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Important Health Plan Information

Accessible Version

Summary of Benefits and Coverage:

What this Plan Covers and What You Pay For Covered Services

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HUMANA HEALTH PLAN, INC.:

KY NCR NPOS 16-SEP ACC&CPY OV&DED/COINS

IP/OP

Coverage Period: Beginning on or after 01/01/2020

Coverage for: Individual + Family

Plan Type: NPOS

Document Number: S102219

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,

www.groupcertificate.humana.com or by calling 1-866-4ASSIST (1-866-427-7478).

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 1-866-4ASSIST (1-866-427-7478) to request a copy.

Important Questions: What is the overall deductible?

Answers:
Network: $4,000 Individual /$8,000 family;

Non-Network: $12,000 Individual / $24,000 family

Why This Matters:

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.

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Important Questions: Are there services covered before you meet your deductible?

Answers: Network Providers

Yes.

Certain Office Visits,

Preventive,

Emergency Room Care,

Urgent Care,

Prescription Drugs and

Certain Therapies

Answers: Non-Network Providers:

Yes.

Emergency Room Care and

Prescription Drugs

Why This Matters:

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.

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Important Questions: Are there other deductibles for specific services?

Answers:
No

Why This Matters:

You don't have to meet deductibles for specific services.

Important Questions: What is the out-of-pocket limit for this plan?

Answers:

For network providers

$6,000 individual / $12,000 family

For non-network providers

$18,000 individual / $36,000 family

Why This Matters:

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.

Important Questions: What is not included in the out-of-pocket limit?

Answers:

Premiums,

Balance-billing charges,

Health care this plan doesn't cover,

Penalties,

Non-network transplant,

non-network prescription drugs,

non-network specialty drugs

Why This Matters:

Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Important Questions: Will you pay less if you use a network provider?

Answers:

Yes.

Please visit

www.humana.com/directories or

call 1-866-4ASSIST (427-7478) (TTY:711)

for a list of network providers

Why This Matters:

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.

Important Questions: Do you need a referral to see a specialist?

Answers:

No.

Why This Matters:

You can see the specialist you choose without a referral.

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Please note:

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

Common Medical Event: If you visit a health care provider's office or clinic

Services You May Need:

Primary care visit to treat an injury or illness

What You Will Pay: Network Provider (You will pay the least)

Primary care visit:
$30 copay/ office visit; deductible does not apply

Telehealth or telemedicine services:
$30 copay/ office visit; deductible does not apply

What You Will Pay: Non-Network Provider (You will pay the most)

Primary care visit:
50% coinsurance

Telehealth or telemedicine services:
50% coinsurance

Limitations, Exceptions, & Other Important Information

None

Common Medical Event: If you visit a health care provider's office or clinic

Services You May Need:

Specialist visit

What You Will Pay: Network Provider (You will pay the least)

$45 copay/ visit; deductible does not apply

What You Will Pay: Non-Network Provider (You will pay the most)

50% coinsurance

Limitations, Exceptions, & Other Important Information

None

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Common Medical Event: If you visit a health care provider's office or clinic

Services You May Need:
Preventive care / screening / immunization

What You Will Pay: Network Provider (You will pay the least)

No charge; deductible does not apply

What You Will Pay: Non-Network Provider (You will pay the most)

50% coinsurance

Limitations, Exceptions, & Other Important Information

You may have to pay for services that aren't preventive.

Ask your provider if the services needed are preventive.

Then check what your plan will pay for.

Common Medical Event: If you have a test

Services You May Need:

Diagnostic test (x-ray, blood work)

What You Will Pay: Network Provider (You will pay the least)

No charge; deductible does not apply

What You Will Pay: Non-Network Provider (You will pay the most)

50% coinsurance

Limitations, Exceptions, & Other Important Information

Diagnostic Test:

Cost sharing may vary based on where service is performed

Imaging:

Cost sharing may vary based on where service is

performed

Preauthorization may be required - if not obtained, penalty

will be 50%

Common Medical Event: If you have a test

Services You May Need:

Imaging (CT/PET scans, MRIs)

What You Will Pay: Network Provider (You will pay the least)

20% coinsurance

What You Will Pay: Non-Network Provider (You will pay the most)

50% coinsurance

Limitations, Exceptions, & Other Important Information

Diagnostic Test:

Cost sharing may vary based on where service is performed

Imaging:

Cost sharing may vary based on where service is performed

Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event: If you need drugs to treat your illness or condition

More information about prescription drug coverage is

available at www.humana.com/2019-RX3

Services You May Need:

Level 1 – Generic Drugs

What You Will Pay: Network Provider (You will pay the least)

(Retail)

$10 copay

deductible does not apply

(Mail Order)

$20 copay

deductible does not apply

What You Will Pay: Non-Network Provider (You will pay the most)

(Retail)

30% coinsurance, after

$10 copay

deductible does not apply

(Mail Order)

30% coinsurance, after

$20 copay

deductible does not apply

Limitations, Exceptions, & Other Important Information

(Retail)

30 day supply

Preauthorization may be required - if not obtained, penalty

will be 100% for certain prescription drugs

Limitations, Exceptions, & Other Important Information

(Mail Order)

90 day supply

Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs

Limitations, Exceptions, & Other Important Information

Non-network cost sharing does not count toward the out-of-pocket limit.

