

2020-2021 Consumer-Directed Health Plan/Health Savings Account Fact Sheet for Members

Your Consumer-Directed Health Plan

A Consumer-Directed Health Plan (CDHP),¹ coupled with an interest-bearing Health Savings Account (HSA), is a health plan that works a little differently from what you might be accustomed to.

Understanding how a CDHP/HSA functions will help you get the most from your benefits. This fact sheet provides CDHP/HSA basics, including how to get started after you enroll and how to use your CDHP/HSA benefits actively. The Episcopal Church Medical Trust (Medical Trust) offers seven CDHPs: three through Anthem Blue Cross and Blue Shield (Anthem BCBS), three through Cigna, and one through Kaiser Permanente (Kaiser). See details below about the plans.

CDHP Overview

A CDHP is designed to have a high deductible, a requirement that allows you to set up an HSA. This annual deductible applies to most covered medical, behavioral, and pharmacy benefits. It does not apply to most preventive care services. That means you pay 100% of your medical, behavioral, and prescription drug expenses until you have met your annual deductible. **Most preventive services are covered at 100% with no cost-sharing when using network providers.**

Once you have met the annual deductible, the plan shares expenses with you. You will then pay coinsurance for eligible services, but the total amount you pay will be limited to the annual out-of-pocket limit, which is the combined total of your annual deductible and annual coinsurance ceiling.

HSA Overview

A qualified CDHP—such as those offered through the Medical Trust from Anthem BCBS, Cigna, and Kaiser—allows employees to open an HSA, provided the HSA eligibility requirements are otherwise met. (See next section.)

With an HSA, you may choose to fund expenses out-of-pocket and let the tax-favored funds grow in your HSA for future healthcare expenses, or you may use them as needed. You, your employer, and/or others have the option of contributing to the account. Contributions are tax-free up to federal annual limits.

You should also understand these basic aspects of how an HSA works:

- Accounts are owned by the employee.
- Accounts are portable from employer to employer.
- Unused funds roll over from year to year.
- HSA funds can earn interest.
- Funds in the HSA may be invested (once any applicable minimum threshold is met).
- Withdrawals from the HSA are not subject to federal income tax when they are used to pay for qualified medical expenses.

¹Consumer-Directed Health Plan/Health Savings Account (CDHP/HSA) is used throughout to refer to the Anthem BCBS, Cigna, and Kaiser HDHPs, where they are alike. Any differences in the plans will be clearly noted within the text.

HSA Eligibility

To open an HSA, you must be enrolled in a qualifying CDHP. Generally, you are not permitted to be covered by other, disqualifying types of health plans, with these exceptions: AFLAC-type coverage, separate dental and vision coverage, and disability coverage. Disqualifying health coverage includes Medicare, TRICARE, non-CDHP coverage under a plan of your spouse's or domestic partner's employer, or healthcare flexible spending account (FSA) coverage. However, you are permitted coverage under a limited-purpose flexible spending account (LPFSA) or limited-purpose health reimbursement account (HRA). LPFSAs and limited-purpose HRAs are designed to work with HSAs. Contact your employer to see if an LPFSA or limited-purpose HRA is offered.

Also note that you may not be claimed as a dependent on another individual's tax return.

CDHP Basics

Preventive Care Services

Certain preventive care services are covered at 100% in-network. This means that you do not need to meet the deductible before the plan pays for recommended routine visits such as adult physicals, well-child visits, and OB/GYN annual exams. Depending on factors such as age and family history, other preventive care services may also be fully covered.

Annual Deductible (medical and pharmacy)

Your deductible is an integrated medical and pharmacy deductible. This means both your medical and pharmacy expenses count toward your deductible. It is important to keep in mind that your network and out-of-network deductibles accumulate separately.

Coinsurance

Once you meet your annual deductible,² you will pay coinsurance for eligible services. Coinsurance is a percentage of the allowed expense that you must pay. (The Medical Trust's CDHPs differ from other employer-provided plans, which often use copayments in addition to or instead of coinsurance.) The percentage you pay is lower when you use network providers than when using out-of-network providers.

After you pay your coinsurance, the plan pays the remainder of the bill for eligible services from network providers. For out-of-network provider services, you are responsible for coinsurance and any charges above the allowed amount, making out-of-network providers more costly than network providers in most cases.

