



The Benefits of Better Health

High-deductible health plan definitions

Allowed amount – The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, then you might have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you might have to pay the \$500 difference. (This is called balance billing.)

Contribution – Money placed in an account (also known as a deposit). When you enroll in a high-deductible health plan (HDHP), monthly contributions are automatically made to your health savings account (HSA). If you do not qualify for an HSA, a bookkeeping allowance is made for your qualified medical expenses through a health reimbursement arrangement (HRA).

Coinsurance – Your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your co-insurance payment of 20% would be \$200. This may change if you haven't met your deductible.

Copayments – Fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.

Custodian – A custodian of an HSA must be a bank, a life insurance company, a person previously approved by the IRS to be a custodian of an individual retirement account (IRA) or Archer MSA, or any other person approved by the IRS. (IRS draft Form 5305)

Deductible – A fixed amount of money you pay before your health plan starts paying benefits.

Distribution – Money withdrawn from an account (also known as a withdrawal).

Eligible individual – An “eligible individual” for a health savings account in a given month is an individual who: (1) is covered under a high-deductible health plan (HDHP) on the first day of such month; (2) is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing certain limited types of coverage); (3) is not enrolled in Medicare; (4) may not be claimed as a dependent on another person's tax return; and has not received VA medical services within the prior 90 days. (Notice 2004-2, 2004-50)

High-deductible health plan (HDHP) – For calendar year 2018, an HDHP for GEHA Self Only coverage has a minimum annual deductible of \$1,500 and an annual out-of-pocket maximum (deductibles, copayments and other amounts, but not premiums) of \$5,000 for participating providers and \$7,000 for non-participating providers. For calendar year 2018, an HDHP for GEHA Self Plus One or Self and Family coverage has a minimum annual deductible of \$3,000 and an annual out-of-pocket maximum of \$10,000 for participating providers and \$12,000 for non-participating providers. Limits are subject to cost-of-living increases. (IRS draft Form 5305)

HRA – The IRS calls a health reimbursement arrangement (HRA) an arrangement that: (1) is paid for solely by the employer and not provided pursuant to salary reduction election or otherwise under a § 125 cafeteria plan; (2) reimburses the employee for medical care expenses [as defined by § 213(d) of the Internal Revenue Code] incurred by the employee and the employee's spouse and dependents (as defined in § 152); and (3) provides reimbursements up to a maximum dollar amount for a coverage period and any unused portion of the maximum dollar amount at the end of a coverage period is carried forward to increase the maximum reimbursement amount in subsequent coverage periods. (Notice 2002-45)

HSA – A health savings account (HSA) is a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a high-deductible health plan. (Notice 2004-2)

Identifying number – The account owner's social security number will serve as the identification number of this HSA. For married persons, each spouse who is eligible to open an HSA and wants to contribute to an HSA must establish his or her own account. (IRS draft Form 5305)

Permitted coverage – Coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care or long-term care. (Notice 2004-2)

Permitted insurance – Insurance under which substantially all of the coverage provided relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property (e.g., automobile insurance), insurance for a specified disease or illness and insurance that pays a fixed amount per day (or other period) of hospitalization. (Notice 2004-2)

Preventive care – Health care designed to provide early detection and prevention of disease. Typically includes routine physical examinations and immunizations. [Preventive care generally does not include any service or benefit intended to treat an existing illness, injury or condition.] (US Treasury/HSA Basics)

Qualified medical expenses – Qualified medical expenses (QME) are amounts paid for medical care as defined in section 213(d) for the account owner, his or her spouse or his or her dependents (as defined in section 152) but only to the extent that such amounts are not compensated for by insurance or otherwise. With certain exceptions, health insurance premiums are not qualified medical expenses. (IRS draft Form 5305)