Common Medical Event: If you need drugs to treat your illness or condition

More information about prescription drug coverage is

available at www.humana.com/2019-RX3

Services You May Need:

Level 2 –Preferred brand-name drugs

What You Will Pay: Network Provider (You will pay the least)

(Retail)

$30 copay

deductible does not apply

(Mail Order)

$60 copay

deductible does not apply

What You Will Pay: Non-Network Provider (You will pay the most)

(Retail)

30% coinsurance, after

$30 copay

deductible does not apply

(Mail Order)

30% coinsurance, after

$60 copay

deductible does not apply

Limitations, Exceptions, & Other Important Information

(Retail)

30 day supply

Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs

Limitations, Exceptions, & Other Important Information

(Mail Order)

90 day supply

Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs

Limitations, Exceptions, & Other Important Information

Non-network cost sharing does not count toward the out-of-pocket limit.

Common Medical Event: If you need drugs to treat your illness or condition

More information about prescription drug coverage is

available at www.humana.com/2019-RX3

Services You May Need:

Level 3 –Higher-cost brand-name drugs

What You Will Pay: Network Provider (You will pay the least)

(Retail)

$50 copay

deductible does not apply

(Mail Order)

$100 copay

deductible does not apply

What You Will Pay: Non-Network Provider (You will pay the most)

(Retail)

30% coinsurance, after

$50 copay

deductible does not apply

(Mail Order)

30% coinsurance, after

$100 copay

deductible does not apply

Limitations, Exceptions, & Other Important Information

(Retail)

30 day supply

Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs

Limitations, Exceptions, & Other Important Information

(Mail Order)

90 day supply

Preauthorization may be required - if not obtained, penalty

will be 100% for certain prescription drugs

Limitations, Exceptions, & Other Important Information

Non-network cost sharing does not count toward the out-of-pocket limit.

Common Medical Event: More information about

Services You May Need

Specialty Drugs

What You Will Pay: Network Provider (You will pay the least)

(Preferred Specialty Pharmacy)

25% coinsurance; deductible does not apply

35% coinsurance; deductible does not apply

What You Will Pay: Non-Network Provider (You will pay the most)

50% coinsurance; deductible does not apply

Limitations, Exceptions, & Other Important Information

30 day supply

Common Medical Event: If you have outpatient surgery

Services You May Need
Facility fee (e.g., ambulatory surgery center)

What You Will Pay: Network Provider (You will pay the least)

20% coinsurance

What You Will Pay: Non-Network Provider (You will pay the most)

50% coinsurance

Limitations, Exceptions, & Other Important Information

Preauthorization may be required –

if not obtained, penalty will be 50%

Common Medical Event: If you have outpatient surgery

Services You May Need

Physician/surgeon fees

What You Will Pay: Network Provider (You will pay the least)

20% coinsurance

What You Will Pay: Non-Network Provider (You will pay the most)

50% coinsurance

Limitations, Exceptions, & Other Important Information

None

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Common Medical Event: If you need immediate medical attention

Services You May Need

Emergency room care

What You Will Pay: Network Provider (You will pay the least)

$200 copay/visit; deductible does not apply

What You Will Pay: Non-Network Provider (You will pay the most)

$200 copay/visit; deductible does not apply

Limitations, Exceptions, & Other Important Information

Emergency room care: Copayment waived if admitted

Common Medical Event: If you need immediate medical attention

Services You May Need

Emergency medical transportation

What You Will Pay: Network Provider (You will pay the least)

20% coinsurance

What You Will Pay: Non-Network Provider (You will pay the most)

20% coinsurance

Limitations, Exceptions, & Other Important Information

Emergency room care: Copayment waived if admitted

Common Medical Event: If you need immediate medical attention

Services You May Need

Urgent care

What You Will Pay: Network Provider (You will pay the least)

$45 copay/visit; deductible does not apply

What You Will Pay: Non-Network Provider (You will pay the most)

50% coinsurance

Limitations, Exceptions, & Other Important Information

Emergency room care: Copayment waived if admitted

Common Medical Event: If you have a hospital stay

Services You May Need

Facility fee (e.g., hospital room)

What You Will Pay: Network Provider (You will pay the least)

