NPOPS PLAN SUMMARY OF BENEFITS AND COVERAGE DOCUMENT AUTHORIZATION

This authorization and agreement is made and entered into by Northern Kentucky University (the "Client") and Humana Health Plan, Inc. ("Humana"), effective January 01, 2020.

This authorization and agreement concerns the establishment and development of a contractual relationship between Humana and the Client for providing the Summary of Benefits and Coverage ("SBC") document which includes the accompanying non-discrimination notice and taglines document ("Notice"), with respect to Northern Kentucky University Health Plan (the "Plan").

The Client and Humana agree as follows:

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(b) By signing this authorization, the Client agrees that the benefits and provisions outlined in this SBC document, draft numbered 2 and the Notice are accurate and approved by the Client.

(c) Humana will create a final SBC for the Client, with the Notice attached to the SBC. The Client is responsible for the distribution of the SBC document with attached Notice to its plan participants.

The Client and Humana have caused this agreement to be executed by their respective officers or representatives as duly authorized.

NORTHERN KENTUCKY UNIVERSITY

By: Bruce R. Smith

Date: 1/6/2020

Accepted:

HUMANA HEALTH PLAN, INC.

By: _____
Tami Quiram
Segment Vice President and President, Large and Small Group

HDHP D1500 PLAN SUMMARY OF BENEFITS AND COVERAGE DOCUMENT AUTHORIZATION

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By: Bruce R. Smith

Date: 1/6/2020

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By: _____
Tami Quiram
Segment Vice President and President, Large and Small Group

HDHP D2500 PLAN SUMMARY OF BENEFITS AND COVERAGE DOCUMENT AUTHORIZATION

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Date: 1/6/2020

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Tami Quiram
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HMO PLAN SUMMARY OF BENEFITS AND COVERAGE DOCUMENT AUTHORIZATION

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By: _____

Tami Quiram

Segment Vice President and President, Large and Small Group

Northern Kentucky University: HDHP NPOS $1500 Plan

Coverage for: Individual +Family | **Plan Type: 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, email benefits@nku.edu or by calling 859-572-5200. 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 859-572-5200 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers: $1,500 Individual / $3,000 Family for Non-Network Providers: $3,000 Individual / $6,000 Family Coinsurance and copayments don't count toward the deductible.	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 policy, the overall family deductible must be met before the plan begins to pay.
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	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network Providers: $3,000 Individual / $6,000 Family; for Non-Network Providers: $6,000 Individual / $12,000 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this Plan, the overall family *out-of-pocket limit* must be 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.	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. www.humana.com/directories or call 1-866-4ASSIST (427-7478) 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 can see the specialist you choose 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 Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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% after deductible	30% after deductible	Includes telehealth or telemedicine services.
	Specialist visit	10% after deductible	30% after deductible	Includes telehealth or telemedicine services
	Preventive care/screening/ immunization	No charge	30% after deductible	- You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for - For Breast Feeding Counseling Non-PAR is No charge - Male Contraceptives Not covered for PAR and Non-PAR. -
If you have a test	Diagnostic test (x-ray, blood work)	10% after deductible	30% after deductible	Cost share may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	10% after deductible	30% after deductible	- Cost share may vary based on where service is performed. - Preauthorization may be required - if not obtained, penalty will be 50%
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Humana.com	Generic and brand-name drugs	Carve-out	Carve-out	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after deductible	30% after deductible	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	10% after deductible	30% after deductible	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	10% after deductible	10% after PAR deductible	None
	Emergency medical transportation	10% after deductible	10% after PAR deductible	None
	Urgent care	10% after deductible	30% after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after deductible	30% after deductible	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	10% after deductible	30% after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% after deductible	30% after deductible	None
	Inpatient services	10% after deductible	30% after deductible	None
If you are pregnant	Office visits	10% after deductible	30% after deductible	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	10% after deductible	30% after deductible	Depending on the type of services, a coinsurance or deductible may apply.
	Childbirth/delivery facility services	10% after deductible	30% 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	30% after deductible	- 100 visits per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Rehabilitation services	10% after deductible	30% after deductible	- 45 visits per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Habilitation services	10% after deductible	30% after deductible	- 45 visits per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Skilled nursing care	10% after deductible	30% after deductible	- 60 days per year - Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	10% after deductible	30% after deductible	- Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. - Preauthorization may be required - if not obtained, penalty will be 50%
	Hospice services	10% after deductible	30% after deductible	None
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 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, if to correct a functional impairment
- Dental Care
- Infertility Counseling and Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult), unless for an eye exam
- 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, unless it is prescribed by a physician for rehabilitation purposes
- Chiropractic Care – spinal manipulations are covered (45 visits per year)
- Hearing Aids

