



# 2015 Consumer-Driven Health Employer Handbook

A guide to health savings accounts, health reimbursement accounts and flexible spending accounts



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# An Introduction to Consumer-Driven Health Care

## Consumer-driven health plans can help employees change their health care behavior for the better.

With the rising cost of health care, employers and employees are looking for ways to successfully manage their health care choices. That's why consumer-driven health plans were created.

At UnitedHealthcare, we believe that when properly designed, delivered and used, consumer-driven health plans can:

- Help you and your employees (our members) become smarter and more effective users of health care services
- Improve the quality of the health care services your employees receive and the quality of their health
- Make paying for health care services more affordable

While these plans have become more popular among employers, many are still confused and sometimes a bit skeptical about how they work. Hopefully, this handbook will answer any questions you may have.

## What is consumer-driven care?

**Consumer-driven health care is a term used to describe health plans that are intended to help employees become more informed and careful about their health care choices and take control over their health and health care purchases.**

The key concepts associated with consumer-driven health plans include:

- 1 The member responsibility**, which is the amount members pay from their own pockets for the deductibles, co-payments and co-insurance payments that are required by their health plans, up to the out-of-pocket maximum.
- 2 An account that helps members pay the out-of-pocket expenses on a pre-tax basis.** The account can either be a health savings account (HSA), a health reimbursement account (HRA), or health care flexible spending account (FSA). As the employer, you may contribute to any of these accounts. The member can elect to contribute to the HSA or FSA.
- 3 Health coverage** that pays benefits after members meet the deductible that applies under their health plan's terms, and that pays 100% of network preventive care services.
- 4 Information resources** that help members make informed decisions with their physicians or health care professionals, and also provide useful information about physicians and health care professionals who are in the network, the cost of health care services, and options for accessing health care that may save them money.



## Why were consumer-driven health plans created?

Traditional health care coverage often operates like an “all-you-can-eat” buffet. Plan members pay a premium for health care coverage (often with only a small deductible and/or employee co-insurance percentage, and usually a moderate co-payment), then choose their health services without much thought to the actual cost of those services.

Many health care experts believe that this encourages inappropriate use of health care services, and contributes to the rising costs of health care coverage. They also believe that it discourages health care professionals from providing services in a consumer-friendly way, such as by offering clear and complete pricing information.

**Consumer-driven health plans were created to help reduce the concern by employers and consumers about the increasing cost of health coverage and services. The purpose is to urge members to become more involved in their health care choices, and more responsible in paying for them. We believe this will encourage price competition among physicians and other health care professionals and give our members better value for their health care dollars. Finally, and most importantly, we believe this will improve the overall quality of their health.**

## Accounts at a glance

The following chart introduces some of the key features of the HSA, HRA and FSA by briefly answering some frequently asked questions. A detailed explanation of these questions and other concepts is covered in the next few chapters of the handbook.

## Consumer-Driven Health Financial Accounts At A Glance

Questions	HSA	HRA	FSA
What does it stand for?	Health savings account	Health reimbursement account	Flexible spending account
Who owns it?	Employee	Employer	Employer
Who is eligible to open and maintain an account?	An eligible individual who: <ul style="list-style-type: none"> <li>• Has qualifying high-deductible health plan coverage and no other disqualifying health coverage on the first day of the month</li> <li>• Cannot be claimed as a tax dependent</li> <li>• Is not entitled to Medicare benefits</li> </ul>	An eligible employee whose employer offers an HRA.	An eligible employee whose employer offers FSA option.
Is the account owned by the employee?	Yes	No	No
What type of corresponding health plan is allowed?	A high-deductible health plan is required in order to qualify for an HSA.	Any type of health plan arrangement is allowed.	Any type of health plan arrangement is allowed.
Can unused amounts carry over?	Yes. The individual owns the account and any contributions made to it, regardless of the source or timing of the contribution.	Yes. Unused funds remaining at the end of the plan year can be carried over to the following year if the employer/plan sponsor chooses to configure the account accordingly. However, rollover is not required.	Yes, the employer can choose to have unused funds carry-over from year to year up to \$500. However, carry over is not required.
Is the account portable between employers?	Yes. When leaving an employer, the individual owns the account and can maintain it with the original custodian/ trustee, or withdraw HSA funds and redeposit them into another open HSA within 60 days to avoid a tax penalty. Individuals may also request an HSA trustee-to-trustee transfer by which funds are transferred directly from the old trustee to the new trustee.	No. The account is not portable between employers. If an employee leaves, the remaining balance is forfeited and remains with the employer.	No. FSAs cannot be rolled over to a new employer.

Note: HSAs and HRAs, along with the health plans that accompany them, are both forms of consumer-driven health care. However, there are differences between the two, which are described later in the handbook. To make it easier to distinguish between the coverage, we refer to the health coverage that can accompany an HSA as a high-deductible health care plan, and the health coverage typically offered with an HRA as a consumer-driven health care plan.

# Health Savings Accounts (HSAs) and High-Deductible Health Plans

## What is an HSA?

A health savings account is a tax-favored individual custodial bank account or trust account established by eligible individuals to pay for current or future qualified medical expenses.

## What is a high-deductible health plan?

HSAs must be used with qualifying high-deductible health plans, which are plans that pay for covered services only after the member meets a minimum deductible (usually not including preventive care) and pays the full cost of covered services once the annual out-of-pocket maximum is met.

A qualifying high-deductible health plan must generally satisfy the following:

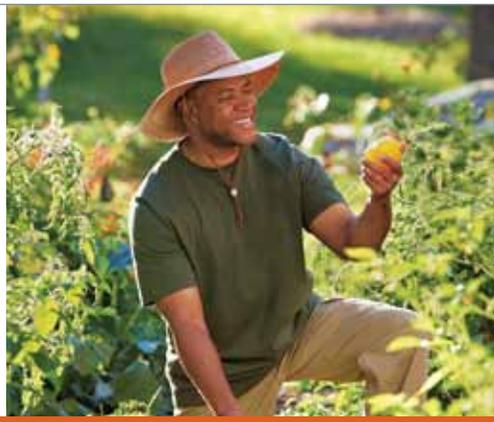
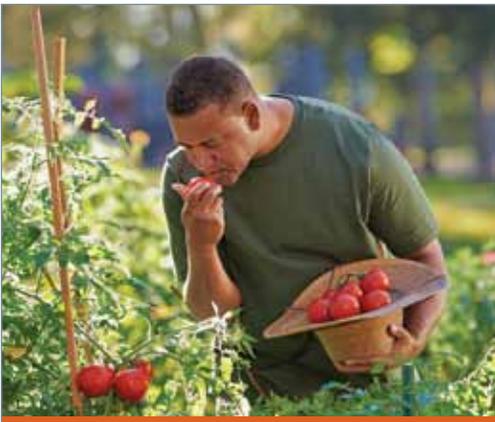
- The annual deductible must be at least \$1,300 for individual coverage and \$2,600 for family coverage in the network.
- The maximum annual out-of-pocket limit is \$6,450 for individual coverage and \$12,900 for family coverage.