Note: The Kaiser CDHP covers network services only.

CDHP Annual Out-of-Pocket Limit

Your plan sets a limit on the amount you will have to pay out-of-pocket for services each year. This is your "out-of-pocket limit" and is equal to the combined total of your annual coinsurance maximum and annual deductible.

After you reach the out-of-pocket limit,³ the plan will pay 100% of eligible charges for the remainder of the plan year.

It is important to note that your network and out-of-network out-of-pocket limits accumulate separately.

Network = Savings

You will usually pay less for services from network providers than you will from out-of-network providers, for two reasons. First, your network coinsurance is lower than your out-of-network coinsurance. Second, network providers can bill you based only on a certain amount, the "allowed amount."

The allowed amount is what our plan vendors—Anthem BCBS, Kaiser, and Cigna—have negotiated with service providers on behalf of the Medical Trust. These discounted rates for medical services from network providers can save you lots of money.

² Members enrolled in a CDHP-15 with covered dependents must meet the family deductible before the plan pays for any covered member.

³ Members enrolled in a CDHP-15 with covered dependents must reach the family out-of-pocket limit before the plan begins to pay 100% of covered services for any covered member.

Using Network Providers

Remember, going to a network provider should make things easier for you overall and may have significant cost-saving advantages.

1. Provide your health plan membership information when you call to make the appointment.
2. If you see a network provider, you are not required to make payment at the time of service.⁴ Your network provider will code the visit and bill it to your plan.
3. If you choose to pay out-of-pocket at the time of service, be sure that the service and your related payment are run through the vendor claims system so that any network discount will apply and your payment will be credited toward your network deductible.
4. Anthem BCBS, Cigna, or Kaiser will send you an Explanation of Benefits (EOB) informing you of the cost share you will pay for the services based on the negotiated rates and plan coverage.
5. You may make payment by using your HSA debit card⁵, or you can use another bank card and either reimburse yourself with funds from your HSA or let your health savings remain in the HSA for future use.
6. Many preventive care services are paid at 100% when you use a network provider; all other services are subject to the annual deductible and, if applicable, coinsurance.

Using Out-of-Network Providers

It is important to note that if you see an out-of-network provider, you may be required to make payment at the time of service. **Note:** The Kaiser CDHP covers network services only.

1. Provide your health plan membership information when you call to make the appointment.
2. You may make payment by using your HSA debit card⁵, or you can use another bank card and either reimburse yourself with funds from your HSA⁴ or let your health savings remain in the HSA for future use.
3. Be sure that the service and your related payment are run through the vendor claims system by reviewing your Explanation of Benefits so that your payment will be credited toward your out-of-network deductible and coinsurance maximum as applicable.

Prescription Benefits

Prescriptions must be paid for at the time of service at a retail pharmacy or through a mail-order pharmacy.

1. Provide the pharmacy with your Express Scripts card to ensure purchases are applied toward your annual deductible and coinsurance maximum, as applicable.
2. You will be paying the negotiated rate. (Coinsurance amounts begin once you have met your annual deductible.)
3. You may make payment by using your HSA⁵ debit card, or you can use another bank card and either reimburse yourself with funds from your HSA or let your health savings remain in the HSA for future use.

Using Your HSA Contributions

Making regular contributions to your Health Savings Account is a simple and convenient way to build up your HSA balance, creating tax-favored savings for future qualified medical expenses.

Keep Your Receipts

The IRS requires that you keep records to show that HSA distributions were used to pay for or reimburse qualified medical expenses that had not been previously paid or reimbursed from another source.

Note that you may cover dependents under a CDHP even if they are not your federal tax code

⁴ We encourage you to wait for your Explanation of Benefits from Anthem BCBS, Cigna, or Kaiser before making payment to ensure that the negotiated rate for service is applied.

⁵ Note that some banks have fees associated with reimbursing yourself through your debit card. Check with your financial institution about any such fees.

dependents for HSA purposes. For example, your 25-year-old child may not be a tax dependent, but he or she would still be eligible for coverage from the CDHP. Because your child is not a tax dependent, however, she or he will not be eligible to have expenses reimbursed from the HSA even though the child is covered under the CDHP.

