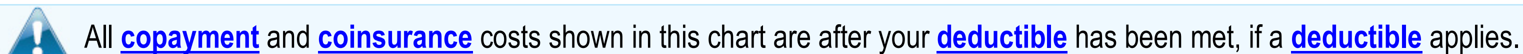
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the contribution or premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.cpg.org/mtdocs or call (800) 480-9967. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cpg.org/uniform-glossary or call (800) 480-9967 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$ 2,800**/Individual or **$5,450** Family network **$3,000** Individual or **$6,000** Family out-of-network	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family deductible. The **network** and **out-of-network deductibles** accumulate separately.
Are there services covered before you meet your deductible?	Yes, for example certain preventive services and COVID-19 expenses	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. See a list of preventive services at **healthcare.gov/coverage/preventive-care-benefits.****
Are there other deductibles for specific services?	No.	
What is the out-of-pocket limit for this plan?	For network providers, **$4,200** individual / **$8,450** family; for out-of-network providers **$7,000** individual / **$13,000** family	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met. The **network** and **out-of-network out-of-pocket limits** accumulate separately.
What is not included in the out-of-pocket limit?	**Premiums** (contributions), **balance-billing** charges, penalties, and healthcare this **plan** doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (844) 812-9207 for a list of **network providers**.	This **plan** uses a provider **network**. You will pay less if you use a **provider** in the plan's **network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the provider's charge and what your **plan** pays (**balance billing**). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

** See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and telehealth services.


All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	45% coinsurance	**
	Specialist visit	20% coinsurance	45% coinsurance	**
	Preventive care/screening/ immunization	No charge.	45% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. See a list of preventive services at **healthcare.gov/coverage/ preventive-care-benefits.**
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	45% coinsurance	**
	Imaging (CT/PET scans, MRIs)	20% coinsurance	45% coinsurance	**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	45% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	45% coinsurance	None.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	**
	Emergency medical transportation	20% coinsurance	20% coinsurance	**
	Urgent care	20% coinsurance	20% coinsurance	**
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	45% coinsurance	Prior authorization is required. **
	Physician/surgeon fees	20% coinsurance	45% coinsurance	
If you need mental health, behavioral health, or substance abuse services.	Outpatient services	20% coinsurance	45% coinsurance	Prior authorization required for inpatient services.
	Inpatient services	20% coinsurance	45% coinsurance	
	Colleague Group	30% coinsurance	30% coinsurance	The plan will reimburse 70% up to a maximum reimbursable fee of $40. The member is responsible for all costs above that amount.
If you are pregnant	Office visits	20% coinsurance	45% coinsurance	
	Childbirth/delivery professional services	20% coinsurance	45% coinsurance	Well-newborn care is covered. Newborn must be enrolled in the Plan within 30 days of birth.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% coinsurance	45% coinsurance	Limited to 210 visits per plan year. Prior authorization is required.
	Rehabilitation services	20% coinsurance	45% coinsurance	Benefits include hearing/speech, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.
	Habilitation services	20% coinsurance	45% coinsurance	
	Skilled nursing care	20% coinsurance	45% coinsurance	Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.
	Durable medical equipment	20% coinsurance	45% coinsurance	None.
	Hospice services	No charge.	45% coinsurance	
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Vision benefits are available through EyeMed Vision Care.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail	Home Delivery	
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	15% (after deductible)		You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery. Your prescription deductible and out-of-pocket limit is combined with your medical deductible and out-of-pocket limit.
	Preferred brand drugs	25% (after deductible)		
	Non-preferred brand drugs	50% (after deductible)		
	Specialty drugs	Your cost is based on whether the specialty drug is a preferred brand or non-preferred brand drug.		

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Bariatric surgery	• Chiropractic care
• Hearing aids	• Infertility treatment	• Non-emergency care when traveling outside the U.S.[1]
• Private-duty nursing		

COVID-19 Evaluation, Testing, and Treatment and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays, deductibles, and coinsurance for all telehealth services received through vendor platforms. The Medical Trust will also allow claims for virtual visits with network and out-of-network providers who do not use a telehealth platform offered by Anthem. Standard deductibles, copays, and coinsurance will apply.

Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements[2]. Nonetheless, subscribers and/or their enrolled dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call (800) 480-9967 for more information.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Anthem Blue Cross and Blue Shield or Express Scripts as appropriate.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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[1] Coverage for non-emergency care when traveling outside the U.S. applies only to services available through Anthem Blue Cross and Blue Shield. Non-emergency care outside the U.S. is not available through Express Scripts.

[2] Under Section 4980B(d) of the Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al (800) 480-9967.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 480-9967.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 480-9967.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 480-9967.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$2,700**
- **Specialist *[cost sharing]*** **20%**
- **Hospital (facility) *[cost sharing]*** **20%**
- **Other *[cost sharing]*** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,739**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$0
Coinsurance	$2,525
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,260**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$2,700**
- **Specialist *[cost sharing]*** **20%**
- **Hospital (facility) *[cost sharing]*** **20%**
- **Other *[cost sharing]*** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$0
Coinsurance	$1,582
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$4,255**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$2,700**
- **Specialist *[cost sharing]*** **20%**
- **Hospital (facility) *[cost sharing]*** **20%**
- **Other *[cost sharing]*** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,540
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

EPISCOPAL CHURCH MEDICAL TRUST

2021-2022 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 a 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 works 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.

How a CDHP Works

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.

A CDHP is a high deductible health plan that allows you to set up an HSA to help pay for eligible healthcare expenses. It has many similarities to other types of health plans:

- Most preventive care services, such as age-appropriate annual preventive exams, well-child visits, and OB/GYN annual exams, are covered at 100% with no member cost-sharing when using network providers. Depending on your age and family history, other preventive care services may also be covered.
- You pay out of pocket until you reach the annual deductible,[2] then the plan begins to pay benefits. Your deductible is an integrated medical (including behavioral) and pharmacy deductible. This means both your medical and pharmacy expenses count toward your deductible.
- You will generally pay less when you use a network provider.[3]
- The plan has an out-of-pocket limit,[4] which is the most you will have to pay for eligible healthcare expenses each plan year. Once you reach this limit, the plan will begin to pay 100% of eligible expenses for the remainder of the plan year.

There are also important differences:

- CDHPs have higher annual deductibles, which include medical and prescription drug costs. That means you pay the full cost of medical and prescription drug costs until you reach the plan's annual deductible.
- Once you meet your annual deductible, you will pay coinsurance, which is a percentage of the cost for eligible services. This is different from other plans, which often use copayments in addition to or instead of coinsurance.
- You may set up an HSA to help pay for eligible expenses, including your annual deductible and coinsurance, with tax-free money. You can also choose to save your HSA money for future healthcare expenses.

[1] *Unless otherwise explicitly stated, Consumer-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.*

[2] *Your network and out-of-network deductibles accumulate separately, meaning one does not apply to the other. Members enrolled in a CDHP-15 with covered dependents must meet the family deductible before the plan pays for any other covered member.*

[3] *The Kaiser CDHPs do not cover out-of-network providers.*

[4] *Your network and out-of-network out-of-pocket limits accumulate separately, meaning one does not apply to the other. 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.*

How a HSA Works

An HSA is like a savings account for eligible healthcare expenses. When you enroll in the CDHP, you can contribute tax-free to an HSA. Here's how it works:

- You decide if you want to contribute and how much, up to IRS maximums. You can change or stop your contributions any time during the year.
- You can use the money in your HSA to pay for eligible healthcare expenses, including your annual deductible and medical, prescription, dental, and vision costs.
- You may also save the money in your HSA for future medical costs—including healthcare expenses in retirement.
- Your HSA is portable and will always belong to you, even if you change employers or retire.

Tax Advantages

There are three tax advantages that come with your HSA:

1. You do not pay taxes on your contributions.
2. Withdrawals from your HSA are tax-free as long as they are used to pay for qualified medical expenses.
3. Your earnings on investments are tax-free, (note that certain restrictions, such as minimum balance requirements, may apply to investment options).

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

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: certain limited forms of supplemental health coverage (described in IRS Publication 969), 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.

To Contribute to an HSA

You must be enrolled in a qualifying Consumer-Directed Health Plan (CDHP) and cannot:

- be covered by Medicare, TRICARE, or other medical insurance,
- be claimed as a dependent on someone's tax return, or
- contribute to a Flexible Spending Account

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.[5] Second, network providers can bill you based only on a certain amount, the "allowed amount."

