

Tax\$ave

State Employees who are Eligible for the State Health Benefits Program

SPECIAL NOTICE ON PENSION REFORM AND SECTION 125 PLANS

Chapter 78, P.L. 2011, the Pension and Health Benefit Reform Law, requires local government and local education employers to offer Section 125 plans to their employees.

Local employers must establish their own Section 125 programs.

Local government and local education employees should contact their human resources office or benefits administrator to determine the specific plans and benefits that are available.

The Tax\$ave Program is only available to eligible State employees as defined below.

TAX\$AVE FOR STATE EMPLOYEES

Tax\$ave, a benefit program available under Section 125 of the Federal Internal Revenue Code, allows eligible employees of the State of New Jersey to set aside before-tax dollars to pay for certain medical, dental, and dependent care expenses, thereby avoiding federal taxes and saving money.

An eligible employee is any **full-time** employee of the State or a State college or university who is eligible to participate in the State Health Benefits Program. Tax\$ave is **only** available to State employees.

Tax\$ave consists of three separate component plans. An eligible employee may elect to participate in any combination — all, some, or none of the plans.

The three components of Tax\$ave are:

- The **Premium Option Plan (POP)** allows an employee to pay any State Health Benefits Program medical and/or dental payroll contributions or premiums with before-tax dollars;
- The **Unreimbursed Medical Flexible Spending Account** allows an employee to set aside money to pay for qualified medical and dental expenses not paid by any group benefits plan under which the employee and dependents are covered; and
- The **Dependent Care Flexible Spending Account** allows an employee to set aside funds to pay for anticipated expenses related to dependent care required to permit the employee and spouse to work.

Note: Tax savings on commuter mass transit and parking expenses are available as a separate benefit to State employees under the Commuter Tax\$ave Program. See Fact Sheet #67, *Commuter Tax\$ave Program*, for details.

PREMIUM OPTION PLAN

If you are an employee eligible to participate in the State Health Benefits Program (SHBP), you can save on taxes by participating in the Premium Option Plan (POP). The POP allows you to pay any of your SHBP medical and/or dental payroll contributions or premium deductions with before-tax dollars. The contributions or

premiums you already pay for your coverage are deducted from each paycheck before federal income and FICA (Social Security and Medicare) taxes are calculated, thereby reducing the taxes withheld. The amount of your savings depends on a variety of factors, such as the amount of the contributions or premiums and your income tax filing status. The plan runs on a calendar-year basis.

If you have a payroll contribution or premium deduction for medical and/or dental coverage, you are automatically enrolled in POP and will pay less taxes. If you choose to decline enrollment in the POP, you must sign and return a *Declination of POP* form each year to your benefits administrator.

POP will increase your take-home pay by reducing your taxes; it does not change the medical and/or dental contributions or premiums you are required to pay.

EFFECT OF POP ON SHBP RULES AND PROCEDURES

The Internal Revenue Service (IRS) strictly regulates the POP because of the tax advantages provided. IRS rules require that for an employee covered by the POP, payroll deductions for medical and dental plan benefits remain the same for the entire plan year. Therefore, no coverage level change can be made which results in a change in the amount of your medical and/or dental plan deduction *unless* a "qualifying event" occurs. If a qualifying event does occur, you may make a change by submitting a completed SHBP medical and/or dental plan application to your employer within 60 days of the event or during the annual Open Enrollment period.

Qualifying Events

Plan elections in effect at the beginning of the plan year will continue throughout the calendar year or upon the occurrence of a "qualifying event." The following are considered qualifying events:

- A marriage (you may enroll your spouse and any other eligible dependents). See also "Civil Union Partners, Domestic Partners, and Tax\$ave" on page 7.
- Addition of an eligible dependent due to birth, adoption, or legal guardianship.
- A change in family status involving the loss of eligibility of a family member (divorce, death; child attains age 26).
- A move outside an HMO service area.
- The termination of your employment for any reason, including retirement.
- An approved unpaid leave of absence (you are entitled to elect the POP upon return to active employment).
- A change in your spouse's or eligible dependent's employment status resulting in their loss of medical and/or dental coverage.
- Such other events that may be determined to be appropriate and in accordance with applicable IRS regulations.

UNREIMBURSED MEDICAL FLEXIBLE SPENDING ACCOUNT

The Unreimbursed Medical Flexible Spending Account (FSA) allows you to save taxes on out-of-pocket medical and dental expenses that reduce your spendable income. Contributing money to the Medical FSA can result in a reduction in taxes because the money you contribute to your account is free from federal income, Social Security, and Medicare taxes and remains tax-free when you receive it.

