manual claim will be used to offset the ASIFlex Card transaction. This will result in ASIFlex showing Lisa's overpaid amount reduced from \$250 to \$150. Two weeks later Lisa submits the follow up documentation for the ASIFlex Card transaction used to purchase the contacts to ASIFlex. ASIFlex will then process the supporting documentation for \$250 and Lisa will be issued a payment of \$100 for her manual prescription claim.

If you are unable to provide documentation for an ASIFlex Card transaction in question, you may submit expenses incurred out-of-pocket to offset the ASIFlex Card transaction. The expenses that are incurred out-of-pocket must not also be paid for using the ASIFlex Card.

Should you neglect to submit the requested documentation and the plan year comes to a to an end (following the Plan's provision for documentation to be submitted by October 15), ASIFlex will provide notice to the State of Delaware that the claim was not substantiated within the plan year as required by IRS Regulations. **If you are actively employed by the State of Delaware and do not repay your claims, a wage attachment will be processed to deduct the amount of the unsubstantiated claim/s from your pay.**

If you do not provide requested documentation and leave State of Delaware employment or retire, a W-2 will be provided to you for the year in which the funds were not repaid and these funds will be reported to the IRS as earnings for which taxes must be paid. See the following example for further explanation:

Example: Lori's daughter Carrie goes to the dentist to receive a crown during the FY27 plan year. Lori uses her ASIFlex Card for the \$750 expense. Lori terminates employment the following week. ASIFlex sends Lori three notices requesting follow up documentation, and receives no response or repayment from Lori. At the end of the plan year (following the grace period provision to September 15, 2027) ASIFlex will notify the State of Delaware of the overpayment. The State of Delaware will then issue a W-2 for 2027 in January, 2028, to the member and to the IRS, which will report the \$750 overpayment as taxable income.



While the ASIFlex Debit Card provides a convenient method to pay for out-of-pocket health care expenses, the ASIFlex Debit Card is **NOT** a paperless option and **DOES NOT** eliminate paperwork. There are times when you may use the ASIFlex Debit Card to purchase FSA eligible items or services and additional documentation **will still be required** to substantiate the transaction in accordance with IRS Regulations.

Concerns and questions regarding this process should be directed to ASIFlex at asi@asiflex.com or 1-800-659-3035.

Is there a cost for the ASIFlex Card?

No. There is no cost for the ASIFlex Card.

How do I request an ASIFlex Card?

You can request to receive an ASIFlex Card through the online enrollment site available during open enrollment, or by completing the ASIFlex Card application form found on the Statewide Benefits website. Generally, it takes about two weeks to receive the card once it has been requested.

Can I request additional ASIFlex Cards?

Yes. Everyone who requests a card will receive two ASIFlex Cards in the mail. If you would like additional cards, complete the ASIFlex Card application form and submit to ASIFlex. Please note that all ASIFlex Cards will be in the name of the FSA participant.

I had an ASIFlex Card for FY26 and re-enrolled in the FSA for FY27. Will my FY26 card still be valid?

Yes, as long as the card is not expired and you have re-enrolled in the FSA program for FY27, your ASIFlex Card will be funded with your new annual election as of July 1, 2026. Please do not throw away your ASIFlex Cards from previous plan years until the expiration date on the physical ASIFlex Card passes. If you have discarded or destroyed your ASIFlex Card and would still like to use the card in FY27, please request a new card by signing into your account. Under the Resources heading on the Main Menu, click on the *Debit Card Information* button. Then click on the *FSA Debit Card Order Form*.

Can I use the ASIFlex Card to pay for OTC medicine at stores that have implemented IIAS?

Yes. Since the requirement for a prescription has been removed, you will be able to pay for OTC medicine with the ASIFlex Card. You may also use the card to purchase OTC health care products.

False or Fraudulent Claims. If ASIFlex believes that false or fraudulent claims have been submitted, ASIFlex will investigate the submitted claims and forward, with all investigational findings, to the State of Delaware's Statewide Benefits Office for further investigation. In the interim, ASIFlex will deny your claim and notify you that your account has been placed on hold until the situation has been resolved. The Statewide Benefits Office will make a decision as to whether your participation will be terminated in FSA and whether to recover any funds that may have been fraudulently obtained. The State of Delaware has the authority to deny claims found to be false or fraudulent and to terminate your participation in the FSA in accordance with its discretionary duty as the Plan Administrator. The State of Delaware may take legal or disciplinary action against a member found to have committed fraud.