If you do not use all of your HSA funds in one calendar year, the remaining money rolls over for use in future years. If you change plans or retire, the HSA is still yours and can be used for qualified medical expenses.

Tax-Free Advantage

You pay absolutely no federal taxes on any contributions (up to applicable limits), interest earned, or investment profits in your HSA. If you make a contribution to your HSA with money on which you have already been taxed, you can take a corresponding deduction on your federal income tax return, again, up to applicable limits. In addition, you are not subject to federal income tax when you withdraw money to pay for qualified medical expenses.

However, if you withdraw money for reasons other than to pay for qualified medical expenses, you will pay taxes and an IRS-determined penalty (currently 20%) on the amount of the withdrawal. The penalty does not apply if you are 65-plus years of age, or disabled, or if you have died and your HSA is being used by your spouse who is 65-plus years of age. (Spouses who are under 65 must then use the money for eligible expenses or pay a penalty.) If you have died and your beneficiary is someone other than your spouse, then the HSA ceases to be an HSA and the money in the account is fully taxable to the beneficiary.

HSA Funding Options

HealthEquity – Members who enroll in any CDHP through the Medical Trust will automatically have an HSA set up by HealthEquity, who will also send them a welcome kit. If the member uses HealthEquity as the HSA vendor, there are no setup fees for the HSA and maintenance fees are waived for the subscribing member only. If a subscribing member's employment is terminated or the member is no longer enrolled in a CDHP through the Medical Trust, she or he will be responsible for all fees.

HealthEquity also offers other advantages, including access to web-based tools that can assist you in tracking and monitoring your HSA activity.

Local bank chosen by your employer – In some cases, your employer may choose to use an institution other than HealthEquity for HSA funding. If so, you will receive information from your employer concerning the HSA funding process.

Financial institution of your choice – Members who do not wish to use HealthEquity as their HSA vendor can choose, after consulting with their employer, to establish an HSA with any appropriate institution (e.g., those qualified to administer IRAs), but they will be responsible for all fees.

If you do so, however, please keep in mind that you may not be able to direct to that financial institution contributions by your employer (if any) or tax-advantaged salary reduction contributions. Please check with your employer and the institution. Consequently, you may lose valuable employer contributions and the ability to make contributions through convenient payroll deduction. (You will still be able to make after-tax contributions up to the applicable contribution limit and claim a corresponding deduction on your federal income tax return.)

If you establish an HSA with HealthEquity (to receive employer contributions and your pre-tax contributions), you may then transfer any funds to an HSA with another bank.

Annual HSA Employer and Employee Combined Contribution Limits

2020	2021
Individual \$3,550	Individual \$3,600
Family \$7,100	Family \$7,200

If you are age 55 or older, you may make additional catch-up contributions of up to \$1,000 for 2020 and 2021.

Timing of HSA Contributions

Contributions to an HSA cannot occur until after the first of the month in which the CDHP becomes effective, and your HSA has been opened. What that means is if your plan becomes effective on January 1, contributions cannot be made until after that date. If you have medical expenses on January 1 before your account is funded, you can pay out-of-pocket and reimburse yourself from your HSA once the funds are deposited. No reimbursement is permitted for expenses incurred before you open your HSA. So, for example, if you delay and do not complete the requisite paperwork to open the account until February 1, expenses incurred in January cannot be reimbursed.

Employer HSA Contributions

Each employer (diocese, parish, school, or other Episcopal organization) establishes its HSA contribution policy in line with IRS requirements.

Your employer's HSA contribution policy will define the amount of funds, if any, your employer will contribute to your HSA, the frequency with which these contributions will be made (bi-weekly, monthly, quarterly, or annually), and who will be eligible for such contributions.

Your employer is responsible for communicating its contribution policy to you.

Employee HSA Contributions

Once opened, you may begin contributing funds into your HSA. To contribute, you can make pre-tax contributions through automatic payroll deductions (if available) or through an after-tax contribution that you mail in. You can then take a corresponding deduction on your taxes at the end of the tax year. You must make HSA contributions for a given calendar year by the tax filing deadline for that year (generally the following April 15, but in some years the date may differ due to the calendar).

