


## Internal Revenue Code Section 223(c)(1)

Health savings accounts.

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(c) Definitions and special rules. For purposes of this section—

 (1) Eligible individual.

(A) In general. The term "eligible individual" means, with respect to any month, any individual if--

(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

(I) which is not a high deductible health plan, and

(II) which provides coverage for any benefit which is covered under the high deductible health plan.

(B) Certain coverage disregarded. Subparagraph (A)(ii) shall be applied without regard to—

(i) coverage for any benefit provided by permitted insurance,

(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care, and

(iii) for taxable years beginning after December 31, 2006, coverage under a health flexible spending arrangement during any period immediately following the end of a plan year of such arrangement during which unused benefits or contributions remaining at the end of such plan year may be paid or reimbursed to plan participants for qualified benefit expenses incurred during such period if—

(I) the balance in such arrangement at the end of such plan year is zero, or

(II) the individual is making a qualified HSA distribution (as defined in section 106(e)) in an amount equal to the remaining balance in such arrangement as of the end of such plan year, in accordance with rules prescribed by the Secretary.

(2) High deductible health plan.

(A) In general [**Caution: For calendar year 2012, see § 2 of Rev. Proc. 2011-32 (note to this section) for inflation adjustments to deductible amounts for purposes of this subparagraph.**]. The term "high deductible health plan" means a health plan—

(i) which has an annual deductible which is not less than--

(I) \$ 1,000 for self-only coverage, and

(II) twice the dollar amount in subclause (I) for family coverage, and

(ii) the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—

(I) \$ 5,000 for self-only coverage, and

(II) twice the dollar amount in subclause (I) for family coverage.

(B) Exclusion of certain plans. Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B).

(C) Safe harbor for absence of preventive care deductible. A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1871 of the Social Security Act, except as otherwise provided by the Secretary).

(D) Special rules for network plans. In the case of a plan using a network of providers—

(i) Annual out-of-pocket limitation. Such plan shall not fail to be treated as a high deductible health plan by reason of having an out-of-pocket limitation for services provided outside of such network which exceeds the applicable limitation under subparagraph (A)(ii).

(ii) Annual deductible. Such plan's annual deductible for services provided outside of such network shall not be taken into account for purposes of subsection (b)(2).

(3) Permitted insurance. The term "permitted insurance" means—

(A) insurance if substantially all of the coverage provided under such insurance relates to--

(i) liabilities incurred under workers' compensation laws,

(ii) tort liabilities,

(iii) liabilities relating to ownership or use of property, or

(iv) such other similar liabilities as the Secretary may specify by regulations,

(B) insurance for a specified disease or illness, and

(C) insurance paying a fixed amount per day (or other period) of hospitalization.

(4) Family coverage. The term "family coverage" means any coverage other than self-only coverage.

(5) Archer MSA. The term "Archer MSA" has the meaning given such term in section 220(d).

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