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:

- For group health coverage subject to ERISA, 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
- 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 1-877-267-2323 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.

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 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 calling 859-572-5200
- Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-866-4ASSIST (427-7478).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-4ASSIST (427-7478).

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-866-4ASSIST (427-7478).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-4ASSIST (427-7478).

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	**$1,500**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other	**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
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$30
The total Peg would pay is	**$2,730**

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

The plan's overall deductible	**$1,500**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other	**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	$1,100
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$6,000
The total Joe would pay is	**$7,200**

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

The plan's overall deductible	**$1,500**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other	**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
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

GCHJV5REN 1018

Language assistance services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.

العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Northern Kentucky University: HDHP NPOS $2,500 Plan

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

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This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, email benefits@nku.edu or by calling 859-572-5200. 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 859-572-5200 to request a copy.

Important Questions	Answers	Why This Matters:
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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	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network Providers: $3,425 Individual / $6,850 Family; for Non-Network Providers: $10,000 Individual / $20,000 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this Plan, the overall family *out-of-pocket limit* must be 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.	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. www.humana.com/directories or call 1-866-4ASSIST (427-7478) 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 can see the specialist you choose 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 Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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% after deductible	30% after deductible	Includes telehealth or telemedicine services.
	Specialist visit	10% after deductible	30% after deductible	Includes telehealth or telemedicine services
	Preventive care/screening/ immunization	No charge	30% after deductible	- You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for - For Breast Feeding Counseling Non-PAR is No charge - Male Contraceptives Not covered for PAR and Non-PAR. -
If you have a test	Diagnostic test (x-ray, blood work)	10% after deductible	30% after deductible	Cost share may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	10% after deductible	30% after deductible	- Cost share may vary based on where service is performed. - Preauthorization may be required - if not obtained, penalty will be 50%
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Humana.com	Generic and brand-name drugs	Carve-out	Carve-out	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after deductible	30% after deductible	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	10% after deductible	30% after deductible	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	10% after deductible	10% after PAR deductible	None
	Emergency medical transportation	10% after deductible	10% after PAR deductible	None
	Urgent care	10% after deductible	30% after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after deductible	30% after deductible	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	10% after deductible	30% after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% after deductible	30% after deductible	None
	Inpatient services	10% after deductible	30% after deductible	None
If you are pregnant	Office visits	10% after deductible	30% after deductible	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	10% after deductible	30% after deductible	Depending on the type of services, a coinsurance or deductible may apply.
	Childbirth/delivery facility services	10% after deductible	30% 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	30% after deductible	- 100 visits per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Rehabilitation services	10% after deductible	30% after deductible	- 45 visits per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Habilitation services	10% after deductible	30% after deductible	- 45 visits per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Skilled nursing care	10% after deductible	30% after deductible	- 60 days per year - Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	10% after deductible	30% after deductible	- Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. - Preauthorization may be required - if not obtained, penalty will be 50%
	Hospice services	10% after deductible	30% after deductible	None
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 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, if to correct a functional impairment
- Dental Care
- Infertility Counseling and Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult), unless for an eye exam
- 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, unless it is prescribed by a physician for rehabilitation purposes
- Chiropractic Care – spinal manipulations are covered (45 visits per year)
- Hearing Aids

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:

- For group health coverage subject to ERISA, 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
- 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 1-877-267-2323 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.

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 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 calling 859-572-5200
- Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-866-4ASSIST (427-7478).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-4ASSIST (427-7478).