## High-deductible health plans may include 100% preventive care coverage

High-deductible health plans now may offer 100% coverage for network preventive care services. Under current law, they include the following services:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine exams, such as annual physicals.
- Routine prenatal and well-child care.
- Child and adult immunizations.
- Tobacco cessation programs.
- Screening services, including those for cancer; heart and vascular diseases; infectious diseases; mental health conditions and substance abuse; metabolic, nutritional and endocrine conditions; musculoskeletal disorders; obstetric and gynecologic conditions; pediatric conditions; and vision and hearing.

Preventive care generally does not include services that are intended to treat an existing illness, injury or condition. However, in situations where it is unreasonable or impractical to perform another procedure to treat the condition, any treatment that is incidental or ancillary to a preventive care service or screening is also considered preventive care. **Members should refer to their Summary Plan Description or Certificate of Coverage for specific preventive care services covered by their plan.**



## **Exception: prescription drugs for preventive care**

The deductible under a high-deductible health plan must apply to prescription drugs, unless the prescription drugs are used for preventive care. Preventative care prescription drugs are usually:

- Taken before risk factors develop for a disease that has not yet manifested itself.
- Taken before a disease becomes clinically apparent; or to prevent recurrence of a disease from which a person has recovered.
- Used in preventive care procedures and services such as weight loss and tobacco cessation programs.

High-deductible health plans may waive the deductible to preventive care prescription drugs, determining when a prescription drug is used for preventive care is challenging, and many employers continue to evaluate whether and how to carve them out of the deductible.

## Characteristics of a typical eligible high-deductible health plan and HSA

Characteristics	Employer design variables
100% preventive care coverage	Preventive care services include immunizations, health care screenings and examinations
Deductible	<ul style="list-style-type: none"> <li>• Dollar amount of deductibles vary by coverage level</li> <li>• Dollar amount of deductibles is larger for non-network services</li> <li>• The law does not allow the deductible to be applied to preventive care received in network</li> </ul>
HSA	<ul style="list-style-type: none"> <li>• Employers are not required to contribute to their employees' HSAs, but many do</li> <li>• Contribution amounts vary among employers and by coverage level</li> <li>• Timing of employer contribution varies</li> <li>• Many, but not all, employers allow employees to make pre-tax HSA contributions via payroll deduction</li> </ul>
Member responsibility	<ul style="list-style-type: none"> <li>• Amount varies among employers and by coverage levels</li> <li>• Amount is larger for non-network services</li> </ul>
Health coverage	<ul style="list-style-type: none"> <li>• Many employers require members to pay for a portion of the cost of covered services in the form of co-payments and/or co-insurance after satisfying the combined medical/pharmacy deductible</li> <li>• Co-insurance percentages and co-payments vary among employers</li> </ul>
Information tools and resources	<ul style="list-style-type: none"> <li>• Websites that contain topics such as network physicians and other health care professionals, services and costs, wellness programs and general wellness information, discounts on health services, and purchasing prescription drugs via mail</li> <li>• Customer service centers or other resources that can be called for more information about all of these resources</li> </ul>

## Who can open an HSA?

Only eligible individuals can open and contribute to an HSA. They are defined as individuals who:

- Are covered under an eligible high-deductible health plan as of the first day of the month.
- Are not covered by another, disqualifying health plan (i.e. Tricare, Medicare Part A or B, other health insurance coverage that is not a qualified High Deductible Health plan).
- Are not enrolled in Medicare (*meaning, generally, have not reached age 65*).
- Cannot be claimed as a dependent on another person's tax return.

In order to be eligible the eligible member needs to have the HDHP on the first day of the month. If the member ceases to be an eligible individual, he or she can continue to use the HSA to pay for qualified medical expenses, but cannot make additional contributions.

## Special rule: permitted coverage and insurance

An eligible member can open and contribute to an HSA if his or her health or other insurance plan includes the following:

- Coverage, whether through insurance or otherwise, for accidents, disability, dental care, vision care or long-term care.
- Insurance in which substantially all of the coverage is for:
  - Liabilities incurred under workers' compensation laws
  - Tort liabilities
  - Liabilities relating to ownership or use of property
  - Insurance for a specified disease or illness
  - Insurance that pays a fixed amount per day or other period of hospitalization

### Example:

If a member is covered by a high-deductible health plan and is also covered by a dental or vision insurance policy or plan, the member may still be considered eligible to open and contribute to an HSA.

## Opening an HSA with Optum Bank<sup>SM</sup>, Member FDIC

Employees enroll in the high-deductible health plan first, and then open the HSA. Many employers allow their employees to enroll in the health plan online or via paper enrollment forms, or both, enabling members to open an HSA concurrent with enrolling in their plan.

**Members can call 1-800-791-9361 for more information about opening an HSA and the terms and conditions that apply.**

## How funds in an HSA are withdrawn or used

With Optum, account holders receive a Health Savings Account (HSA) Debit MasterCard<sup>®</sup> that they can use when making purchases at the pharmacy, when paying a bill to a provider, or to withdraw money from their HSA through an ATM, where the provider or ATM accepts MasterCard.

**Investments are not FDIC insured, are not guaranteed by Optum Bank and may lose value.**

## Expenses

### What medical expenses can be paid with an HSA?

The funds that an account holder or others deposit into an account holder's HSA may be distributed on a tax-free basis to pay for qualified medical expenses incurred by the account holder and his or her spouse or tax dependents. Spouses and dependents do not need to be covered under the member's high-deductible health plan to take a tax-free HSA distribution to pay for their medical expense.

Qualified medical expenses are amounts paid by the member, spouse or dependents for Code Section 213(d) Medical Expenses (with some exceptions), which are not compensated for by insurance or otherwise and are not reimbursable by another health plan.

#### Generally, qualified medical expenses include:

- Expenses for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- Transportation and lodging expenses that are incurred primarily for, and are essential to, medical care.
- Amounts paid for certain away-from-home lodging that is primarily for, and essential to, medical care.

#### Generally, insurance premiums are not qualified medical expenses, except premiums for:

- COBRA continuation coverage under a group health plan.
- A qualified long-term care insurance contract as defined in Code Section 7702B(b) (within certain limits).
- A health plan during a period in which the individual is receiving unemployment compensation under any federal or state law.
- Premiums for Medicare Part A, B, or D, Medicare HMO, and the employee share of premiums for employer-sponsored health insurance, including premiums for employer-sponsored retiree health insurance, for individuals over age 65. Medigap premiums are not qualified medical expenses.

Note: Account holders have the freedom to decide whether and when to use their HSA funds to pay for qualified medical expenses including vision, dental, pharmacy, or other medical expenses they incur. Some may choose to pay for some expenses out of personal funds and save their HSA funds for future medical expenses or general retirement purposes.

### Not sure if an expense is qualified?

As a result of health care reform laws passed in 2010, over-the-counter medications and drugs are only a qualified medical expense if they are prescribed. If an account holder is not sure if an expense is qualified, he or she should read IRS Publication 969, which explains that qualified medical expenses are those that would generally qualify for the medical and dental expenses deduction, as listed in IRS Publication 502. Both publications are available on the IRS website at [www.irs.gov](http://www.irs.gov).