FLEXIBLE SPENDING ACCOUNT CLAIMS

- Claims processed daily – within 1-3 business days of receipt of qualified claim.
- File Claims Online! Go to www.asiflex.com, account detail section, and upload your scanned documentation.
- Go mobile! Snap a picture of your documentation and submit via the ASIFlex Mobile App.
- Fax Claims: 1-877-879-9038
- Mail Claims: P O Box 6044 Columbia, MO 65205-6044
- Go to www.asiflex.com for claim forms and personal account information.
- Direct deposit is available for claims payment – Sign up through your online account.
- Direct deposit notices are sent via E- mail or USPS the day that payment is initiated.
- Email/Text Alerts – Sign up through your online account.

Allowable expenses must be incurred during the portion of the Plan Year or Grace Period that you are a participant.

Claims must be filed by October 15th following the end of the Plan Year. After that, your account will be closed and any balance remaining will be forfeited to the State of Delaware in accordance with federal regulations.

You must submit your claim along with copies of itemized statements of service from the provider to serve as proof that you have incurred an allowable expense in order to receive payment. Itemized Statements of service are required to include, the provider's name/address, patient name, the date(s) of service, a description of the service(s), and the expense amount. You may also submit a copy of your insurance plan explanation of benefits statement to substantiate your claims. Copies of personal checks and paid receipts, without the above information, are not acceptable. Documentation or copies will not be returned.

Information on Over-the-counter Medicines and Supplies: For over-the-counter medicines and supplies that do not require a prescription, the receipt or documentation from the store must include the name of the item pre-printed on the receipt.

Claim forms are available online at www.asiflex.com or de.gov/statewidebenefits.

Purchases for general good health are not eligible.

Claims for items that are purchased for an existing medical condition must be accompanied by a letter from your attending physician stating the medical condition and the items that are required as treatment for that specific medical condition (if they would otherwise not qualify as a general good health item). A sample letter is available at www.asiflex.com. This letter can be used as support for 12 months from the date of the letter. To learn which expenses may require a letter from your attending physician, view the Eligible Expenses listing at www.asiflex.com.



GO GREEN!!!

Electronic Communications – You can sign up to receive email and text alerts instead of mail. Sign into your account at www.asiflex.com and update your account settings under “Manage Your Account.”

Direct deposit into the bank account of your choice is available for your claim payments. By using direct deposit you will not need to wait for a check to arrive and be deposited. A notice that a payment was made will be sent to you. To sign up for direct deposit, sign into your account at www.asiflex.com and update your account settings under “Manage Your Account.”

If you receive a check for reimbursement and forget to cash it, the check is valid for six months from the issuance date. If you have received a check and have not cashed it within six months, ASIFlex will attempt to contact you via email or postal mail, and will offer to reissue the reimbursement to you. If ASIFlex cannot reach you, the amount of the uncashed check will be reported and remitted to your state of residence's unclaimed property division. For State of Delaware residents, remittance shall be made to the State of Delaware Department of Finance, Bureau of Unclaimed Property.

If you have unused funds at the end of the claims filing period, those funds are forfeited to the State of Delaware and used to a) offset reimbursements to health care FSA participants who terminate employment mid-year and have been reimbursed more than contributed at that point in time and b) pay ASIFlex's administrative fees.

If a claim is denied in whole or in part, ASIFlex will notify the Participant in writing within 30 days of the date that ASI received the claim. This time may be extended for an additional 15 days for matters beyond the control of ASIFlex. Notification of a denied claim will include:

- The specific reasons for the denial;
- The specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary to validate the claim and an explanation of why such material or information is necessary; and
- Appropriate information on the steps to take to appeal ASI's adverse benefits determination*

**If a claim for benefits is denied in whole or in part, an appeal process is available. Participants may appeal by sending a signed letter of appeal to ASIFlex within 30 days after the denial is received. If ASIFlex denies the appeal, participants may appeal a second and final time within 20 days of the denied appeal by sending a signed letter of appeal to the following address: Appeals Administrator, RE: APPEAL, Statewide Benefits Office, 841 Silver Lake Boulevard, Suite 100, Dover, DE 19904. If an appeal is not made within the above referenced timeframes, all rights to appeal will be forfeited.*

Here are a few simple rules to keep in mind:

- The FSA plan is regulated by the IRS.
- You do not have to pay federal income tax, FICA tax, and (in most cases) state income tax on pretax dollars.
- You can enroll each year, and make a new election each year during open enrollment.
- You can access your total elected amount for health care, even if you have not contributed all funds.
- Qualified expenses are eligible if incurred during your period of coverage. Incurred means the service was provided that gave rise to the expense, regardless of when paid, billed or charged.
- Each FSA is separate and distinct; you cannot take money from the Dependent Care FSA to put into the Health Care FSA or vice versa.
- You can use the health care funds to pay for your own health expenses, as well as health care expenses for your spouse and eligible children.
- Your election remains in effect for the plan year. However, you may be able to change your election mid-year if you have a qualifying status change as described in the plan.
- The FSA is a year-to-year account so you should set aside only what you know you will spend on a regular and recurring basis, or planned expenses that you know you will incur during the plan year.
- Unused funds are forfeited. You can avoid forfeitures by planning carefully and setting aside enough to pay for predictable and recurring expenses.
- Submit your claims no later than October 15, 2027.

