

Republic Bancorp Inc: HIGH DEDUCTIBLE HEALTH PLAN

Coverage for: Individual +Family | Plan Type: PPO HDHP



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 contact Tammy Pate, tpate@republicbank.com or by calling 502-588-1681. 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.healthcare.gov/sbc-glossary> or call 502-588-1681 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	<u>Network</u> : \$3,000 Individual / \$6,000 Family. <u>Non-network</u> : \$6,000 Individual / \$12,000 Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	<u>Network Providers</u> : Yes. <u>Preventive Care</u> , <u>Certain Office Visits</u> , <u>Emergency Room Care</u> , <u>Urgent Care</u> , <u>Prescription Drugs</u> and <u>Certain therapies</u> . <u>Non-Network Providers</u> : Yes. <u>Emergency Room Care</u> and <u>Prescription Drugs</u>	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive care services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive care services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, such as annual routine / preventive services.
What is the out-of-pocket limit for this plan?	For <u>Network Providers</u> : \$7,500 Individual / \$15,000 Family. For <u>Non-network providers</u> : \$15,000 Individual / \$30,000 Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties, <u>Non-network transplant</u> , <u>non-network prescription drugs</u> , <u>non-network specialty drugs</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <u>network providers</u> .	This <u>plan</u> uses a <u>network provider</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-pocket limit provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance-billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral?	No.	You can see any <u>specialist</u> you choose without a <u>referral</u> .


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 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)	Non-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	Primary care visit: \$20 <u>copay</u> /visit; <u>deductible</u> does not apply Virtual visit: \$20 <u>copay</u> /visit; <u>deductible</u> does not apply	30% after <u>deductible</u>	None
	<u>Specialist</u> visit	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	30% after <u>deductible</u>	None
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	30% after <u>deductible</u>	You may have to pay for services that aren't <u>preventive care</u> . Ask your <u>provider</u> if the services needed are <u>preventive care</u> . Then check what your <u>plan</u> will pay for. For Breast Feeding Counseling Non-PAR is No charge. For Male Contraceptives PAR & Non PAR is Not covered.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge after <u>deductible</u>	30% after <u>deductible</u>	<u>Cost-sharing</u> may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	No charge after <u>deductible</u>	30% after <u>deductible</u>	<u>Cost-sharing</u> may vary based on where service is performed. <u>Preauthorization</u> may be required - if obtained, penalty will be Flat <u>20% penalty</u> before any <u>copay/deductible/coinsurance</u> .
If you need drugs to treat your illness or condition More information about <u>prescription</u>	Level 1 – Low-cost generic and brand-name drugs	\$10 <u>copay</u> after deductible (Retail) \$20 <u>copay</u> after deductible (Mail Order)	30% <u>coinsurance</u> after \$10 <u>copay</u> and <u>deductible</u> (Retail) 30% <u>coinsurance</u> after \$20 <u>copay</u> and <u>deductible</u> (Mail Order)	(Retail) 30 day supply. <u>Preauthorization</u> may be required - if not obtained, member is responsible for 100% of the cost of the drug. (Mail Order) 90 day supply.

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		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
drug coverage is available at www.humana.com	Level 2 – Higher-cost generic and brand-name drugs	\$40 <u>copay</u> after deductible (Retail) \$80 <u>copay</u> after deductible (Mail Order)	30% <u>coinsurance</u> after \$40 <u>copay</u> and <u>deductible</u> (Retail) 30% <u>coinsurance</u> after \$80 <u>copay</u> and <u>deductible</u> (Mail Order)	<u>Preauthorization</u> may be required - if not obtained, member is responsible for 100% of the cost of the drug. <u>Plan Pharmacy Maximum Out-of-Pocket: Network Providers: \$3,000 Individual / \$6,000 Family; for Out-of-Network Providers: \$6,000 Individual / \$12,000 Family.</u> <u>Plan Maximum Out-of-Pocket: Network Providers: \$6,350 Individual / \$12,700 Family; for Out-of-Network Providers: N/A Individual / N/A Family.</u>
	Level 3 - High-cost, mostly brand-name drugs	\$60 <u>copay</u> after deductible (Retail) \$120 <u>copay</u> after deductible (Mail Order)	30% <u>coinsurance</u> after \$60 <u>copay</u> and <u>deductible</u> (Retail) 30% <u>coinsurance</u> after \$120 <u>copay</u> and <u>deductible</u> (Mail Order)	
	Level 4 – Highest-cost drugs	25% <u>coinsurance</u> after <u>deductible</u> (Retail) 25% <u>coinsurance</u> after <u>deductible</u> (Mail Order)	30% <u>coinsurance</u> after 25% <u>coinsurance</u> and <u>deductible</u> (Retail) 30% <u>coinsurance</u> after 25% <u>coinsurance</u> and <u>deductible</u> (Mail Order)	
	<u>Office administered Specialty drugs</u>	No charge after <u>deductible</u>	30% after <u>deductible</u>	30 day supply. <u>Preauthorization</u> 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)	No charge after <u>deductible</u>	30% after <u>deductible</u>	<u>Preauthorization</u> may be required - if obtained, penalty will be Flat <u>20% penalty</u> before any copay/deductible/coinsurance.
	Physician/surgeon fees	No charge after <u>deductible</u>	30% after <u>deductible</u>	None
If you need immediate medical attention	<u>Emergency room care</u> True Emergency	\$300 <u>copay</u> /visit then No charge after <u>deductible</u>	300 <u>copay</u> /visit then No charge after <u>network deductible</u>	<u>Copayment</u> waived if admitted.
	Non-True Emergency	\$300 <u>copay</u> /visit then No charge after <u>deductible</u>	30% after <u>network deductible</u>	