The account holder is not required to submit a receipt or other information about the expense to the HSA trustee or custodian when a distribution is taken, or to the IRS when they file a tax return. However, the member does have to retain qualified medical expense receipts to substantiate in the event the IRS or state taxing authority audits the account holder's individual income tax return.

## What happens if an HSA is used for non-qualified medical expenses?

If HSA funds are used for non-qualified medical expenses, the payments or reimbursements are taxable and are subject to an additional 20 percent tax. The account holder must report distributions for expenses that are not qualified medical expenses in the account holder's federal income tax return.

Note: The additional 20 percent tax does not apply if the distribution for a non-qualified medical expense is made after the account holder reaches age 65, becomes disabled, or dies.

## Contributions

### Can employers contribute to an HSA?

Employers can (but are not required to) contribute. An employer contribution has shown to be the most effective action an employer can take to get employees to open and engage in accounts. If the employer does contribute to an HSA, the contributions are excluded from the employee's gross income and not subject to federal income tax (or subject to FICA or FUTA). Employers can structure their contributions in several ways. It is common for employers to provide full funding at the start of the year, or to contribute a fixed dollar amount spread over time (e.g., \$100 per month). Others may choose to make matching contributions through their Code Section 125 cafeteria plans (e.g., they contribute 50 cents to the HSA for every \$1 the employee contributes).

### How much can an employee contribute to an HSA?

In 2015, the total that an employee can contribute to his or her HSA is \$3,350 for individual coverage and \$6,650 for family coverage.

### Employees can make tax-deductible contributions

Employees can contribute after-tax money to their HSAs, and if they do, can take an above-the-line tax deduction on their federal Form 1040 individual tax returns for the tax year in which or for which they make the contributions except in a limited number of states. **This means they will not pay income tax on the money that has been contributed.** Employees do not have to itemize deductions (i.e., file a Schedule A with the Form 1040) to take this deduction. However, they do have to complete the standard Form 1040 and not the Form 1040-EZ.

### Employees can make pre-tax payroll deduction contributions

Employees can also make pre-tax contributions to their HSAs via payroll deduction, if permitted by the employer. In that case, the following applies:

- The account holder avoids his or her share of the Federal Insurance Contributions Act (FICA) tax, which results in greater tax savings than when the account holder contributes after-tax amounts to the HSA and takes the allowable income tax deduction.
- Tax liability and payments are reduced throughout the year when each contribution is made via payroll, and the account holder does not need to wait until the end of the year to reduce his or her income taxes.
- The account holder may be more likely to obtain the maximum tax advantage because the salary reduction election is effective at the beginning of the plan year and contributions are automatically deducted from salary throughout the year.
- Investment and interest earnings may accumulate faster when contributions are made earlier in the year rather than waiting until end of year.

Note: Any person other than the employee or employer can also contribute to the HSA. If the contribution is made by a third party, the account holder can take an above-the-line tax deduction for the contribution on their federal Form 1040 individual tax return.

## **One-time transfer from an IRA to an HSA**

An HSA holder may make a one-time rollover from an IRA into an HSA. The contribution must be made in a direct trustee-to-trustee transfer and is irrevocable once made. The transferred amount is neither included in income, nor subject to the 20 percent additional tax applicable to early withdrawals from an IRA. The transferred amount is also not deductible and does not count against the maximum HSA contribution limit for the year.

If the member has individual high-deductible health plan coverage and transfers amounts from an IRA to an HSA, that member may later make an additional transfer if switching to family coverage. If at any time during the 13-month testing period beginning with the month of the transfer the account holder is no longer an eligible individual, the transferred amounts are includable in income and subject to a 20 percent additional tax.

## **Deadline for contributing**

The deadline for making HSA contributions for a calendar year is the due date of the individual federal income tax return for that calendar year, which is usually April 15 of the following year, or the first business day following April 15 if it falls on a weekend.

## **What happens if an account holder contributes too much?**

If HSA contributions exceed the limit that applies in a year, the amount that exceeds the limit is an excess contribution. If contributions are after-tax contributions, the account holder cannot deduct the excess portion on his or her individual income tax return for the year. Excess contributions may be subject to an excise tax of 6 percent for each tax year during which they remain in the HSA. The account holder can avoid this excise tax for a given year by withdrawing the excess contribution and the related interest earnings from the HSA before the income tax return for the year is due (excluding extensions).

## Special rules that affect contributions

### What if the member is married?

If the member is married and the member's spouse is covered by a high-deductible health plan (whether one high-deductible health plan or two separate high-deductible health plans), and if they are eligible individuals, they must each open a separate HSA, since joint ownership is not permitted. If only one is an eligible individual, only the eligible individual may open and contribute to an HSA. The contribution limits for married individuals are as follows:

- If the two of them have family coverage under one high-deductible health plan and are both eligible individuals, they are each treated as having family coverage. The contribution limit for each of them is one half of the family contribution limit, unless they agree on a different division.

#### Example 1:

Joe and Sally are married. Both are under age 55, and they have two dependent children. Joe is enrolled in a high-deductible health plan and elected the family coverage level. Joe has no non-high-deductible health plan coverage and is an eligible individual. Sally has employee-only coverage under a non-high-deductible health plan, which means that she is not an eligible individual and cannot open or contribute to an HSA. Joe can open an HSA and he (and his employer or any others) can contribute up to the family contribution limit for that year to his HSA.

#### Example 2:

This time, Sally has no non-high-deductible health plan coverage, which makes her an eligible individual because she is covered under Joe's high-deductible health plan. Sally can open her own HSA, and she and Joe can each contribute to their respective HSAs an amount equal to half of the family contribution limit for that year (or any other division they agree on).

### What happens if a member is enrolled in Medicare?

If the member is enrolled in Medicare Part A or Part B, the member is not an eligible individual and cannot contribute to an HSA (neither can other individuals).

### Catch-up contributions if an account holder is 55 or older

Eligible individuals who are 55 or older can make additional catch-up contributions to their HSAs. The catch-up contribution limit is \$1,000. These contributions are not required to be prorated in the year in which the account holder turns 55, but they can be made only for the months during which the member is an eligible individual.

If both the member and the member's spouse are eligible individuals, and are age 55 or older, and each wants to make catch-up contributions, they can do so, but they must each open and contribute to their own separate HSA. Catch-up contributions cannot be allocated between spouses.

## What happens if a member has an embedded individual deductible?

Some high-deductible health plans have both an umbrella family deductible, which is the dollar amount that the family as a unit must pay for covered services before the high-deductible health plan pays benefits for all members of the family, and a lower embedded individual deductible, which is the lower dollar amount that any one family member must pay for covered services before the high-deductible health plan pays benefits for the individual family member. The embedded individual deductible must be at least as much as the minimum required deductible for family coverage.

## Paying Claims

### Member responsibility: meeting the deductible

The plan may contain several different deductibles, such as deductibles that apply to services from network physicians and other health care professionals, and higher deductibles that apply to services from non-network professionals. In addition, deductibles may vary based upon different coverage levels.