Provider Direct Pay

ASIFlex offers a way for you to pay your provider using your health care flexible spending account.

The Direct Pay program eliminates your need to pay the health care provider in advance and then file a claim for reimbursement. It also eliminates the waiting for reimbursement from your Health Care account. Direct Pay can be set up as a one-time payment or a recurring payment.

How will this help you?

- Payments are made directly to your health care provider on the schedule you and the provider choose.
- You no longer need to file claims.
- The full amount that you owe will be paid to the provider using any funds that are available in your Health Care Flexible Spending Account.
- You will receive notification of the payment (as will your provider).
- You can make changes to or stop payments at any time, if recurring payment is set up.
- Hassle free payment process for recurring expenses such as orthodontia payments, physical therapy and chiropractic visits.
- This feature is completely **free** to you!

How do you get started?

You can enroll in the program by logging into your account at www.asiflex.com. Click on *Schedule a Recurring or One-Time Direct Payment* and simply enter the requested information. If your provider is not currently participating, you can request that ASIFlex reach out to recruit your provider.

Once you are enrolled in the Direct Pay program, you will have the ability to view the payments that have been made on your behalf.

Payment Process

Payment from your Health Care Flexible Spending Account will be made up to the approved amount of your claim or your current balance, whichever is less. The provider will receive payment directly from ASIFlex. Any amount you owe the provider in excess of your available Health Care FSA funds will need to be paid separately by you.

Important Things to Remember:

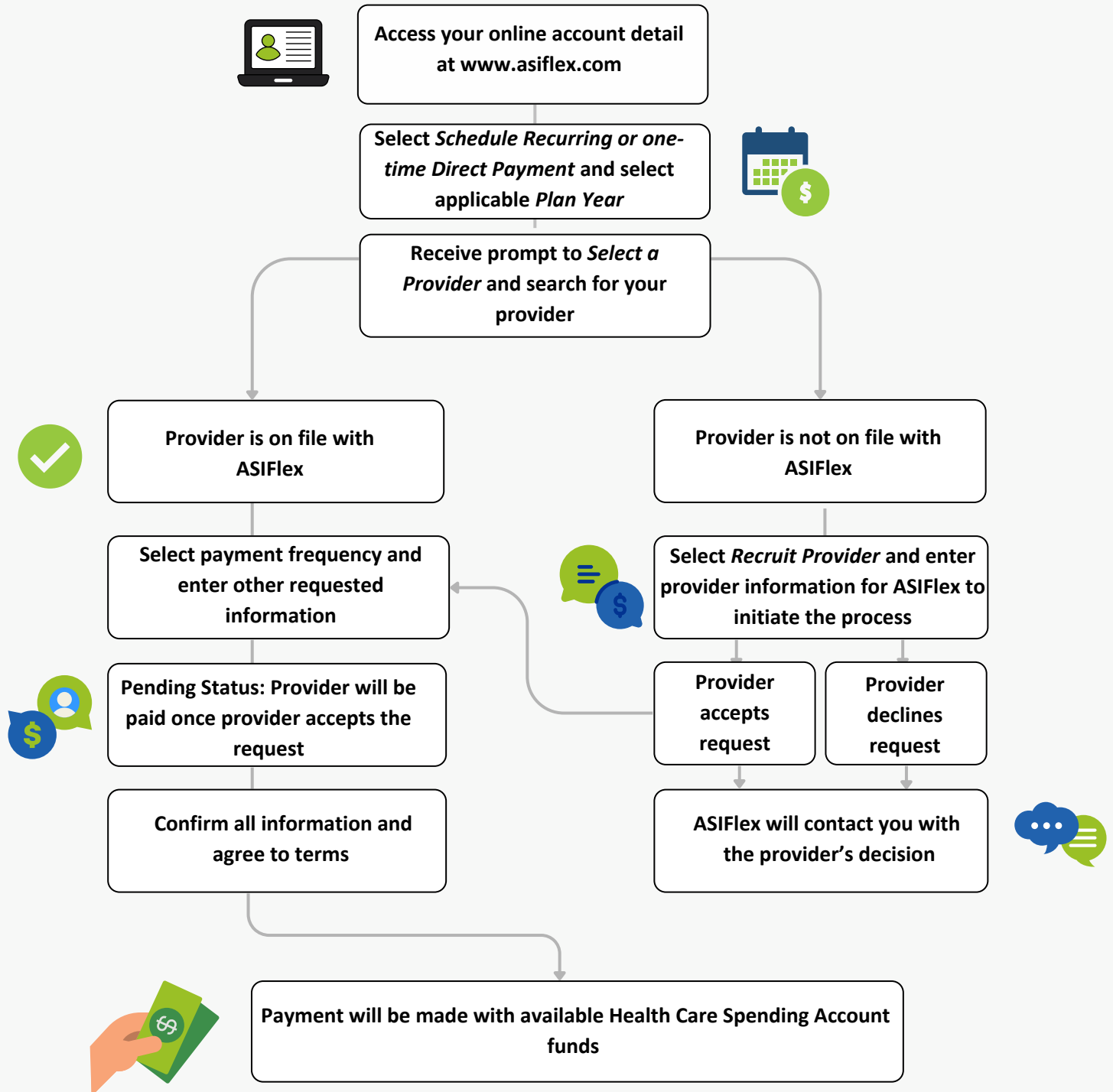
- If you terminate employment, your participation in the Direct Pay program will end as well.
- Your health care provider must agree to participate in the program. If they agree to participate, they will certify to ASIFlex that the services are being provided.