20% coinsurance

What You Will Pay: Non-Network Provider (You will pay the most)

50% coinsurance

Limitations, Exceptions, & Other Important Information

Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event: If you have a hospital stay

Services You May Need

Physician/surgeon fees

What You Will Pay: Network Provider (You will pay the least)

20% coinsurance

What You Will Pay: Non-Network Provider (You will pay the most)

50% coinsurance

Limitations, Exceptions, & Other Important Information

None

Common Medical Event: If you need mental health, behavioral health, or substance abuse services

Services You May Need

Outpatient services

What You Will Pay: Network Provider (You will pay the least)

Therapy:

$30 copay/visit; deductible does not apply

Other outpatient services:

20% coinsurance

What You Will Pay: Non-Network Provider (You will pay the most)

Therapy:

50% coinsurance

Other outpatient services:

50% coinsurance

Limitations, Exceptions, & Other Important Information

None

Common Medical Event: If you need mental health, behavioral health, or substance abuse services

Services You May Need

Inpatient services

What You Will Pay: Network Provider (You will pay the least)

20% coinsurance

What You Will Pay:Non-Network Provider (You will pay the most)

50% coinsurance

Limitations, Exceptions, & Other Important Information

Inpatient services: Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event: If you are pregnant

Services You May Need

Office visits

What You Will Pay: Network Provider (You will pay the least)

No charge; deductible does not apply

What You Will Pay: Non-Network Provider (You will pay the most)

50% coinsurance

Limitations, Exceptions, & Other Important Information

Office visits: Cost sharing does not apply for preventive services.

Common Medical Event: If you are pregnant

Services You May Need

Childbirth/delivery professional services

What You Will Pay: Network Provider (You will pay the least)

20% coinsurance

What You Will Pay: Non-Network Provider (You will pay the most)

50% coinsurance

Limitations, Exceptions, & Other Important Information

Childbirth/delivery professional services:

Depending on the type of services, a coinsurance or

deductible may apply.

Common Medical Event: If you are pregnant

Services You May Need
Childbirth/delivery facility services.

What You Will Pay: Network Provider (You will pay the least)
20% coinsurance

What You Will Pay: Non-Network Provider (You will pay the most)
50% coinsurance

Limitations, Exceptions, & Other Important Information
Childbirth/delivery facility services:

Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).

Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event: If you need help recovering or have other special health needs

Services You May Need

Home health care.

What You Will Pay: Network Provider (You will pay the least)
20% coinsurance

What You Will Pay: Non-Network Provider (You will pay the most)
50% coinsurance

Limitations, Exceptions, & Other Important Information

100 visit limit per year Preauthorization may be required -

if not obtained, penalty will be 50%

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Common Medical Event: If you need help recovering or have other special health needs

Services You May Need
Rehabilitation services

What You Will Pay: Network Provider (You will pay the least)

$30 copay/visit; deductible does not apply

Physical,

occupational therapy

and

manipulations:

What You Will Pay: Non-Network Provider (You will pay the most)

50% coinsurance

Physical,

occupational,

speech,

cognitive,

audiology therapy and

manipulations:

Limitations, Exceptions, & Other Important Information

For network, 60 visits per year combined

Therapies:

Physical,

occupational,

speech,

cognitive,

audiology therapy and

manipulations:

Limitations, Exceptions, & Other Important Information

For non-network,10 visits per year combined.

Therapies:

Physical,

occupational,

speech,

cognitive,

audiology therapy and

manipulations:

Limitations, Exceptions, & Other Important Information

PLEASE NOTE:

Network and non-network visit limits reduce each other.

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Common Medical Event: If you need help recovering or have other special health needs

Services You May Need

Habilitation services

What You Will Pay: Network Provider (You will pay the least)

$30 copay/visit; deductible does not apply

Physical,

occupational therapy and

manipulations:

What You Will Pay: Non-Network Provider (You will pay the most)

50% coinsurance

Physical,

occupational,

speech,

audiology therapy and

manipulations:

Limitations, Exceptions, & Other Important Information

For network,

60 visits per year combined

Therapies:

Physical,

occupational,

speech,

cognitive,

audiology therapy and

manipulations

Limitations, Exceptions, & Other Important Information

For non-network,

10 visits per year combined.

Therapies:

Physical,

occupational,

speech,

cognitive,

audiology therapy and

manipulations:

Limitations, Exceptions, & Other Important Information

PLEASE NOTE:

Network and non-network visit limits reduce each other.

Common Medical Event: If you need help recovering or have other special health needs

Services You May Need

Skilled nursing care

What You Will Pay: Network Provider (You will pay the least)

20% coinsurance

What You Will Pay: Non-Network Provider (You will pay the most)

50% coinsurance

Limitations, Exceptions, & Other Important Information

60 day limit per year

Preauthorization may be required - if not obtained, penalty

will be 50%

Common Medical Event: If you need help recovering or have other special health needs

Services You May Need
Durable medical equipment.