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-866-4ASSIST (427-7478).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-4ASSIST (427-7478).

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	$2,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other	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	$2,500
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$30
The total Peg would pay is	**$3,730**

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

The plan's overall deductible	$2,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other	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	$1,100
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$6,000
The total Joe would pay is	**$7,200**

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

The plan's overall deductible	$2,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other	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	$1,700
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

GCHJV5REN 1018

Language assistance services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.

العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Northern Kentucky University: HMO Plan

Coverage for: Individual +Family | **Plan Type: HMO**

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, email benefits@nku.edu or by calling 859-572-5200. 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 859-572-5200 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers: $2,000 Individual / $4,000 Family for Non-Network Providers: Not covered Coinsurance and copayments don't count toward the deductible.	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, Office Visit, Emergency Room Care, Urgent Care, Therapies and Prescription Drugs are 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	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network Providers: $4,500 Individual / $9,000 Family; for Non-Network Providers: Not covered	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.	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. www.humana.com/directories or call 1-866-4ASSIST (427-7478) 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 can see the specialist you choose 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 Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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	$25 copay/visit deductible does not apply	Not covered	Includes telehealth or telemedicine services.
	Specialist visit	$55 copay/visit deductible does not apply	Not covered	Includes telehealth or telemedicine services.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for - Male Contraceptives Not covered for PAR
If you have a test	Diagnostic test (x-ray, blood work) -Inpatient -Outpatient	No charge 20% after deductible	Not covered	Cost share may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	20% after deductible	Not covered	- Cost share may vary based on where service is performed. - Preauthorization may be required - if not obtained, penalty will be 50%
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.humana.com	Level 1 - Lowest cost generic and brand-name drugs:	Carved out	Not covered	None
	Level 2 - Higher cost generic and brand-name drugs:			
	Level 3 - Generic and brand-name drugs with higher cost than Level 2:			
	Level 4 - Highest cost drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	Not covered	Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% after deductible	Not covered	None
If you need immediate medical attention	Emergency room care	$250 copay/visit deductible does not apply	$250 copay/visit deductible does not apply	Copay waived if admitted
	Emergency medical transportation	20% after deductible	20% after PAR deductible	None
	Urgent care	$75 copay/visit deductible does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	Not covered	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	20% after deductible	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit deductible does not apply	Not covered	None
	Inpatient services	20% after deductible	Not covered	None
If you are pregnant	Office visits	$25 PCP/ $55 Specialist copay/visit deductible does not apply	Not covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% after deductible	Not covered	Depending on the type of services, a coinsurance or deductible may apply.
	Childbirth/delivery facility services	20% after deductible	Not covered	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	20% after deductible	Not covered	- 100 Visits per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Rehabilitation services Physical & Occupational All other Therapies	$25 copay/visit deductible does not apply $55 copay/visit deductible does not apply	Not covered	- 30 Visits per year - Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services Physical & Occupational All other Therapies	$25 copay/visit deductible does not apply $55 copay/visit deductible does not apply	Not covered	- 30 Visits per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Skilled nursing care	20% after deductible	Not covered	- 60 days per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Durable medical equipment	20% after deductible	Not covered	- Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. - Preauthorization may be required - if not obtained, penalty will be 50%
	Hospice services	No charge	Not covered	None
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 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, if to correct a functional impairment
- Dental Care
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult), unless for an eye exam
- 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, unless it is prescribed by a physician for rehabilitation purposes
- Chiropractic Care – spinal manipulations are covered (30 visits per year)
- Infertility

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Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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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.

