PPO 250 PLAN: Republic Bancorp Inc.

Coverage Period: 01/01/2023 – 12/31/2023

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **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 tpate@republicbank.com or call 1-502-588-1681.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$500** Individual **/ $1,000** Family. Non-Network **$1,000** Individual **/$2,000** 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 meet your deductible?	Network Providers: Yes. Preventive Care, Certain Office Visits, Emergency Room Care, Urgent Care, Prescription Drugs and Certain therapies. Non-Network Providers: Yes. Emergency Room Care and Prescription Drugs.	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 care services without cost-sharing and before you meet your deductible. See a list of covered preventive care services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Name Brand Pharmacy Deductible: Network Providers: $250 Individual / $0 Family. Non-network providers: $250 Individual / $0 Family. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific Name Brand deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For Network Providers: $2,250 Individual / $4,500 Family. For Non-network providers: $4,500 Individual / $9,000 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
What is not included in the out–of–pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties, Non-network transplant, non-network prescription drugs, non-network specialty drugs.	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.humana.com/directories or call 866-4ASSIST (427-7478) for a list of network providers.	This plan uses a network provider. 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-pocket limit 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 I need a referral to see a specialist?	No	You can see the **specialist** you choose without a referral.

- **Copayments** are fixed dollar amounts (for example, $25) 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. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 10% would be $100. This may change if you haven't met your **deductible**.
- 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	Primary care visit: $25 copay/visit; deductible does not apply Virtual visit: $25 copay/visit; deductible does not apply	40% after deductible	——————none——————
	Specialist visit	$40 copay/visit; deductible does not apply	40% after deductible	——————none——————
	Preventive care/screening/immunization	No charge; deductible does not apply	40% after deductible	You may have to pay for services that aren't preventive care. Ask your provider if the services needed are preventive care. Then check what your plan will pay for.

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
				For Breast Feeding Counseling Non-PAR is No charge. For Male Contraceptives PAR & Non PAR is Not covered.
If you have a test	Diagnostic test (x-ray, blood work)	No charge; deductible does not apply	40% after deductible	Cost-sharing may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	No charge; deductible does not apply	40% after deductible	Cost-sharing may vary based on where service is performed. Preauthorization may be required - if obtained, penalty will be Flat 20% penalty before any copay/deductible/coinsurance
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.humana.com.	Level 1 – Low-cost generic and *brand-name drugs	$10 copay; (Retail) $20 copay; (Mail Order)	30% coinsurance after $10 copay; deductible does not apply (Retail) 30% coinsurance after $20 copay; deductible does not apply (Mail Order)	***Special Brand Name Drug Deductible will apply to all Brand Name Drugs before Copays or Coinsurance apply. However, the standard annual Plan Deductible described on page one does not apply.** (Retail) 30 day supply. Preauthorization may be required – if not obtained, member is responsible for 100% of the cost of the drug. (Mail Order) 90 day supply. Preauthorization may be required – if not obtained, member is responsible for 100% of the cost of the drug. Plan Pharmacy Maximum Out-of-Pocket: Network Providers: $6,350 Individual /
	Level 2 – Higher-cost generic and *brand name drugs	$40 copay; (Retail) $80 copay; (Mail Order)	30% coinsurance after $40 copay; deductible does not apply (Retail) 30% coinsurance after $80 copay; deductible does not apply (Mail Order)	
	Level 3 – High-cost, mostly *brand name drugs	$60 copay; (Retail) $120 copay; (Mail Order)	30% coinsurance after $60 copay; deductible does not apply (Retail)	

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
			30% coinsurance after $120 copay; deductible does not apply (Mail Order)	$12,700 Family; for Out-of-Network Providers: N/A Individual / N/A Family Plan Maximum Out-of-Pocket: Network Providers: $6,350 Individual / $12,700 Family; for Out-of-Network Providers: N/A Individual / N/A Family
	Level 4 – *Highest-cost drugs	25% coinsurance; (Retail) 25% coinsurance; (Mail Order)	30% coinsurance after 25% coinsurance; deductible does not apply (Retail) 30% coinsurance after 25% coinsurance; deductible does not apply (Mail Order)	
	Office Administered Specialty drugs	No charge; deductible does not apply	Not Covered	30 day supply. Preauthorization may be required – if not obtained, member is responsible for 100% of the cost of the drug.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after deductible	40% after deductible	Preauthorization may be required – if obtained, penalty will be Flat 20% penalty before any copay/deductible/coinsurance.
	Physician/surgeon fees Assistant Surgeon	10% after deductible 10% after deductible	40% after deductible 40% after deductible	——————none——————