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Under the Unreimbursed Medical FSA, each calendar year you may set aside up to \$2,500 of your salary before taxes in a health care spending account, so that you and your eligible dependents can be reimbursed for eligible expenses incurred during the year. Eligible expenses include copayments and deductibles for medical, prescription, and dental bills, qualified expenses for medical services not covered by health plans or your State vision plan such as contact lenses solution, hearing aids, etc., and other health care expense you can deduct on your income tax, except payroll contributions or premium deductions for health care which are covered under the POP (see above for details).

Effective January 1, 2011, **over-the-counter drugs and medicines are no longer eligible for reimbursement without a prescription from an attending provider.** This includes over-the-counter items like: allergy drugs, pain relievers, cold and cough medicines, sleep aids, digestive aids, anti-gas medications, baby rash creams, and insect bite treatments. To be reimbursed for these types of over-the-counter items using your Unreimbursed Medical FSA, you must obtain a doctor's prescription and submit it with a *Claim Form* for reimbursement. (**Note:** The *WageWorks® Health Care Card* can be used to pay for over-the-counter items that are accompanied by a prescription and filled by the pharmacist.)

Over-the-counter items like eyeglasses, wrist splints, and bandages, as well as durable medical items such as crutches and canes will continue to be reimbursed without a doctor's order.

IRS Publication #502, *Medical and Dental Expenses*, provides a complete list of services eligible for reimbursement.

Using Your Unreimbursed Medical FSA

First, you must estimate how much you will spend on unreimbursed health care during the plan year. Based on the amount you elect, contributions will be taken out of your paycheck each pay period throughout the calendar year. It is important to base this estimate on past experience **because unused contributions must be forfeited.** Carefully review your history of unreimbursed health care expenses before making an election, to anticipate what you will spend in the coming year and eliminate the possibility of having to forfeit unused contributions at the end of the calendar year.

You may submit claims to the Medical FSA for unreimbursed expenses between January 1 of the plan year and March 15 of the following year (For example: January 1, 2012 through March 15, 2013).

Claim forms for eligible expenses must be submitted no later than April 30 of the following year.

When you file your claim, you will be reimbursed for up to the total amount you have elected to contribute, whether or not the deductions from your pay to date have totaled the amount of your claim. When filing for reimbursement, you must verify that you have not been reimbursed for the expense from any other source.

While the federal government offers a federal income tax deduction for unreimbursed eligible health care expenses which exceed 7.5% of your adjusted gross income, the Medical FSA offers tax-free reimbursement on each and every dollar of your eligible expenses, which may provide immediate tax savings for those who do not meet the medical expense deduction threshold. In addition, the Medical FSA saves you Social Security and Medicare taxes, another 7.65% on every dollar. Keep in mind, however, that you cannot deduct expenses reimbursed by the Medical FSA on your federal income tax.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

If you have to pay for care for your dependents in order to work, you may want to take advantage of the Dependent Care Flexible Spending Account (FSA) plan. Contributing money to the Dependent Care FSA can result in a reduction in taxes because the money you contribute to your account is free from federal income,

Social Security, and Medicare taxes and remains tax-free when you receive it. The plan allows you to set aside up to \$5,000 of your salary before-taxes each calendar year to pay for qualified dependent care expenses incurred in that calendar year. You then file claims for reimbursement of eligible expenses. Note that when you file your Dependent Care FSA claim, you cannot be fully reimbursed until your deductions to date from your pay are at least equal to the amount of your claim.

Eligible dependents include an employee's children below age 13, the employee's non-working spouse if physically or mentally incapable of self-care, and any other person considered a dependent for tax purposes who is incapable of self-care and who normally spends at least eight hours each day in the employee's home. The types of services eligible for reimbursement include a qualified day care center, nursery school, or summer day camp (but not overnight camping), a baby-sitter if needed to allow the employee to work, a housekeeper whose duties include day care, and someone who cares for an elderly or incapacitated dependent.

IRS Publication #503, Child and Dependent Care Expenses, provides a complete list of dependent care expenses.

Using Your Dependent Care FSA

First, you must estimate how much you will spend on dependent care during the plan year. Based on the amount you elect, contributions will be taken out of your paycheck each pay period throughout the calendar year. It is important to base this estimate on past experience **because unused contributions must be forfeited**. Carefully estimate of your dependent care expenses before making an election to eliminate the possibility of having to forfeit unused contributions at the end of the calendar year.

You may submit claims to the FSA for dependent care provided between January 1 of the plan year and March 15 of the following year (For example: January 1, 2012 through March 15, 2013). Claim forms for eligible services must be submitted no later than April 30 of the following year.

The federal government offers a dependent care tax credit on your federal income tax that you can use *instead of* the Dependent Care FSA. You will have to decide which method is better for you based on your income and personal tax status. Keep in mind, however, that any payment received from the Dependent Care FSA will reduce dollar-for-dollar the amount that can be considered for dependent care tax credit and vice versa.