Provider Direct Pay

How Does It Work?

Reserve a portion of your FSA annual election amount for payment to a designated provider.
Set up options for a recurring payment or a one-time payment, including a future event!



ONLINE ACCESS

You can access your Health Care Flexible Spending Account online 24/7. If you have not yet set up your account, simply click the “Create an Account” button and follow the instructions.

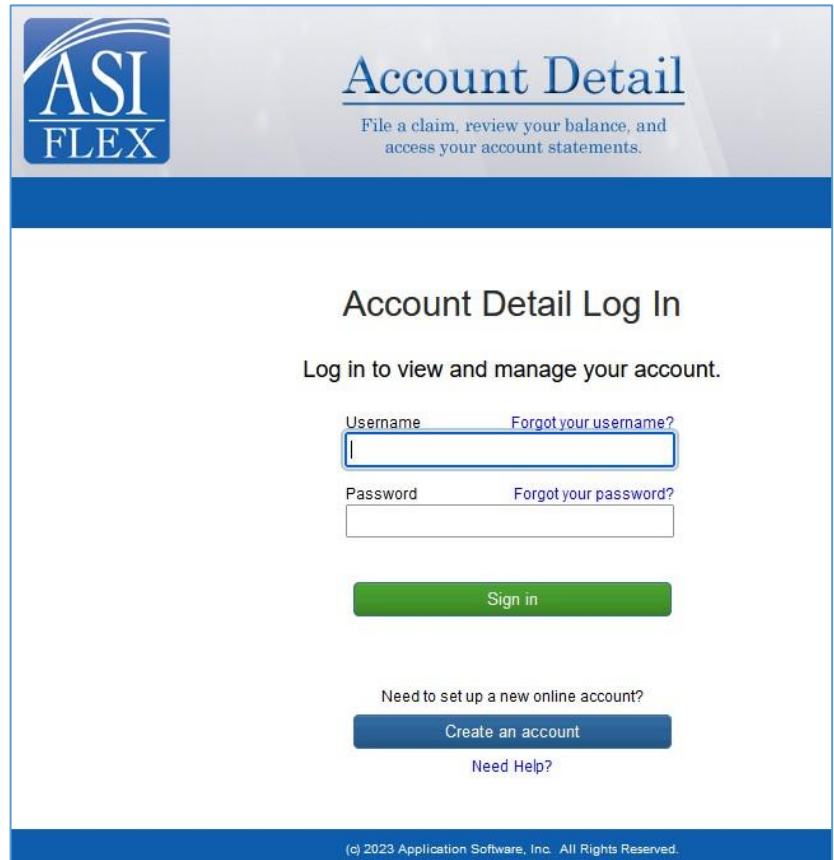
To access your account:

1. Go to asiflex.com
2. Select “**Employee (Participant) Login.**”
3. Sign in using your User Name, Password and Security Image.

Online access allows you to manage your FSA anytime, anywhere! Register to access your Account Detail at ASIFlex.com.

- Sign up for email and text alerts
- Sign up for direct deposit reimbursements
- Access your account statement and balance
- Read secure messages sent to you from ASIFlex
- Submit claims

ASIFlex.com is an educational site as well. You can view an extensive listing of eligible expenses, read frequently asked questions, view educational videos, obtain claim and administrative forms, and access IRS forms and publications.



ASIFLEX MOBILE APP



ASIFlex provides access to your account with its free mobile app. The app works on your mobile devices such as your smartphone or your notepad. You can download the app from either the Google Play store or the App Store for free!

Use the ASIFlex mobile app to check your balance and submit claims or backup documentation for the ASIFlex card from the palm of your hand.

Just snap a picture of your itemized statement of services and submit via the mobile app for fast reimbursement! You can do this right from your provider’s office!