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?	$500 /Individual or $1,000 /family	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 $2,050 individual / $4,100 family;	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. $6,500 /Individual or $13,000/family	The maximum annual HRA benefit is $6,500 for each person 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	$500
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$500
HRA reimburses	$6,500
Copayments	$400
Coinsurance	$1,150
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,050**

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

The overall HRA deductible	$500
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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*	$500
HRA reimburses	$5,000
Copayments	$480
Coinsurance	$1,070
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,050**

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

The overall HRA deductible	$500
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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*	$500
HRA reimburses	$600
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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: $7,000 / individual or $14,000 / family Out of Network: : $14,000 / individual or $28,000 / 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 mee your deductible?	Yes. Preventive Care, is covered before you meet your deductible	This plan 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 $8,550 / individual or $17,100 / family; for out-of-network Unlimited / individual or Unlimited / 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.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan cover. Preauthorization penalties, and charges that exceed eligible expenses	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 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 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

Important Questions	Answers	Why This Matters:
		services.
Do you need a referral to see a specialist?	No.	You may see any specialist without a referral.

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

Common Medical Even	Services You May Nee	What You Will Pay		Limitations, Exceptions, & Other Import Information
		Network Provider (You will pay the leas	Out-of-Network Provide (You will pay the most	
If you visit a health car office or clinic	Primary care visit to treat an injury or illness	$40 copay, deductible does not apply	50% coinsurance after deductible	None
	Specialist visit	$40 copay, deductible does not apply	50% coinsurance after deductible	None
	Preventive care/screening/ immunization	Covered 100%, deductible does not apply	50% coinsurance after deductible	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)	20% coinsurance after deductible	50% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required or benefits may be reduced
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Retail $15 copay, deductible does not apply	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 $30 copay, deductible does not apply		
	Preferred brand drugs (Tier 2)	Retail $25 copay, deductible does not apply	Not covered	
		Mail Order $50 copay, deductible does not apply		

Common Medical Even	Services You May Nee	What You Will Pay		Limitations, Exceptions, & Other Import Information
		Network Provider (You will pay the leas	Out-of-Network Provide (You will pay the most	
	Non-preferred brand drugs (Tier 3)	Retail $45 copay, deductible does not apply	Not covered	
		Mail Order $90 copay, deductible does not apply		
	Specialty drugs (Tier 4)	$100 copay, deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required or benefits may be reduced
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$250 copay then 30% coinsurance		Copay waived if admitted to inpatient status.
	Emergency medical transportation	30% coinsurance after in network deductible		None
	Urgent care	$40 copay, deductible does not apply	50% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. If Preauthorization is not obtained your benefits may be reduced.
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay, deductible does not apply	50% coinsurance after deductible	None
	Inpatient services	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. If Preauthorization is not obtained your benefits may be reduced.
If you are pregnant	Office visits	30% 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
	Childbirth/delivery professional services	30% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery facility services	30% coinsurance after deductible	50% coinsurance after deductible	

Common Medical Even	Services You May Nee	What You Will Pay		Limitations, Exceptions, & Other Import Information
		Network Provider (You will pay the leas	Out-of-Network Provide (You will pay the most	
				or 96 hours for cesarean section delivery
If you need help recovering o have other special health needs	Home health care	30% coinsurance after deductible	50% coinsurance after deductible	Limited to 130 visits per plan year. Preauthorization required or benefits may be reduced
	Rehabilitation services	Outpatient: $40 copay, deductible does not apply	50% coinsurance after deductible	Preauthorization required or benefits may be reduced. Limited to 45 visits per plan year. Combined with Habilitation Services
		Inpatient 30% coinsurance after deductible		Preauthorization required or benefits may be reduced. Limited to 30 days per plan year. Combined with Habilitation Services
	Habilitation services	Outpatient $40 copay, deductible does not apply	50% coinsurance after deductible	Preauthorization required or benefits may be reduced. Limited to 45 visits per plan year. Combined with Rehabilitation services
		Inpatient 30% coinsurance after deductible		Preauthorization required or benefits will be denied. Limited to 30 days per plan year. Combined with Rehabilitation services
	Skilled nursing care	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required or benefits may be reduced. Limited to 60 days per plan year, combined with in and out of network providers.
	Durable medical equipment	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required or benefits may be reduced. Orthotics covered up to $300 per plan year, subject to formulary guidelines.
	Hospice services	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required or benefits may be reduced.
If your child needs dental or eye care		Covered 100%, deductible does not apply	Covered 100%, deductible does not apply	Refractive exam only limited to 1 exam every 12 months.
		Not covered	Not covered	None.
	-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	Long-term care	Routine eye care (Adult)
Cosmetic surgery	Non-emergency care when traveling outside the U.S.	Routine foot care
Dental care (Adult)		Weight loss programs
Hearing aids		
Infertility treatment		

plan document.)	
Acupuncture (if prescribed for rehabilitation purposes)	Chiropractic care
	Private-duty nursing

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 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 at 1-541-664-1261. You may also contact the -866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. vailable 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 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 -541-664-1261

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa -541-664-1261

Chinese ( ): , -541-664-1261

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' -541-664-1261

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

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About these Coverage Examples

This is not a cost estimator. The 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 overall deductible	$5,000
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	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	$12,70

In this example, Peg would pay: $

Cost Sharing	
Deductibles	
Copayments	
Coinsurance	
Limits or exclusions	
The total Peg would pay is	

(a year of routine in-network care of a well-controlled condition)

The overall deductible	$
Specialist copayment	
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$5,60

In this example, Joe would pay: $

Cost Sharing	
Deductibles*	
Copayments	
Coinsurance	
Limits or exclusions	
The total Joe would pay is	

(in-network emergency room visit and follow up care)

The overall deductible	
Specialist copayment	
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,80

In this example, Mia would pay: $

Cost Sharing	
Deductibles*	
Copayments	
Coinsurance	
Limits or exclusions	
The total Mia would pay is	