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		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<u>Emergency medical transportation</u>	No charge after <u>deductible</u>	No charge after <u>network deductible</u>	None
	<u>Urgent care</u>	\$75 <u>copay</u> /visit then No charge after <u>deductible</u>	30% after <u>deductible</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after <u>deductible</u>	30% after <u>deductible</u>	<u>Preauthorization</u> may be required - if obtained, penalty will be Flat <u>20% penalty before any copay/deductible/coinsurance.</u>
	Physician/surgeon fees	No charge after <u>deductible</u>	30% after <u>deductible</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: \$20 <u>copay</u> /visit then No charge after deductible Other outpatient non-surgical services: No charge after <u>deductible</u>	30% after <u>deductible</u>	None
	Inpatient services	No charge after <u>deductible</u>	30% after <u>deductible</u>	<u>Preauthorization</u> may be required - if obtained, penalty will be Flat <u>20% penalty before any copay/deductible/coinsurance.</u>
If you are pregnant	Office visits	<u>Primary care visit</u> : \$20 <u>copay</u> /visit then No charge after deductible	30% after <u>deductible</u>	<u>Copay</u> will only apply to the initial <u>maternity visit</u> . <u>Cost-sharing</u> does not apply for <u>preventive care services</u> .
	Childbirth/delivery professional services	No charge after <u>deductible</u>	30% after <u>deductible</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply.

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	Childbirth/delivery facility services	No charge after <u>deductible</u>	30% after <u>deductible</u>	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	<u>Home health care</u>	No charge after <u>deductible</u>	30% after <u>deductible</u>	40 visit per year. <u>Preauthorization</u> may be required - if obtained, penalty will be Flat <u>20% penalty before any copay/deductible/coinsurance.</u>
	<u>Rehabilitation services</u>	No charge after <u>deductible</u>	30% after <u>deductible</u>	Therapies: Physical, occupational, speech, cognitive and audiology therapy 60 visits per year. <u>Preauthorization</u> may be required - if obtained, penalty will be Flat <u>20% penalty before any copay/deductible/coinsurance.</u>
	<u>Habilitation services</u>	No charge after <u>deductible</u>	30% after <u>deductible</u>	Therapies: Physical, occupational, speech, cognitive and audiology therapy 60 visits per year. <u>Preauthorization</u> may be required - if obtained, penalty will be Flat <u>20% penalty before any copay/deductible/coinsurance.</u>
	<u>Skilled nursing care</u>	No charge after <u>deductible</u>	30% after <u>deductible</u>	30 days per year. <u>Preauthorization</u> may be required - if obtained, penalty will be Flat <u>20% penalty before any copay/deductible/coinsurance.</u>
	<u>Durable medical equipment</u>	No charge after <u>deductible</u>	30% after <u>deductible</u>	<u>Preauthorization</u> may be required - if obtained, penalty will be Flat <u>20% penalty before any copay/deductible/coinsurance.</u>

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		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<u>Hospice services</u>	No charge after <u>deductible</u>	30% after <u>deductible</u>	<u>Preauthorization</u> may be required - if obtained, penalty will be Flat <u>20% penalty before any copay/deductible/coinsurance.</u>
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
	Children’s dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)		
<ul style="list-style-type: none"> Acupuncture (unless prescribed by physician) Bariatric surgery Child dental check-up Child eye exam Child glasses Cosmetic Surgery, and if to correct functional impairment 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Routine eye care (Adult) Routine foot care Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> Hearing aids 	<ul style="list-style-type: none"> Manipulations – 20 visits per year 	<ul style="list-style-type: none"> Private duty nursing

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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 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 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 866-4ASSIST (427-7478) (TTY: 711).

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. 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 **\$3,000**
- Specialist copayment **\$35**
- Hospital (facility) coinsurance **0%**
- Other coinsurance **0%**

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$3,030

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible **\$3,000**
- Specialist copayment **\$35**
- 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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,400

Mia's Simple Fracture

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

- The plan's overall deductible **\$3,000**
- Specialist copayment **\$35**
- 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	\$3,000
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,800
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,500

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

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