**The Summary Plan Description or Certificate of Coverage will identify covered services that are and are not subject to the deductible.** The member must pay for covered services until the applicable deductible is met. After that, the employer's plan pays for the covered services, subject to any co-insurance or co-payments that are the member's responsibility. The member can use their HSA funds to pay for covered services that are subject to the deductible.

If the member uses all of the HSA funds before the end of a year, the member is responsible for paying for covered services until the remainder of the applicable deductible for that year is met.

### Members should submit claims to the health plan first

When a member visits a physician for a covered service, the member should not pay for it immediately. Instead, the physician (or non-network physician) should submit the claim to the health plan for processing to make sure that:

- The claim is a covered service.
- The member receives the benefit of any discounts that have been negotiated with a physician.
- The claim is counted toward the member's deductible and the out-of-pocket maximum, if appropriate.

The insurer or administrator of the plan will notify the provider if the member has not met the deductible and is responsible for payment of the claim; and the physician or health care professional should bill the member directly. The member then pays the physician or health care professional directly with his or her HSA funds.

## Paying claims after HSA funds are depleted and before the deductible is met

If HSA funds are used before the member meets the applicable deductible (or the member chooses to not use HSA funds), the member is responsible for paying for the covered services received until the remainder of the deductible is met. The member should not pay for the covered services immediately, but should wait until the claim is first processed by the health plan. The member can then pay the physician or health care professional directly with his or her own funds.

## Paying claims after the deductible is met

Once the member meets the deductible, the plan starts paying claims for covered services, but subject to any co-insurance requirement or co-payments that apply to the services the member receives.

The following examples assume that the plan is designed so that the employer's HSA contributions, the network and non-network deductibles, co-insurance and out-of-pocket maximums are as follows for the employee-only coverage level:

### HSA Contribution:

Employer \$400

Employee \$2,450

	Network	Non-Network
Deductible	\$1,500	\$2,000
Co-insurance	Plan pays 85%	Plan pays 55%
Member responsibility	15%	45%
Out-of-pocket maximum	\$3,000	\$5,000

### Example 1: Preventive Care Services Covered 100%

Mr. Adams sees a network physician for a preventive care physical. The network expense is \$300. The network physician submits a claim for the physical. The claim is processed and is determined to be a covered service performed by a network physician, which is not subject to the high-deductible health plan's deductible. The plan pays the \$300 expense to the network physician, and Mr. Adams pays nothing.

Transaction	HSA	Deductible	Expenses	Out-of-pocket	Balance
Employee deposits	\$400				
Deductible		\$1,500			
Physical			\$300		\$400

### Example 2: Urgent Care Services

Mr. Adams visits a network physician in an urgent care center. The network expense is \$200. The network physician submits a claim for the urgent care visit. The claim is processed and is determined to be a covered service performed by a network physician, which is subject to the plan's deductible. Mr. Adams must satisfy the \$1,500 individual network deductible before the plan pays for the visit. Mr. Adams must pay the \$200 claim. He has \$400 in his HSA at the time of the claim and can use it to pay the urgent care center. If he uses his HSA funds, the payment will reduce his HSA balance to \$200 (\$400 less \$200). The payment counts toward his \$1,500 network deductible, and the remaining network deductible is now \$1,300 (\$1,500 less \$200).

Transaction	HSA	Deductible	Out-of-pocket	HSA Balance
Employee deposits	\$400			
Deductible		\$1,500		
Physical			\$300	\$400
Urgent Care		\$1,300	\$200	\$200

### Example 3: Outpatient Services

Mr. Adams visits a network physician for an outpatient procedure. The network expense is \$500. The network physician submits a claim for the outpatient procedure. The claim is processed and is determined to be a covered service performed by a network physician, which is subject to the plan's deductible. Mr. Adams must satisfy the remainder of his individual network deductible balance of \$1,300 before the plan pays for the procedure. Mr. Adams must pay the \$500 claim. He has \$200 in his HSA, and can use it to pay the network physician. If he uses his HSA funds, his HSA balance is now \$0. The total network expense of \$500 also counts toward his \$1,300 network deductible leaving the remaining network deductible balance at \$800.

Transaction	HSA	Deductible	Expenses	Out-of-pocket	HSA Balance
Employee deposits	\$400				\$400
Deductible		\$1,500			
Physical (preventive)			\$300		\$400
Urgent Care				\$200	\$200
Procedure	\$800		\$300	\$300	\$0
Pharmacy Services				\$200	

## Frequently Asked Questions

### What happens when HSA funds remain after one year?

An HSA is a personal account and is owned by the account holder, and there is no use-it-or-lose-it rule. Funds in the account carry over from year to year and may earn interest (or other earnings as applicable under the HSA), and are available for use in future years.

### What happens when HSA funds are depleted in a year?

If an account holder uses all the HSA funds in a year, and the account holder (or others) have contributed the maximum amount to the HSA for that year, the account holder must pay with other personal funds, and the account holder is responsible for paying for any medical expenses incurred during that year. However, the account holder can maintain the HSA and make additional contributions in the subsequent year or years, provided he or she is covered by an HSA-qualifying, high-deductible health plan.

## **What happens if different medical coverage is chosen while the member remains employed?**

If the member chooses to change medical coverage options so that the new option is also a high-deductible health plan, the member can continue to maintain and contribute to the HSA.

If the new option is not a high-deductible health plan, the member will no longer be an eligible individual, so the member cannot make additional contributions to the HSA. However, the member may continue to use the HSA for qualified medical expenses or for taxable distributions for other expenses.

## **What happens if the spouse's coverage ends because of divorce?**

If the member and the member's spouse divorce and the member is the HSA holder, the account holder cannot withdraw amounts from the HSA on a non-taxable basis to pay the former spouse's medical expenses. If the account holder does withdraw for the spouse, the distribution is taxable to the account holder and subject to the 20 percent additional tax.

The account holder can transfer all or a portion of the HSA to the account holder's former spouse as part of the divorce proceedings. If that is done, the transfer is not taxable to either party, the HSA continues to be an HSA, and the former spouse can use it for his or her qualifying medical expenses.

## **What happens if employment ends?**

Since the HSA is a personal account, the employee owns it and the employer does not. Therefore, the account holder remains the owner of the HSA when his or her employment ends. If the trustee or custodian will not administer the existing HSA after employment ends, the account holder can open a second HSA with another trustee or custodian, and either request an HSA distribution that rolls over to the new HSA within 60 days, or request a trustee-to-trustee transfer.

## Tax issues

### How annual cost-of-living adjustments affect the member

Each year, the annual deductible and out-of-pocket maximum limits that apply to high-deductible health plans are adjusted for inflation using annual cost-of-living adjustments (COLAs). The COLAs must be announced by the Treasury by June 1 of the preceding year. They are effective as of Jan. 1 of the next calendar year for calendar year high-deductible health plans, and as of the first day of the plan year that starts after Jan. 1 for fiscal year plans.

### Who reports HSA activity to the IRS?

The account holder must report any contributions made to the HSA and any payments made or reimbursements received from the HSA on Form 8889, which is filed with the Form 1040 individual income tax return. On this form, the account holder also calculates the deduction for after-tax contributions he or she (or someone other than the account holder's employer) has made to the HSA, the amount of any excess contributions to the HSA that are withdrawn in a timely manner, and the additional tax on any taxable payments or reimbursements from the HSA.