If you need immediate medical attention	True-Emergency room services	$300 copay/visit; deductible does not apply	$300 copay/visit; deductible does not apply	Copayment waived if admitted.
	Non- Emergency room services	$300 copay/visit; deductible does not apply	40% after network deductible	
	Emergency medical transportation	$50 copay/visit; deductible does not apply	$50 copay/visit; deductible does not apply	———none———
	Urgent care	$75 copay/visit; deductible does not apply	40% after deductible	———none———
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after deductible	40% after deductible	Prior authorization may be required – if obtained, penalty will be Flat 20% penalty before any copays/deductible/coinsurance
	Physician/surgeon fee Assistant Surgeon	10% after deductible 10% after deductible	40% after deductible 40% after deductible	———none———

If you have mental health, behavioral health, or substance abuse needs	Outpatient services	Therapy: $25 copay/visit; deductible does not apply Other outpatient non-surgical services: 10% after deductible	40% after deductible	——————none——————
	Inpatient services	10% after deductible	40% after deductible	Prior authorization may be required – if obtained, penalty will be Flat 20% penalty before any copays/deductible/coinsurance
If you are pregnant	Office Visits	Primary care visit: $25 copay/visit; deductible does not apply Specialist: $40 copay/visit; deductible does not apply	50% after deductible	Copay will only apply to the initial maternity visit. Cost-sharing does not apply for preventative care services.
	Delivery/childbirth professional services Physician Assistant Surgeon	10% after deductible 10% after deductible	40% after deductible 40% after deductible	Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery facility services	10% after deductible	40% after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).

If you need help recovering or have other special health needs	Home health care	10% after deductible	40% after deductible	40 visits per year. Prior authorization may be required – if obtained, penalty will be Flat 20% penalty before any copays/deductible/coinsurance
	Rehabilitation services	Physical, occupational Cognitive, speech and audiology therapy: $25 PCP/ $40 Specialist copay/visit deductible does not apply	40% after deductible	Therapies: Physical, occupational, speech, cognitive, and audiology therapy 60 visits per year. Prior authorization may be required – if obtained, penalty will be Flat 20% penalty before any copays/deductible/coinsurance
	Habilitation services	Physical, occupational Cognitive, speech and audiology therapy: $25 PCP/ $40 Specialist copay/visit deductible does not apply	40% after deductible	
	Skilled nursing care	10% after deductible	40% after deductible	30 days per year. Prior authorization may be required – if obtained, penalty will be Flat 20% penalty before any copays/deductible/coinsurance
	Durable medical equipment	10% after deductible	40% after deductible	Prior authorization may be required – if obtained, penalty will be Flat 20% penalty before any copays/deductible/coinsurance
	Hospice services	No charge; deductible does not apply.	40% after deductible	Prior authorization may be required – if obtained, penalty will be Flat 20% penalty before any copays/deductible/coinsurance
If your child needs dental or eye care	Children's Eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Routine Dental check-up	Not covered	Not covered	None

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 (unless prescribed by physician)
- Bariatric surgery
- Child dental check-up
- Child eye exam
- Child glasses
- Cosmetic Surgery, and if to correct functional impairment
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S., when traveling outside the U.S. more than 6 consecutive months in a year
- Routine eye care (Adult)
- 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.)

- Hearing aids
- Manipulations – 20 visits per year
- 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:

• www.humana.com or 866-4ASSIST (427-7478).
• For group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
• For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or www.cciio.cms.gov.
• If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law

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 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:

- Your Plan at 502-588-1681
- Department of Labor Employee Benefits Security Administration: 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Does this Coverage 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 Coverage Meet the Minimum Value Standard? 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 866-4ASSIST (427-7478) (TTY: 711)

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** $6,780
- **Patient pays** $760

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	$500
Copays	$50
Coinsurance	$60
Limits or exclusions	$150
Total	**$760**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,000
- **Patient pays** $1,400

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	$500
Copays	$700
Coinsurance	$120
Limits or exclusions	$80
Total	**$1,400**

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.