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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	$2,000
Specialist copayment	$55
Hospital (facility) coinsurance	20%
Other	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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$30
The total Peg would pay is	**$4,330**

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

The plan's overall deductible	$2,000
Specialist copayment	$55
Hospital (facility) coinsurance	20%
Other	20%

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	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,000
The total Joe would pay is	**$6,300**

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

The plan's overall deductible	$2,000
Specialist copayment	$55
Hospital (facility) coinsurance	20%
Other	20%

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	$700
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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

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العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Northern Kentucky University: NPOS Plan

Coverage for: Individual +Family | **Plan Type: NPOS**

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, email benefits@nku.edu or by calling 859-572-5200. 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 859-572-5200 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers: $1,000 Individual / $2,000 Family for Non-Network Providers: $3,000 Individual / $6,000 Family Coinsurance and copayments don't count toward the deductible.	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, Office Visit, Emergency Room Care, Urgent Care, Therapies and Prescription Drugs are 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	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network Providers: $4,000 Individual / $8,000 Family; for Non-Network Providers: $12,000 Individual / $24,000 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.	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. www.humana.com/directories or call 1-866-4ASSIST (427-7478) 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 can see the specialist you choose 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 Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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	$25 copay/visit deductible does not apply	50% after deductible	Includes telehealth or telemedicine services.
	Specialist visit	$40 copay/visit deductible does not apply	50% after deductible	Includes telehealth or telemedicine services.
	Preventive care/screening/ immunization	No charge	50% after deductible	- You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for - Breast feeding counseling No charge for non-PAR. - Male Contraceptives Not covered for PAR and Non-PAR
If you have a test	Diagnostic test (x-ray, blood work) -Inpatient -Outpatient	No charge 20% after deductible	50% after deductible 50% after deductible	Cost share may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	20% after deductible	50% after deductible	- Cost share may vary based on where service is performed. - Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.humana.com	Level 1 - Lowest cost generic and brand-name drugs:	Carved out	Carved out	None
	Level 2 - Higher cost generic and brand-name drugs:			
	Level 3 - Generic and brand-name drugs with higher cost than Level 2:			
	Level 4 - Highest cost drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	50% after deductible	- Preauthorization may be required - if not obtained, penalty will be 50% - Must cover the same as services rendered by a hospital
	Physician/surgeon fees	20% after deductible	50% after deductible	None
If you need immediate medical attention	Emergency room care	$200 copay/visit deductible does not apply	$200 copay/visit deductible does not apply	Copay waived if admitted
	Emergency medical transportation	20% after deductible	20% after PAR deductible	None
	Urgent care	$40 copay/visit deductible does not apply	50% after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	50% after deductible	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	20% after deductible	50% after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit deductible does not apply	50% after deductible	None
	Inpatient services	20% after deductible	50% after deductible	None
If you are pregnant	Office visits	$25 PCP/ $40 Specialist copay/visit deductible does not apply	50% after deductible	Cost sharing does not apply for preventive services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% after deductible	50% after deductible	Depending on the type of services, a coinsurance or deductible may apply.
	Childbirth/delivery facility services	20% after deductible	50% 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	20% after deductible	50% after deductible	- 100 Visits per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Rehabilitation services Physical & Occupational All other Therapies	$25 copay/visit deductible does not apply 20% after deductible	50% after deductible	- 60 Visits per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Habilitation services Physical & Occupational All other Therapies	$25 copay/visit deductible does not apply $20% after deductible	50% after deductible	- 60 Visits per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Skilled nursing care	20% after deductible	50% after deductible	- 60 days per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Durable medical equipment	20% after deductible	50% after deductible	- Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. - Preauthorization may be required - if not obtained, penalty will be 50%
	Hospice services	No charge	No charge	None
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 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, if to correct a functional impairment • Dental Care	• Infertility • Long Term Care • Non-emergency care when traveling outside the U.S.	• Private Duty Nursing • Routine eye care (Adult), unless for an eye exam • 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, unless it is prescribed by a physician for rehabilitation purposes	• Chiropractic Care – spinal manipulations are covered (60 visits per year)	• Hearing Aids

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:

- For group health coverage subject to ERISA, 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
- 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 1-877-267-2323 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.

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 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 calling 859-572-5200
- Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-866-4ASSIST (427-7478).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-4ASSIST (427-7478).

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-866-4ASSIST (427-7478).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-4ASSIST (427-7478).

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	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other	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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$30
The total Peg would pay is	**$3,330**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other	20%

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	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,000
The total Joe would pay is	**$6,300**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other	20%

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	$700
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

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

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