If the account holder has excess contributions in his or her HSA in a tax year, the account holder must also file Form 5329 and calculate and pay the tax and any excess contributions that are not removed by the applicable deadline (the April 15 due date, with extensions).

The employer reports in box 12 of the employee's Form W-2, using code "W," any amounts the employer contributed to the account holder's HSA and any amounts that the account holder contributed via pre-tax payroll deduction.

The HSA trustee or custodian must file Form 5498-SA to report contributions to the HSA, including rollovers, and Form 1099-SA to report distributions from the HSA.

### How state and federal tax treatment of HSAs differ

Although most states follow the federal tax law to determine taxable income, some states do not provide tax benefits for HSAs. Therefore, we encourage employers and employees to review the instructions for their state income tax return and consult their own tax advisor for specific guidance on how their state's law affects the HSA.

# Health Reimbursement Accounts (HSAs)

## What is an HRA?

**An HRA is an account to which the employer can make contributions that are not included in the employee's gross income.** When an employee elects coverage under a consumer-driven health plan that offers an HRA, he or she receives the health coverage as well as the employer's contributions or credits to the HRA.

IRS rules for HRAs include the following:

- Only the employer can contribute to an HRA.
- If the HRA dollars are not completely used in a plan year, the unused funds may (if permitted by the employer or plan sponsor) remain in the HRA to be used for eligible medical expenses incurred in the next year or years.
- Any contributions the employer makes to the HRA are not taxable to the member. Any contributions the employer makes to the HRA are excluded from the employee's gross income (and not subject to federal income tax, FICA, FUTA)
- Payments from the HRA are not considered taxable income for eligible members.

## Characteristics of a typical consumer-driven health plan

Characteristics	Employer design variables
100% preventive care coverage for in network	<ul style="list-style-type: none"> <li>• Preventive care services include immunizations, health care screenings and examinations</li> </ul>
Deductible	<ul style="list-style-type: none"> <li>• Dollar amount of deductibles vary by coverage level</li> <li>• Dollar amount of deductibles is larger for non-network services</li> <li>• UnitedHealthcare recommends minimum deductible levels of \$1,000 for individuals and \$2,000 for families</li> </ul>
HRA	<ul style="list-style-type: none"> <li>• HRAs can be offered with a high-deductible health plan</li> <li>• Contribution amounts vary by employer</li> <li>• Contribution amounts vary by coverage levels</li> <li>• Employer contribution is a bookkeeping credit</li> <li>• Timing of employer contribution can vary</li> <li>• Funds are collected from the customer after HRA checks are cashed</li> <li>• Expenses that can be paid with HRA vary by employer</li> </ul>
Member responsibility	<ul style="list-style-type: none"> <li>• Amounts vary by employer</li> <li>• Amounts vary by coverage level</li> <li>• Amounts are larger for non-network services</li> </ul>
Health coverage	<ul style="list-style-type: none"> <li>• Many employers require their employees to pay for a portion of the cost of covered services in the form of co-payments/co-insurance, but limit the employees' expenses to the out-of-pocket maximum.</li> </ul>
Information tools and resources	<ul style="list-style-type: none"> <li>• Websites (such as myuhc.com<sup>®</sup>) that contain information about network physicians and other health care professionals, services and costs, wellness programs and general wellness information, discounts on health services, and purchasing prescription drugs via mail</li> <li>• Customer service centers or other resources that the member can call for more information about all of these items</li> </ul>

### Who can participate in an HRA?

Current and former employees (including retired employees) and their eligible dependents can participate in HRAs, but federal law does not require employers to allow all current and former employees to participate.

## Who can contribute to an HRA, and how much can be contributed?

Only the employer can contribute. As stated earlier, eligible contributions to the HRA, and reimbursements from the HRA are not taxable to the member.

Federal tax law does not limit the dollar amount that the employer can contribute to the HRA. That amount is determined by the employer. As a practical matter, employers usually contribute a percentage (but not all) of the deductible that applies under the high deductible health plan. The most common funding for UnitedHealthcare customers is 50 percent of the deductible.

## How does a consumer-driven health plan with an HRA work?

Basically, the employer offers a consumer-driven health plan that is bundled with an HRA. When we receive the list of employees that elect the HRA plan offering, we will automatically set up their reimbursement account. The HRA can then be used to help pay for expenses incurred under the medical plan deductible.

**Read your Summary Plan Description or Certificate of Coverage for the specific rules that apply under your consumer-driven health plan.**

## Who sets up the HRA and when?

UnitedHealthcare can set up HRA notional accounts on the employer's behalf, where bookkeeping credits are applied as their contributions. Notional accounts are not bank accounts and do not have money in them. Employers could contribute money to a trust or similar arrangement to set aside actual HRA dollars, but they are not required by law to do this, and generally do not. The HRA contribution is available on the first day of the plan year for employees, or upon completing any activities, if applicable.

## What medical expenses can be paid with HRAs?

The expenses members can pay with their HRAs are determined in part by law and in part by the employer's plan design. Generally, the law allows the HRA to pay for medical care expenses, as they are defined in Code Section 213(d), that are not covered or reimbursable by insurance or some other form of medical coverage. This generally means that the following covered services are allowable:

- Any expenses covered by the health plan.
- Any combination of deductible, co-insurance or co-payment expenses.
- Other medical care expenses incurred that are not covered by the health plan as defined in section 213(d).

HRAs are most commonly set up to pay expenses that the medical plan will cover only, with or without pharmacy included. However, an employer may customize an expense list of other services that they wish to be covered without allowing all 213(d) expenses to be payable.

## Meeting the deductible and using the HRA

- The medical plan may contain different deductibles: those that apply to services from network physicians and other health care professionals; higher deductibles that apply to services from non-network physicians and other health care professionals; and deductibles that apply to different coverage levels.
- Preventive care services are covered by the plan immediately, not applicable to the deductible or use of HRA funds.
- Members can use their debit MasterCard®, if offered, for co-payments and any member/patient responsibility that is received from one of our affiliated Pharmacy Benefit Managers (i.e., UnitedHealth Pharmaceutical Solutions, Medco®, Caremark, LLC and Advanced PCS).

Recent guidance from the IRS has clarified substantiation requirements for debit card transactions, and has approved an Inventory Information Approval System (IIAS) as a method for retailers to identify and substantiate qualified medical expenses, per Section 213(d) of the Internal Revenue Code.

## Submitting a claim

When a member receives a covered service the member's network physician (or the member if a service is from a non-network provider) should submit the claim to the health plan for processing to make sure that:

- The claim is a covered service.
- The member receives the benefit of any discounts that have been negotiated with a network physician.
- The claim is counted toward the deductible(s) and the member's out-of-pocket maximum(s).

UnitedHealthcare will then use available HRA funds to pay providers, or members, directly for expenses applied to the deductible.

### Example 1: Preventive Care Services Covered at 100%

Mr. Adams sees a network physician for a preventive care physical. The network expense is \$300. The network physician submits a claim to the plan for the physical. The claim is processed and is determined to be a covered service performed by a network physician, which is not subject to the plan's deductible. The plan pays the \$300 expense to the network physician, and Mr. Adams pays nothing.