Under the federal dependent tax credit provision, you can take a direct tax credit on your income taxes ranging from 20% to 30% of your eligible dependent care expenses. With the tax credit, eligible care expenses are limited to an annual maximum of \$2,400 for one dependent or \$4,800 for two or more dependents.

Generally, if your adjusted gross income is more than \$24,000 a year, using the Dependent Care FSA is better. For example, if you're paying \$90 per week (about \$4,700 per year) for day care and you're in the 15% federal tax bracket, you would save \$1,060 in taxes by paying your day care bills through your Dependent Care FSA. If you are in the 28% federal tax bracket, your savings would be \$1,670.

USE IT OR LOSE IT

*Under either the Unreimbursed Medical FSA or the Dependent Care FSA, **any unused contributions remaining in an account at the end of the plan year are forfeited**. You have until **April 30** of the following year to file for eligible reimbursement.*

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CONTINUATION UNDER COBRA

Federal COBRA* law requires that most group health plans, including Medical Flexible Spending Accounts (Unreimbursed Medical FSAs), give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. “Qualified beneficiaries” can include the employee covered under the FSA, a covered employee’s spouse, and dependent children of the covered employee. Each qualified beneficiary who elects continuation of coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan. COBRA is only available under **Tax\$ave** for **Unreimbursed Medical FSAs**.

Note: The Tax\$ave Dependent Care FSA election is **not** eligible for continuation of coverage under COBRA.

The Tax\$ave Unreimbursed Medical FSA is an “excepted” plan, and therefore offers only a limited COBRA option. One of the features of a limited COBRA option is that it is only offered for the remainder of the Plan Year — not the 18 months of full COBRA. Also, the limited COBRA option is only offered if the account is “underspent”. This occurs when the *contributions paid to date* are more than *claims paid out*. Be aware that an account is considered “overspent” — and ineligible to participate in COBRA — if the contributions paid to date are less than the claims paid out.

- **COBRA Election Example:** Arnold has an Unreimbursed Medical FSA annual election of \$1,000 for the current plan year. He breaks with employment in July and has paid in \$500 in payroll (pre-tax) contributions up to his termination date, but has received only \$200 in reimbursement. The \$300 balance (\$500 in contribution minus \$200 in claims) is considered “underspent” and allows Arnold to participate in COBRA. If Arnold was “overspent” he could not participate in COBRA.

Tax\$ave coverage terminates on the date that employment ends. If Arnold does not enroll for COBRA, the \$300 balance will be forfeited (unless he can submit \$300 of claims incurred prior to termination).

Since Arnold does not have qualified expenses that he can immediately submit against the \$300 balance, he elects to participate in COBRA. He will complete and return the *COBRA Election Form* and send in the first COBRA payment. Once his first payment has been received, Arnold is eligible to submit claims that were incurred after his termination from employment. Arnold can continue to incur and submit claims through the end of the Tax\$ave Plan Year, or until he has exhausted his original election for the Unreimbursed Medical FSA benefit of \$1,000.

Arnold’s *Form W-2* will show \$500 of Section 125 Medical Expense Plan Contributions.

Election for Continuation Coverage

The *COBRA Notice* and *COBRA Election Form* will be mailed to each eligible participant by the company administering the Tax\$ave Unreimbursed Medical FSA for the State of New Jersey. You have 60 days from the date of receipt of the *COBRA Notice* or the last date of coverage, whichever is later, to elect to continue coverage by completing and submitting the *COBRA Election Form*.

First Payment for Continuation Coverage

If you elect continuation of coverage, you do not have to send any payment for continuation coverage with the *COBRA Election Form*. However, you must make your first payment for continuation of coverage **within 45 days after the date of your election**. (This is the date the *COBRA Election Form* is post-marked, if

*The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

mailed.) If you do not make your first payment within the 45 days, you will lose all continuation of coverage rights under the Unreimbursed Medical FSA. Your first payment must cover the cost of continuation of coverage from the time your coverage under Tax\$ave would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact Fringe Benefits Management Company (see “FSA Plan Administrator” below) to confirm the correct amount of your first payment. Instructions for sending your first payment for continuation of coverage will be shown on your *COBRA Notice*.

Note: All COBRA payments are made with *after-tax* dollars, which negates the tax savings advantage of the FSA plan. COBRA is not a tax savings plan, and is only intended to prevent participants from forfeiting contributions made prior to termination.

Periodic Payments for Continuation Coverage

After you make your first payment for continuation of coverage, you will be required to pay for continuation of coverage for each subsequent month of coverage. Under the Unreimbursed Medical FSA, these periodic payments for continuation coverage are due on the first day of each month. Instructions for sending your periodic payments for continuation coverage will be shown on your *COBRA Notice* and *COBRA Election Form*.