What You Will Pay: Network Provider (You will pay the least)
20% coinsurance

What You Will Pay: Non-Network Provider (You will pay the most)
50% coinsurance

Limitations, Exceptions, & Other Important Information
Preauthorization may be required - if not obtained, penalty

will be 50%

Excludes vehicle and home modifications, exercise and

bathroom equipment

Common Medical Event: If you need help recovering or have other special health needs

Services You May Need

Hospice services

What You Will Pay: Network Provider (You will pay the least)

No charge; deductible does not apply

What You Will Pay: Non-Network Provider (You will pay the most)

No charge; deductible does not apply

Limitations, Exceptions, & Other Important Information

Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event: If your child needs dental or eye care

Services You May Need

Children's eye exam

What You Will Pay: Network Provider (You will pay the least)

Not Covered

What You Will Pay: Non-Network Provider (You will pay the most)

Not Covered

Limitations, Exceptions, & Other Important Information

None

Common Medical Event: If your child needs dental or eye care

Services You May Need

Children's glasses

What You Will Pay: Network Provider (You will pay the least)

Not Covered

What You Will Pay: Non-Network Provider (You will pay the most)

Not Covered

Limitations, Exceptions, & Other Important Information

None

Common Medical Event: If your child needs dental or eye care

Services You May Need

Children's dental check-up

What You Will Pay: Network Provider (You will pay the least)

Not Covered

What You Will Pay: Non-Network Provider (You will pay the most)

Not Covered

Limitations, Exceptions, & Other Important Information

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 other excluded services.)

Bariatric Surgery

Child Dental Check-Up

Child Eye Exam

Child Glasses

Infertility Treatment

Long Term Care

Non-emergency care when traveling outside of the U.S.

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Private Duty Nursing

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 plan document.)

Acupuncture,

if it is prescribed by a physician

Chiropractic Care –

spinal manipulations are covered

Cosmetic Surgery,

if to correct a functional impairment

Dental Care (Adult),

if for dental injury of a sound natural tooth

Hearing Aids,

1 hearing aid per impaired ear every 36 months under the age of 18

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

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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 (1-866-444-3272) or www.dol.gov/ebsa/healthreform.

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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.

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 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim.

This complaint is called a grievance or appeal.

For more information about your rights, look at the explanation of benefits you will receive for that medical claim.

Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan.

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For more information about your rights, this notice, or assistance, contact:

www.humana.com or 1-866-4ASSIST (1-866-427-7478).

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Department of Labor Employee Benefits Security

Administration: 1-866-444-EBSA (3272) or

www.dol.gov/ebsa/healthreform.

Kentucky Department of Insurance,

P.O. Box 517,

Frankfort, KY 40602-0517,

Phone: 502-564-3630 or

502-564-6034 or

800-595-6053,

TTY: 800-648-6056,

Fax: 502-564-6090,

Email: David.Wilhoite@ky.gov; Rodney.Hugle@ky.gov,

Website: http://insurance.ky.gov.

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 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.

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.

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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.

EXAMPLE 1: Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible: $4,000

Specialist copayment: $45

Hospital (facility) coinsurance: 20%

Other coinsurance: 20%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

Diagnostic tests (ultrasounds and blood work)

Specialist visit (anesthesia)

In this example, Peg would pay:

Total Example Cost: $12,800

Cost Sharing

Deductibles: $4,000

Copayments: $20

Coinsurance: $2,300

What isn't covered

Limits or exclusions: $10

The total Peg would pay is: $6,330

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

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EXAMPLE 2: Managing Joe's type 2 Diabetes

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

The plan's overall deductible: $4,000

Specialist copayment: $45

Hospital (facility) coinsurance: 20%

Other coinsurance: 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)

In this example, Joe would pay:

Total Example Cost: $7,400

Cost Sharing

Deductibles: $0

Copayments: $1,900

Coinsurance: $0

What isn't covered

Limits or exclusions: $0

The total Joe would pay is: $1,900

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

EXAMPLE 3: Mia's Simple Fracture

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

The plan's overall deductible: $4,000

Specialist copayment: $45

Hospital (facility) coinsurance: 20%

Other coinsurance: 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)

In this example, Mia would pay:

Total Example Cost: $1,900

Cost Sharing

Deductibles: $1,000

Copayments: $400

Coinsurance: $300

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.

Or call Humana Concierge Service for Accessibility directly at 1-877-320-2233.

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

or 800-537-7697 (TDD).

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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.

1-877-427-7478 (TTY:711)

or

Humana Concierge Service for Accessibility direct line

1-877-320-2233

(available 24 hours a day and 7 days a week)

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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.