This Supplement to your Summary of Benefits and Coverage (SBC) document will help understand how your health plan costs are reduced by a Health Reimbursement Arrangement (HRA). You received an SBC from your insurer that shows how you and the plan would share the cost for covered health care services. This Supplement shows how your deductible and out of pocket costs under the plan are reduced by the HRA.
This is only a supplement to your summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact your employer. For general definitions of common terms, please see the SBC provided by your insurer.

Important Questions	Answers	Why This Matters:
What is the overall HRA deductible?	$1,500 /Employee Only or $3,000 Employee + Dependents	Generally, you must pay all of the costs from providers up to the deductible amount before this HRA component of the 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.
Are there other deductibles for specific services?	No	You must pay all of the costs for these services up to the specific deductible amount before this HRA component of the plan begins to pay for these services.
What is the out-of-pocket limit for the HRA?	For network providers $1,500 for Employee Only / $3,000 Employee + Dependents	Your out-of-pocket limit is reduced by the benefits paid from the HRA. 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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the HRA pays?	Yes. $4,700 Employee Only or $5,550 Employee + Dependents	The maximum annual HRA benefit is $4,700 for Employee Only and $5,550 for Employee + Dependents subject to the insurance deductible. You are responsible for all other expenses above the HRA benefit, subject to the terms of your health plan.

Your Rights to Continue Coverage: If you want to continue your HRA coverage after it ends, contact your employer or the U.S. Department of Labor, 200 Constitution Ave. NW, Washington DC 20210 1-866-444-EBSA. Other coverage that may be available as described in the plan SBC will not include HRA benefits.

Your Grievance and Appeals Rights: For more information about your rights, refer to the plan SBC.

Does this plan provide Minimum Essential Coverage? Yes, in combination with the insured portion of your plan.

Does this plan meet Minimum Value Standards? Yes, in combination with the insured portion of your plan.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care with the HRA. 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 with the HRA. 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 overall HRA deductible	$1,500
Specialist copayment	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
HRA reimburses	$4,700
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,500**

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

The overall HRA deductible	$1,500
Specialist copayment	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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*	$1,500
HRA reimburses	$4,700
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,500**

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

The overall HRA deductible	$1,500
Specialist copayment	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,500
HRA reimburses	$900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

Note: The HRA does not include a wellness program. Please refer to the SBC for the plan for any wellness program information that may apply.

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

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 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 the website: secure.healthx.com/ssh.aspx 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Uniform-Glossary-01-2020.pdf or call 1-855-522-1917 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $6,000 / individual or $8,350 / family Out of Network: : $12,000 / individual or $16,700 / family	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.
Are there services covered before you meet your deductible?	Yes. Preventive Care, is covered before you meet your deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	There are no other deductibles.
What is the out-of-pocket limit for this plan?	For network providers $6,200 / individual or $8,550 / family; for out- of-network Unlimited	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.
What is not included in the out-of-pocket limit?	premiums, balance-billing charges, and health care this plan doesn't cover. Preauthorization penalties, and charges that exceed eligible expenses	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 : secure.healthx.com/ssh.aspx . or call 1-855-522-1917 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 may see any specialist without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay more)	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	10% coinsurance after deductible	50% coinsurance after deductible	None
	Specialist visit	10% coinsurance after deductible	50% coinsurance after deductible	None
	Preventive care/screening/ immunization	Covered 100%, deductible does not apply	50% coinsurance after deductible	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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	50% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required or benefits will be denied.
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Retail 10% coinsurance after deductible	Not covered	ACA Preventive Generic are covered at 100%, no deductible Covers up to a 30-day supply (retail subscription); 31-90-day supply (mail order prescription).
		Mail Order 10% coinsurance after deductible		
	Preferred brand drugs (Tier 2)	Retail 10% coinsurance after deductible	Not covered	
		Mail Order 10% coinsurance after deductible		
	Non-preferred brand drugs (Tier 3)	Retail 10% coinsurance after deductible	Not covered	
		Mail Order 10% coinsurance after deductible		
	Specialty drugs (Tier 4)	Retail 10% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
		after deductible		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required or benefits will be denied.
	Physician/surgeon fees	10% coinsurance after deductible	50% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	10% coinsurance after network deductible		None
	Emergency medical transportation	10% coinsurance after network deductible		None
	Urgent care	10% coinsurance after deductible	50% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required or benefits will be denied.
	Physician/surgeon fees	10% coinsurance after deductible	50% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Office visits	10% coinsurance after deductible	50% coinsurance after deductible	None
	Inpatient services	10% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required or benefits will be denied.
If you are pregnant	Office visits	10% coinsurance after deductible	50% coinsurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization required for hospital stays longer than 48 hours of normal vaginal deliver or 96 hours for cesarean section delivery
	Childbirth/delivery professional services	10% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery facility services	10% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	50% coinsurance after deductible	Limited to 130 visits per plan year. Preauthorization required or benefits will be denied.
	Rehabilitation services	Outpatient 10% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required or benefits will be denied. Limited to 45 visits per plan year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
				Combined with Habilitation Services
		Inpatient 10% coinsurance after deductible		Preauthorization required or benefits will be denied. Limited to 30 days per plan year. Combined with Habilitation Services
	Habilitation services	Outpatient 10% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required or benefits will be denied. Limited to 45 visits per plan year. Combined with Rehabilitation services
		Inpatient 10% coinsurance after deductible		Preauthorization required or benefits will be denied. Limited to 30 days per plan year. Combined with Rehabilitation services
	Skilled nursing care	10% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required or benefits will be denied. Limited to 60 days per plan year, combined with in and out of network providers.
	Durable medical equipment	10% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required or benefits will be denied. Orthotics covered up to $300 per plan year, subject to formulary guidelines.
	Hospice services	10% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required or benefits will be denied.
If your child needs dental or eye care	Children's eye exam	10% coinsurance after deductible	Covered 100%, deductible does not apply	Refractive exam only limited to 1 exam every 12 months.
	Children's glasses	Not covered	Not covered	None.
	Children's dental check-up	Not covered	Not covered	Not covered except services listed under the ACA guidelines (Network)

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (12 visits per plan year)
- Chiropractic care (15 visits per plan year
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

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 on how 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: contact the plan administrator. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. "Additionally, a consumer assistance program can help you file your appeal. Contact ." A list of states with Consumer Assistance Programs is available at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al -1-855-522-1917

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa -1-855-522-1917

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 -1-855-522-1917

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' -1-855-522-1917

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

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** **$6,000**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	**$12,700**
In this example, Peg would pay: $	
Cost Sharing	
Deductibles	$6,000
Copayments	$100
Coinsurance	$1,263
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,323**

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

- **The plan's overall deductible** **$6,000**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	**$5,600**
In this example, Joe would pay: $	
Cost Sharing	
Deductibles*	$6,000
Copayments	$0
Coinsurance	$718
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$6,774**

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

- **The plan's overall deductible** **$6,000**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	**$2,800**
In this example, Mia would pay: $	
Cost Sharing	
Deductibles*	$1,733
Copayments	$0
Coinsurance	$193
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**