Transaction	HRA	Deductible	Expenses	Out-of-pocket	HRA Balance
Employer contributes	\$400				
Deductible		\$1,000			
Physical			\$300	\$0	\$400

### Example 2: Urgent Care Services

Mr. Adams visits a network physician in an urgent care center. The network expense is \$200. The network physician submits a claim to the plan for the urgent care visit. The claim is processed and is determined to be a covered service performed by a network physician, which is subject to the plan's deductible. Mr. Adams' plan has a \$1,000 individual network deductible, which must be met before the plan pays for the visit. Mr. Adams must pay the \$200 claim. He has \$400 in his HRA, so \$200 will automatically be withdrawn to pay the urgent care center. The funds in his HRA now total \$200 (\$400 less \$200). His network deductible is now \$800 (\$1,000 less \$200).

Transaction	HRA	Deductible	Expenses	Out-of-pocket	HRA Balance
Employer deposits	\$400				\$400
Deductible		\$1,000			
Physical			\$300		\$400
Urgent Care		\$200	\$200		\$200

### Example 3: Outpatient Services

Mr. Adams visits a network physician for an outpatient procedure. The network expense is \$500. The network physician submits a claim to the plan for the outpatient procedure. The claim is processed and is determined to be a covered service performed by a network physician, which is subject to the plan's deductible. Mr. Adams must meet the remainder of his individual network deductible balance of \$800 before the plan pays for the procedure. Mr. Adams must pay the \$500 claim. He has \$200 in his HRA, so \$200 will automatically be withdrawn to pay the network physician. The funds in his HRA now total \$0. Mr. Adams must pay the \$300 remainder to the network physician.

Transaction	HRA	Deductible	Expenses	HRA Pays	Out-of-pocket	HRA Balance
Employer deposits	\$400					\$400
Deductible		\$1,000				
Physical (preventive)			\$300			\$400
Urgent Care		\$200	\$200			\$200
Procedure		\$500	\$500	\$200	\$300	\$0

If Mr. Adams does not have an FSA that a UnitedHealthcare company administers, he must pay with his own funds. If he does have an FSA that a UnitedHealthcare company administers, the remaining \$300 will automatically be withdrawn from the FSA, if funds are available, and paid to the member. The HRA payment and the payment from the FSA, or his personal payment of \$300, count toward his remaining \$800 network deductible. The remaining network deductible is now \$300 (\$1,000 less \$200 less \$300).

Note: all FSA payments are always to the member

## Frequently asked questions

### What happens when a member does not use up HRA funds in a year?

If the member remains employed and is participating in the employer's plan, the following will happen:

- The employer's plan can (but is not required to) allow unused HRA funds to roll over to the next year.
- If the employer does permit all or a portion of unused funds to be rolled over, members can typically use the funds in the subsequent year or years for eligible expenses that they must pay for until they meet their deductible that applies under the plan, or to pay co-payments or co-insurance for covered services.

## What happens if the member elects a different medical coverage option while remaining employed?

If the member remains employed and later chooses coverage under a different medical option, such as a high-deductible health plan that allows establishment of an HSA, or a medical option that offers neither an HRA nor HSA:

- The employer cannot distribute unused funds to the member (the member cannot cash out an HRA).
- An employer may elect, at the plan level, to allow returning HRA participants access to prior balances, or provide a new balance to returning HRA members.

## What happens in the event of divorce?

If a member and his or her spouse divorce, the spouse typically loses coverage under the employer's consumer-driven health plan and becomes eligible to elect COBRA continuation coverage. The COBRA rules can be very complicated in this situation and **the member should refer to their Summary Plan Description or Certificate of Coverage for specific rules that apply.**

In general, the former spouse can elect COBRA continuation coverage under the plan and/or the HRA for a period of up to 36 months.

## What happens when employment ends?

When employment ends and a member can no longer participate in the HRA, the employer cannot cash out or distribute the unused HRA funds to the member. However, the member may have the right to continue coverage under the plan and/or the HRA under COBRA. The former employee, spouse and dependents each have an independent right to elect COBRA. The employee does not elect it on their behalf. The unused HRA balance remains available, and the employer must continue to credit contributions to the HRA while the COBRA coverage is in effect. **Members should refer to their Summary Plan Description or Certificate of Coverage for specific rules that apply.** Note that if the employer is not subject to COBRA, any right of continuation will likely not apply.

## Tax issues

- Under federal and state tax law, the contributions the employer makes to the HRA and the benefits paid from it are not taxable to the member
- Since contributions are not limited by law, the annual cost-of-living adjustments do not apply to HRAs.

# Flexible Spending Accounts (FSAs)

## How FSAs, HSAs and HRAs work together

The purpose of this section is to generally discuss the extent to which a member can participate in an FSA when participating in an HRA or owning an HSA.

### What is an FSA?

A flexible spending account (FSA) is an account offered by an employer to which members can make pre-tax contributions that can be used to reimburse the member for eligible medical expenses that are not otherwise covered or reimbursed by another health or insurance plan.

Any contributions the member makes to the FSA are made via pre-tax payroll deduction and are not taxable to the member. Reimbursements made to the member from his or her FSA are also not generally subject to federal income tax.

An FSA is subject to IRS statute and regulation, including:

- Generally, members can use an FSA to pay for medical care expenses, as they are defined in Code Section 213(d) that are incurred for themselves, their spouses and their eligible dependents.
- If the member doesn't use all of the funds in the FSA in a plan year or in the grace period following the plan year, the IRS allows an employer to roll over \$500 in an employee's FSA.
- Members cannot use their FSAs for health insurance premiums, or for expenses that are reimbursed or reimbursable by another source.
- Members can only change their FSA contribution election prospectively during a plan year when they experience a change in life status or other permitted events.

### Who can participate in an FSA?

Federal law allows current and former employees (such as former employees who receive severance pay) may participate, depending on plan design. Employers are not required to allow all current and former members to participate.

## **Who can contribute to an FSA and how much can they contribute?**

Both employers and members can contribute to an FSA; however, most employers do not contribute. Pre-tax contributions are usually deducted from each paycheck, but this can vary depending on the employer's FSA plan's rules.

Once an individual has decided on the amount to contribute, he or she can only change this amount when certain permitted events occur, including but not limited to, change in status events. Federal tax law does limit the dollar amount that an individual or employer can contribute to the FSA participants can only contribute \$2500 per plan year.

## **What happens when FSA funds are not used?**

Generally, the member forfeits any money contributed to the member's FSA that is not used to reimburse incurred expenses during the period of coverage, which is typically the 12-month plan year for the employer's FSA plan. IRS Regulations allow employers to offer a period of up to 2 ½ months following the end of the plan year during which participants can continue to incur expenses, and request reimbursement for those expenses, from his or her unused FSA balance for the prior year. FSA plan sponsors are also allowed to offer a carry over of \$500 to its plan participants.