Be mindful that your own contributions and any funding you will receive from your employer do not exceed the annual limits for HSA contributions.

Qualified Medical Expenses

Qualified medical expenses include, but are not limited to, deductibles and coinsurance, prescription drugs, mental health and substance use disorder treatment, as well as dental and vision services. HSA distributions can be used for qualified medical expenses for you, your spouse, and your federal tax code dependents. A list of qualified medical expenses can be found on the IRS website.

Funds in the HSA are yours to determine how best to use. You may use them right away to cover deductibles and coinsurance amounts, or you may choose to use your own money and pay out-of-pocket, and reserve the funds in your HSA as your tax-favored health savings for future expenses.

Managing HSA Funds

If, for instance, in March you have \$1,000 in your HSA and a \$1,500 medical bill, you can use the \$1,000 in the HSA and pay the additional \$500 from your own funds. Throughout the year, the IRS allows you to reimburse yourself the remaining \$500 from the HSA, as contributions are made into the account. You are responsible for keeping documentation to prove that the HSA funds being reimbursed were used for qualified medical expenses.

Tax Information

Your HSA custodian will provide the following forms to both you and the IRS annually:

Form 5498-SA – This form details HSA contributions made by you and your employer for the year.

Form 1099-SA – This form reports all HSA distributions made during the year.

Your employer must report to you on your Form W-2, in box 12 with code W, all employer HSA contributions as well as any HSA amounts contributed by you (from your paycheck) on a pre-tax basis through an Internal

Revenue Code section 125 cafeteria plan. You will be responsible for completing Form 8889, which details HSA contributions, when you file your Form 1040. Also, please note that any additional amounts contributed to your HSA must be reported on Form 8889 and may be eligible to be claimed as a tax deduction, which could lower your taxable income.

Domestic Partners and Same-Gender Spouses

If your group allows domestic partners to be covered as dependents on your health plan, then your domestic partner can be enrolled in the CDHP. However, the IRS does not permit an employee's HSA funds to be used to cover the healthcare expenses of domestic partners, unless the domestic partner otherwise qualifies as your federal tax code dependent.

The domestic partner can open his or her own HSA, which your employer may or may not choose to fund. Note, however, that an employer contribution to an HSA of a non-employee domestic partner would be included in the employee's taxable income.

Same-gender couples who are legally married can use the account in the same way as different-gender married couples.

Additional Benefits

CDHP members have access to the Medical Trust's value-added benefits, such as vision care through EyeMed, the Cigna Employee Assistance Program (EAP), Health Advocate, Amplifon Hearing Health Care discounts, and UnitedHealthcare Global Travel Assistance. For more information about these value-added benefits, please visit our website at cpg.org.

Members may use their HSA funds, if available, to cover any applicable coinsurance amounts under these benefits.

U.S. Treasury Department HSA Information

The HSA section of the IRS website has links to informational brochures, up-to-date regulations, FAQs, IRS forms, and publications, including these:

Publication 502 – A list of qualified medical expenses

Publication 969 – A detailed explanation of HSAs and how the IRS treats them

Questions?

For assistance with HSA procedures and account questions, members using HealthEquity can reach its Member Services team 24/7 at (866) 346-5800 or email memberservices@healthequity.com. Otherwise, please contact our Client Services team at (800) 480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET, or email mtcustserv@cpg.org.

This document contains only a partial description of the Medical Trust Plans and is intended for informational purposes only. It should not be viewed as a contract, an offer of coverage, or investment, tax, medical, or other advice. In the event of a conflict between this document and the official Plan documents (summary of benefits and coverage, Plan Document Handbooks), the official Plan documents will govern. The Church Pension Fund and its affiliates, including but not limited to the Medical Trust and the ECCEBT, retain the right to amend, terminate, or modify the terms of any benefit plans described in this document at any time, as well as any post-retirement health subsidy, for any reason, and unless required by law, without notice.

The Plans are church plans within the meaning of section 3(33) of the Employee Retirement Income Security Act and section 414(e) of the Internal Revenue Code. Not all Plans are available in all areas of the United States, and not all Plans are available on both a self-funded and fully-insured basis. The Plans do not cover all healthcare expenses, and members should read the official Plan documents carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.

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