Grace Periods for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a **grace period** of 30 days to make each periodic payment. Your continuation of coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a periodic payment later than its due date but during its grace period, your coverage under the Unreimbursed Medical FSA will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Unreimbursed Medical FSA.

For more information about your COBRA rights, please contact Fringe Benefits Management Company (see next section for contact information), or the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at: www.dol.gov/ebsa

FSA PLAN ADMINISTRATION

WageWorks, Inc. administers the Unreimbursed Medical Flexible Spending Account and Dependent Care Flexible Spending Account plans for the State of New Jersey and the Division of Pensions and Benefits.

If you have questions about the Unreimbursed Medical FSA or the Dependent Care FSA, contact WageWorks Customer Service at 1-855-428-0446, Monday through Friday from 8:00 a.m.-8:00 p.m., or visit: www.wageworks.com

The WageWorks Web site is also available through the Tax\$ave link on the Pensions and Benefits' Web site at: www.state.nj.us/treasury/pensions/taxsave.shtml

TAX\$AVE ADMINISTRATION AND APPEALS

The Division of Pensions and Benefits is the overall administrator of **Tax\$ave** for the State of New Jersey.

If you have a mid-plan year election change, FSA reimbursement claim, or other similar request that is denied, in full or in part, you have the right to appeal the decision by sending a written request for review with-

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in 30 days of the denial to:

Mr. Tim McMullen, Plan Administrator
Tax\$ave
NJ Division of Pensions and Benefits
PO Box 295
Trenton, NJ 08625-0295

Any request for appeal must include:

- The date of the services for which your request was denied, if applicable;
- A copy of the denied request, if available;
- Why you think your request should not have been denied; and
- Any additional documents, information, or comments you think may have a bearing on your appeal.

Appeal requests and supporting documentation will be reviewed and you will be notified of the results within 30 business days of receipt. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's, and the IRS' regulations governing the plan.

SOCIAL SECURITY IMPLICATIONS

Since payments to the Premium Option Plan and Flexible Spending Accounts lower annual earnings against which Social Security deductions or employer contributions are made, there is a concern that participation in these plans would result in reduced Social Security benefits at retirement.

If you were born after 1928, your Social Security benefits are calculated using a 35-year average of your earnings. A reduction of \$2,000 a year or even \$5,000 a year over some portion of this 35-year span would have little effect on your average salary and, therefore, minimal impact on your Social Security benefits. The Social Security Administration has provided us with an example of an employee who retired in 1998 at age 65 whose wages had been at the maximum wages subject to Social Security deductions. Upon retirement, this individual's monthly Social Security allowance was \$1,343. If that same person had been contributing \$2,000 a year for the last 10 years to a Flexible Spending Account, the subsequent reduction in Social Security wages would have produced a monthly Social Security allowance of \$1,335, a difference of only \$8 per month.

CIVIL UNION PARTNERS, DOMESTIC PARTNERS AND TAX\$AVE

The Internal Revenue Service does not recognize a New Jersey civil union partner or same-sex domestic partner as a dependent for tax purposes in the same manner that it recognizes a spouse or the dependent children of an employee. Therefore, your employer may have to treat civil union or same-sex domestic partner benefits as federally taxable.

As a result, a partner must be able to qualify as a "tax dependent" of the employee for federal tax filing purposes — under Internal Revenue Code Section 152 — before an out-of-pocket medical expense incurred by the partner can be reimbursed under the Unreimbursed Medical Flexible Spending Account and before any premiums that the employee pays for the partner's coverage can be made on a pre-tax basis under the

Premium Option Plan. See *IRS Publication #503, Dependents*, for additional information on the requirements for establishing dependent status for federal tax purposes.

If the civil union partner or same-sex domestic partner is not a “qualified tax dependent” of the employee, the partner's SHBP coverage is considered federally taxable and the employee cannot be reimbursed under the Unreimbursed Medical FSA for any out-of-pocket medical expense incurred by the partner, nor make pre-tax payments for the cost of the partner's coverage under the Premium Option Plan. (Pre-tax dollars may still be used to pay for the employee's portion of the cost of his or her own and dependent children's coverage.) Civil union partners or same-sex domestic partner SHBP benefits are not subject to New Jersey State income tax. If you live outside of New Jersey, you should check with your State's tax agency to determine if the civil union or same-sex domestic partner benefit is subject to state taxes.

For additional information about New Jersey Civil Unions, see Fact Sheet #75, *Civil Unions*.

For additional information about the New Jersey Domestic Partnership Act, see Fact Sheet #71, *Benefits Under the Domestic Partnership Act*.

This fact sheet has been produced and distributed by:

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This fact sheet is a summary and not intended to provide total information.

Although every attempt at accuracy is made, it cannot be guaranteed.