This 2 ½-month extension can create difficulties for the employees who want to participate in an high-deductible health plan and make a full-year contribution to an HSA during the calendar year in which the extension is offered. If an employer offers a 2 ½-month extension for a FSA, but a member has a zero balance in his or her FSA at the end of the previous calendar year, the member may make a full-year contribution to the HSA during the calendar year in which the extension falls (assuming the member is an eligible individual who has enrolled in high-deductible health plan coverage).

However, if the member does not have a zero balance in his or her FSA at the end of the previous calendar year, and the member's employer offers the extension under the FSA, the member may generally not contribute the full amount to the HSA during the calendar year in which the extension falls.

Rather, because the coverage during the 2 ½-month extension is viewed as disqualifying coverage, the maximum HSA contribution is reduced by three months of contributions to nine-twelfths the contribution the member would otherwise be permitted to make.

For plan years beginning after December 31, 2012, plans may allow up to \$500 of unused amounts remaining at the end of the plan year to be paid or reimbursed for qualified medical expenses you incur in the following plan year. The plan may specify a lower dollar amount as the maximum carryover amount. If the plan permits a carry-over, any unused amounts in excess of the carryover amount are forfeited. The carryover does not affect the maximum amount of salary reduction contributions that you are permitted to make. A plan may allow either the grace period or a carryover, but it cannot allow both.

## What medical expenses can be paid with an FSA?

Like an HRA, the expenses paid with an FSA are determined in part by law and in part by the employer's FSA plan design. Federal tax law generally allows members to use the FSA to pay for medical expenses that are:

- Defined under Code Section 213(d), except for premiums for health coverage, which are not reimbursable by the FSA, and over-the-counter expenses, which, based on the new health care reform laws, are only considered a reimbursable expense if the member obtains a prescription.
- Incurred for the member, the member's spouse or eligible dependents during the period of time that the member is covered by the employer's FSA plan.
- Not deducted on the member's personal income tax return.
- Not or reimbursed by some other form of health insurance or coverage.

**Code Section 213(d) Expenses are expenses for health care which generally include amounts paid for:**

- The diagnosis, mitigation, cure, treatment or prevention of disease, or for the purpose of affecting any structure or body function.
- Certain transportation and lodging expenses that are incurred primarily for, and are essential to, such medical care.

Many expenses considered to be medical in nature are not eligible for reimbursement in a FSA. Below are some examples of items not eligible for reimbursement, this is not an exhaustive list:

- Expenses for cosmetic procedures, treatments and other services that are directed at improving appearance and that do not meaningfully promote the proper function of the body or prevent or treat illness or disease (unless they are necessary to correct a deformity that arises from, or is directly related to, a congenital abnormality, a personal injury that results from an accident or trauma, or a disfiguring disease).
- Illegal operations or treatments.
- Expenses that merely benefit your general health.
- Over-the-counter drugs or medications without a prescription.

Members may also access **myuhc.com** for a list of expenses that are generally reimbursable through a FSA. **For more information about the types of expenses that members can pay through their FSAs, members should read the Summary Plan Description for their employer's FSA plan.**



## Can employers offer HRA and FSA, and if so, what can be paid with each account?

Combining a UnitedHealthcare HRA with a FSA is a great way to help employees further control their health care costs.

Employees can opt to set aside a portion of their pre-tax earnings in an FSA to pay for uncovered out-of-pocket expenses, such as prescription drug payments, vision and dental expenses, and any remaining deductible that is not paid for by their UnitedHealthcare HRA. With careful planning, employees can use the two accounts to cover most, if not all, of their out-of-pocket health care costs.

## Can an HSA be used with an HRA or an FSA?

Depending on the employer's FSA plan design, members generally can use a FSA to pay for eligible expenses before they satisfy the applicable deductible under the medical plan, to pay for co-payments and co-insurance payments under the medical plan, and to pay for any Code Section 213(d) expenses that are not covered by the medical plan. This kind of general purpose FSA plan design, and similarly, a general purpose HRA plan design, is considered a non-high-deductible health plan. This prevents the member from being considered an eligible individual for purposes of making HSA contributions. **So as long as a member is participating in a general purpose FSA or HRA, the member cannot contribute to an HSA.**

There are, however, several types of HRAs and FSAs that do not prevent a member from being an eligible individual. The two most common types are the limited-purpose FSA and the post-deductible FSA.

- A limited-purpose HRA or FSA reimburses expenses for dental or vision that are not covered by an employer's consumer-driven or high-deductible health plan.
- A post-deductible FSA pays for covered services obtained under a high-deductible health plan, but only after the statutory minimum deductible is met that applies.

While federal tax law allows an employer to offer these alternative forms of HRAs and FSAs, an employer is not required to offer them to their employees. UnitedHealthcare can offer a limited-purpose FSA to pair with an HSA; however, we currently do not offer a post-deductible FSA, or a limited-purpose or post-deductible HRA.

## GLOSSARY

We developed the following definitions specifically for this handbook. If you already participate in a consumer-driven health plan or a high-deductible health plan, you should refer to the plan documents' terms for the specific definitions that apply to you.

**COBRA:** The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

**Code:** The United States Internal Revenue Code of 1986, as amended from time to time.

**Code Section 213(d) Medical Expenses:** Expenses for health care as defined in Code Section 213(d) which generally include amounts paid for:

- The diagnosis, mitigation, cure, treatment or prevention of disease or for the purpose of affecting any structure or body function; and
- Certain transportation and lodging expenses that are incurred primarily for and are essential to such medical care.

**Co-insurance:** Sharing, between the member and the member's health plan, of the cost of covered services. Co-insurance is the portion of the network expense that the member is responsible for paying to a network physician, usually expressed as a percentage. If services are obtained from a non-network physician, the member's co-insurance is the portion of the non-network expense that the member is responsible for paying to the non-network physician.

The health plan's co-insurance is the portion of the network expense that the plan is responsible for paying to a network physician or the portion of the non-network expense that the plan is responsible for paying to a non-network physician, also expressed as a percentage.

**Consumer-Driven Health Plan (CDH plan):** For the purposes of this handbook, a health plan that offers an HRA, and requires members to meet applicable deductibles, but which does not meet the statutory definition of a high-deductible health plan.

**Co-payment:** The fixed dollar amount the member must pay directly to a physician at the time certain covered services, such as prescription drugs, are received.

**Coverage Level:** Any of several different enrollment categories in which you can enroll under most health plans, and which may include some or all of the following:

- Employee;
- Employee plus spouse or employee plus one;
- Employee plus children; or
- Family.

**Covered Services:** Services and supplies that are listed in a health plan's Schedule of Benefits and provided while the person who receives the services is eligible to participate in and covered under the health plan.

**Deductible:** The fixed dollar amount the member must pay for covered services each plan year before the member's health plan begins to pay benefits.

**ERISA:** The Employee Retirement Income Security Act of 1974, as amended from time to time, is a federal law that regulates the administration of employee benefit plans, which are subject to its rules.

**FICA Taxes:** The combined taxes withheld for Social Security and Medicare.

**FUTA Taxes:** Federal unemployment taxes.

**Flexible Spending Account (FSA):** An employee's account in a health care flexible spending account plan that is set up under Code Section 125, to which the employee makes pre-tax contributions via payroll deduction, and which can be used to reimburse the employee for Code Section 213(d) Medical Expenses.