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

Using Network Providers

Remember, going to a network provider 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.[6] 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 health plan carrier 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 card,[7] 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.[5]

1. Provide your health plan membership information when you call to make the appointment.
2. You may make payment by using your HSA debit card, or you can use another bank card and either reimburse yourself with funds from your HSA[7] 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 health plan carrier 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 pay the negotiated rate. (Coinsurance begins once you have met your annual deductible.)
3. You may make payment by using your HSA debit card,[7] 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.

[5] *The Kaiser CDHPs do not cover out-of-network providers.*

[6] *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.*

[7] *Note that some banks have fees associated with reimbursing yourself through your debit card. Check with your financial institution.*

Keep Your Receipts

The IRS requires that you keep records to show that HSA withdrawals 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 Medical Trust CDHP even if they are not your federal tax code dependents for HSA purposes. For example, your 25-year-old child may not be a tax dependent, but they would still be eligible for coverage under the CDHP. Because your child is not a tax dependent, however, they will not be eligible to have expenses reimbursed from the HSA even though the child is covered under the CDHP. Remember: CDHP coverage depends on the Medical Trust's plan eligibility rules, but using HSA funds on a tax-free basis depends on the Federal tax code.

Any unused HSA funds will remain in your HSA for use in future years—there is no "use it or lose it" rule. If you change medical plans or retire, the HSA is still yours and can be used for qualified medical expenses.

Setting up an HSA

HealthEquity—If you enroll in a Medical Trust CDHP, you will automatically have an HSA set up by HealthEquity, who will send you a welcome kit. If you use HealthEquity, there are no setup fees for the HSA and your maintenance fees are waived. If your employment ends or you are no longer enrolled in a CDHP through the Medical Trust, you will be responsible for all fees.

HealthEquity also offers many 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 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—If you do not wish to use HealthEquity, you may, after consulting with your employer, establish an HSA with any qualified financial institution., but You will be responsible for all fees.

If you do so, please keep in mind that you may not be able to direct contributions by your employer (if any) or pre-tax contributions to that financial institution. 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 contribution limits and claim a 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 funds to an HSA with another qualified financial institution.

Annual HSA Employer and Employee Combined Contribution Limits

The IRS sets the maximum amount that can be contributed to an HSA each year.

2021		2022	
Individual	$3,600	Individual	$3,650
Family	$7,200	Family	$7,300

If you are age 55 or older, you may make additional catch-up contributions of up to $1,000 per year.

These limits include your contributions plus any employer contributions, so keep that in mind when choosing how much to set aside in your HSA.

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

If you set up an HSA with HealthEquity or a financial institution chosen by your employer, you can make pre-tax contributions through automatic payroll deductions (if available). If you use a different financial institution, you can mail in an after-tax contribution, for which you can take a corresponding tax deduction at the end of the tax year. HSA contributions for a given calendar year must be made by the tax filing deadline for that year (generally, the following April 15).

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

If Your Qualified Expenses Exceed the Amount in Your HSA

If your HSA funds do not cover your healthcare expenses, you can pay the difference out-of-pocket and reimburse yourself as funds are added to your account. For example, if you have $1,000 in your HSA in March and you incur $1,500 in medical expenses, you can use the $1,000 from your HSA and pay the additional $500 out-of-pocket. Throughout the year, you may reimburse yourself the remaining $500 from the HSA, as contributions are added to your account. You are responsible for keeping documentation to prove that the HSA funds being reimbursed were used for qualified medical expenses.

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.

Domestic Partners and Same-Gender Spouses

If your group allows domestic partners to be covered as dependents on your health plan, you may enroll your domestic partner in the CDHP. However, the IRS only permits an employee's HSA funds to be used to cover the healthcare expenses of a domestic partner if that domestic partner otherwise qualifies as your federal tax code dependent.

Your domestic partner can open their 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

If you enroll in the CDHP, you will 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*.

You may use your 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

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.

Questions?

If you have an HSA through HealthEquity and have questions or need assistance with HSA procedures and account questions, you may contact their 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.