COVERAGE FIRST PLAN: Republic Bancorp Inc.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2022 – 12/31/2022

Coverage for: Individual/Family **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by contacting the Plan Administrator at hhaggard@republicbank.com or call 1-502-420-1804.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PAR providers **$2,500** single**/$7,500** family per plan year. For NONPAR provider's **$5,000** single**/$15,000** family. **Coinsurance** & **copayments** don't apply to the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use (with some exceptions such as Office Visits or therapy services that are covered at 100% after the applicable co-pay). The Plan's **deductible** starts over January 1st of each year. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes.** For PAR providers **$0** single**/$0** family per plan year. For NONPAR providers **$4,000** single**/$12,000** family. Plan Maximum Out-of-Pocket for PAR providers: $6,350 single/$12,700 family; For Non-PAR providers: not applicable.	The **out-of-pocket limit** is the most you could pay during a coverage period (calendar year) for your share of the cost of covered services which include annual deductible, coinsurance and copays. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Penalties and Non-Par transplant.	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 plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.humana.com** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-502-420-1804 or send email to hhaggard@republicbank.com
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. In this Plan, for example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment for a network hospital would be 0%, but still subject to the annual in-network deductible. However, if the service were provided by a non-network hospital, you would be responsible for the non-network provider benefit of 30% coinsurance after the non-network deductible is satisfied.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan encourages you to use PAR **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PAR Provider	Your Cost If You Use a NONPAR Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment	30% after deductible	——————none——————
	Specialist visit	$40 copayment	30% after deductible	——————none——————
	Other practitioner office visit (Chiro)	$40 copayment	30% after deductible	Limited to 20 visits per year
	Preventive care/screening/immunization	No charge	30% after deductible	-Proctosigmoidoscopy and Sigmoidoscopy screenings limited to 1 per year. -Limited to 1 well women visit per year.
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	30% after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge after deductible	30% after deductible	Prior auth is required. Failure to do so will cause a penalty of 20% before any copays/deductible/coinsurance.

Common Medical Event	Services You May Need	Your Cost If You Use a PAR Provider	Your Cost If You Use a NONPAR Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.humana.com.	Level 1 – 30-days at Retail 90 days at Retail 90 days at Mail Order	$10 $20 $20	30% coinsurance after PAR deductible	• Retail day supply - 30 • Mail day supply - 90 • $250 front-end deductible applies to brand name drugs only. • Flu and Pneumonia immunizations, Shingles vaccine and drugs on the Women's Healthcare Drug List at PAR pharmacies: No charge. • Smoking Cessation products - 50% cost share. • Prior auth and step therapy may be required for some medications. • For specialty drugs administered in a doctor's office there is no charge after deductible. If administered by a network hospital inpatient or outpatient there is no charge after deductible; and if by a non-network inpatient or outpatient your cost is 30% after non-network deductible.
	Level 2 – 30-days at Retail 90 days at Retail 90 days at Mail Order	$40 $80 $80	30% coinsurance after PAR deductible	
	Level 3 – 30-days at Retail 90 days at Retail 90 days at Mail Order	$60 $120 $120	30% coinsurance after PAR deductible	
	Level 4 – 30-days at Retail 90 days at Retail 90 days at Mail Order	25% Copay 25% copay 25% copay	30% coinsurance after PAR deductible	
	Specialty Drugs administered for Home Health Care	No charge (RightSource Home Health Care) $50 copay (Other Home Health Care)	50% coinsurance after Non-PAR deductible 50% coinsurance after Non-PAR deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copayment then no charge after deductible	30% after deductible	——————none——————
	Physician/surgeon fees	No charge after deductible	30% after deductible	——————none——————

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Common Medical Event	Services You May Need	Your Cost If You Use a PAR Provider	Your Cost If You Use a NONPAR Provider	Limitations & Exceptions
If you need immediate medical attention	True-Emergency room services Non- Emergency room services	$300 copayment then no charge after deductible. $300 copayment then no charge after deductible.	$150 copayment then no charge after PAR deductible. 30% after deductible	——————none——————
	Emergency medical transportation	No charge after deductible	No charge after PAR deductible	——————none——————
	Urgent care	$75 copayment	30% after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 copay for the first 5 days then no charge after deductible.	30% after deductible	Prior auth is required. Failure to do so will cause a penalty of 20% before any copays/deductible/coinsurance.
	Physician/surgeon fee	No charge after deductible	30% after deductible	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copayment	30% after deductible	——————none——————
	Mental/Behavioral health inpatient services	$150 copay for the first 5 days then no charge after deductible	30% after deductible	Prior auth is required. Failure to do so will cause a penalty of 20% before any copays/deductible/coinsurance.
	Substance use disorder outpatient services	$40 copayment	30% after deductible	——————none——————
	Substance use disorder inpatient services	$150 copay for the first 5 days then no charge after deductible	30% after deductible	Prior auth is required. Failure to do so will cause a penalty of 20% before any copays/deductible/coinsurance.
If you are pregnant	Prenatal and postnatal care	$40 copayment	30% after deductible	——————none——————
	Delivery and all inpatient services	$150 copay for the first 5 days then no charge after deductible.	30% after deductible	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a PAR Provider	Your Cost If You Use a NONPAR Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge after deductible	30% after deductible	Limited to 100 visits per year.
	Rehabilitation services	No charge after deductible	30% after deductible	Limited to 60 combined visits for physical, occupational, speech and cognitive therapies.
	Habilitation services	No charge after deductible	30% after deductible	
	Skilled nursing care	No charge after deductible	30% after deductible	Limited to 60 days per year. Prior auth is required. Failure to do so will cause a penalty of 20% before any copays/ deductible/coinsurance.
	Durable medical equipment	No charge after deductible	30% after deductible	• Wigs for cancer patients due to hair loss resulting from Chemotherapy and/or radiation. Limited to $1,000 per year. • Prior auth is required for DME over $750. Failure to do so will cause a penalty of 20% before any copays/deductible/coinsurance.
	Hospice service	No charge	No charge	Prior auth is required. Failure to do so will cause a penalty of 20% before any copays/deductible/coinsurance.
If your child needs dental or eye care	Eye exam, glasses and contacts	Not covered	Not covered	Routine vision care is *not covered* by the medical plan.
	Routine Dental care	Not covered	Not covered	Non-injury related dental services not covered by medical plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Dental care (adult and child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care (Limited to 20 visits)
- Private-duty nursing (inpatient only; limited to 30 days per year)
- Cosmetic surgery (Requires prior auth. Services will only be considered if due to a bodily injury or illness and functional impairment is present.)
- Hearing aids (for member s under 18 years of age limited to 1 hearing aid per impaired ear up to $1,400 every 36 months)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-502-420-1804. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,590
- **Patient pays** $2,950

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,500
Copays	$300
Coinsurance	$0
Limits or exclusions	$150
Total	**$2,950**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,660
- **Patient pays** $2,740

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,500
Copays	$160
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,740**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.