**Health Reimbursement Account (HRA):** An account that an employer sets up for employees who elect coverage under a consumer-driven health plan which offers an HRA, and to which the employer makes pre tax contributions for its employees, and which generally can be used to pay for Code Section 213(d) Medical Expenses.

**Health Savings Account (HSA):** An individual account that is established by an eligible individual who elects medical coverage under a high-deductible health plan with a bank or insurance company for the purpose of paying qualified medical expenses.

**High-Deductible Health Plan:**

A health plan, as defined by Code Section 223:

- That does not pay benefits until the covered person meets a deductible that satisfies a statutory minimum amount (the minimum deductible amount depends on the coverage level the covered person elects); and
- Under which the covered person's out-of-pocket expenses do not exceed a statutory maximum amount.

**IRS:** The Internal Revenue Service.

**Network:** A group of network physicians or health care professionals who have entered into an agreement to provide covered services at a discounted rate.

**Network Expense:** The negotiated discounted fee for covered services that a network physician or health care professional agrees to accept as full payment for such services.

**Network Physician:** A physician or other health care professional who has entered into an agreement to provide covered services at a discounted rate, which is referred to as a network expense.

**Non-Network Expense:** The portion of a billed charge imposed by a non-network physician and other health care professional for a covered service that the health plan uses in determining the co-insurance that the health plan and the member pay for the covered service. If the plan negotiates a fee with a non-network physician, the non-network expense is that negotiated fee. If a fee is not negotiated, the non-network expense is generally determined under the rules set forth in the applicable health plan document.

**Non-Network Physician:** A physician or other health care professional who has not previously entered into an agreement to provide covered services at a discounted rate.

**Out-of-Pocket Maximum:** The maximum dollar amount that a member has to pay under the terms of his or her health plan in a calendar year for covered services.

**Qualified Medical Expense:** Qualified medical expenses includes expenditures for medical care, as defined in Code 213(d) for the HSA account holder and his or her legal spouse and tax dependents, to the extent that such amounts are not reimbursed by insurance or any other source.

- Code Section 213(d) Medical Expenses, which include but are not limited to:
  - Payments members make for covered services until they meet the deductible that applies to them;
  - Co-insurance payments for covered services;
  - Co-payments for prescription drugs

Premium payments for:

- Continuation coverage under COBRA;
- Coverage under certain long-term care insurance contracts;
- Coverage under a health plan when a member receives federal or state unemployment compensation

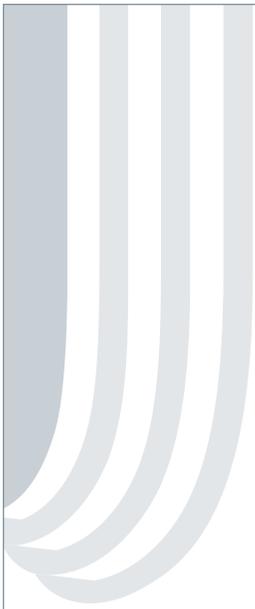
If a member is at least age 65, health insurance coverage other than a Medicare supplemental policy.

The following chart identifies several additional resources through which you and your employees can obtain more information about consumer-driven health plans and HRAs, high-deductible health plans and HSAs, and FSAs.

Please note that the content of these websites and applications may change from time to time.

Resource	Content	How to access
UnitedHealthcare's member website, myuhc.com®	<ul style="list-style-type: none"> <li>• Access personal health habits, learn techniques to stay healthy and get other useful information about general health and wellness</li> <li>• View (and track) claims information online</li> <li>• Use the customized physicians directory to find a physician who is in UnitedHealthcare's network</li> <li>• Select a hospital in your area based on the quality of care and cost ratings at the procedure level</li> <li>• Find pharmacy information to help make informed decisions regarding medications for you and your family</li> <li>• Simplify how you manage your health care account with immediate online access to the answers you need quickly and easily</li> <li>• Print a temporary ID card or request a replacement card</li> </ul>	www.myuhc.com
CDH Toolkit	The CDH Employer Toolkit has been enhanced to provide improved, consumer-tested communications to either help introduce a CDH plan or encourage increased adoption of an existing CDH plan or when transitioning from a traditional plan	Communication Resource Center (CRC) at www.uhctools.com
U.S. Department of the Treasury's website	<ul style="list-style-type: none"> <li>• FAQs about HSAs and HRAs</li> <li>• A link to the IRS forms and publications that are contained in the IRS website</li> <li>• Summaries of the tax rules that apply to HSAs</li> <li>• Links to the technical guidance that the IRS and Department of Labor have published about HSAs</li> <li>• List of links to other resources that address HSAs</li> </ul>	www.treas.gov
IRS website	<ul style="list-style-type: none"> <li>• Federal tax forms and instructions</li> <li>• Publications</li> <li>• Notices</li> <li>• Revenue procedures</li> <li>• Private letter rulings</li> <li>• Other guidances, all of which address HRAs, HSAs, and FSAs</li> </ul>	www.irs.gov
IRS Publication 502, Medical and Dental Expenses, IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans	Explains the medical and dental expenses that are deductible on a member's federal tax return	<ul style="list-style-type: none"> <li>• Via www.irs.gov and searching the "Forms and Publications" link.</li> <li>• Via phone by calling 1-800-TAX-FORM or requesting publication 502</li> </ul>
Health coverage	Summarizes some of the tax rules that apply to HRAs, HSAs, and FSAs	<ul style="list-style-type: none"> <li>• Via www.irs.gov and searching the "Forms and Publications" link.</li> <li>• Via phone by calling 1-800-TAX-FORM or requesting publication 969</li> </ul>





The UnitedHealthcare plan with Health Reimbursement Account (HRA) combines the flexibility of a medical benefit plan with an employer-funded reimbursement account.

Health savings accounts (HSAs) are individual accounts offered by Optum Bank<sup>SM</sup>, Member FDIC, and are subject to eligibility and restrictions, including but not limited to restrictions on distributions for qualified medical expenses set forth in section 213(d) of the Internal Revenue Code. State taxes may apply. Fees may reduce earnings on account.

Flexible spending arrangements (FSAs) and health reimbursement arrangements (HRAs) are administered by OptumHealth Financial Services<sup>SM</sup>.

This communication is not intended as legal or tax advice. Please contact a competent legal or tax professional for personal advice on eligibility, tax treatment, and restrictions. Federal and state laws and regulations are subject to change.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. The UnitedHealthcare plan with Health Savings Account (HSA) is a high deductible health plan (HDHP) that is designed to comply with IRS requirements so eligible enrollees may open a Health Savings Account (HSA) with a bank of their choice or through Optum Bank, Member of FDIC. The HSA refers only and specifically to the Health Savings Account that is provided in conjunction with a particular bank, such as Optum Bank, and not to the associated HDHP. This communication is not intended as legal or tax advice. Please contact a competent legal or tax professional for personal advice on eligibility, tax treatment and restrictions. Federal and state laws and regulations are subject to change.

Hypothetical examples are for illustrative purposes only. All events, persons and results described herein are entirely fictitious and amounts will vary depending on your unique circumstances. Any resemblance to