Calendar Year Maximum Benefits for TrueNorth Companies HDHP $2,000 – Family Plan Effective 1.1.2025	
All Essential Health Benefits	Unlimited

	In Network	Out of Network	Limits
Deductible			
Individual within a Family	$3,300	$4,000	The deductibles for In Network and out of Network do not cross-apply
Family	$4,000	$8,000	
Embedded Deductible*: 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.*			
Maximum Out-of-Pocket (includes Deductibles, Coinsurance, and Copayments)			
Individual within a Family	$4,000	$8,000	The OOP for In Network and Out of Network do not cross-apply.
Family	$8,000	$16,000	
Embedded Out-of-Pocket Maximum*: If you have other family members on this plan, they have to meet their own Out-of-Pocket limits until the overall family Out-of-Pocket limit has been met.*			

The following table identifies what does and does not apply toward the In Network and Out of Network Out-of-Pocket Maximums:

Plan Features	Applies to the In Network Out-of-Pocket Maximum?	Applies to the Out of Network Out-of-Pocket Maximum?
Payments toward the annual Deductible	Yes	Yes
Coinsurance payments**,** even those for covered services available in the Prescription Drug Benefits section, except for those covered health services identified in the Summary of Benefits that do not apply to the Out-of-Pocket Maximum	Yes	Yes
Copayments	Yes	Yes
Charges for non-covered services	No	No
The amounts of any Pre-Certification penalties	No	No
Charges that exceed Allowable Expenses	No	No

Coinsurance shown below is what Plan Pays and applies after deductible has been met, unless stated otherwise. Visits limits apply to In Network and Out of Network services combined.			
	In Network	**Out of Network**	**Limits**
Allergy Services			
Office Visit	80% coinsurance	60% coinsurance	
Injections	50% coinsurance (Deductible waived)	60% coinsurance	
Serum	80% coinsurance	60% coinsurance	
Acupuncture	80% coinsurance	80% coinsurance	
Ambulance	80% coinsurance, In Network Deductible applies		Inter-facility Air transport must be pre-certified through Sentinel Air Medical Alliance at 1-877-542-8828.
Ambulatory Surgical Center	80% coinsurance	60% coinsurance	Preauthorization is required for some outpatient procedures.
Anesthesia	80% coinsurance	60% coinsurance	
Bariatric Surgery	**Not Covered**		
Birthing Center	80% coinsurance	60% coinsurance	Preauthorization is required for some maternity stays
Blood & Plasma	80% coinsurance	60% coinsurance	
Captive Health Services	No Charge	No Charge	
Cardiac Rehabilitation	80% coinsurance	60% coinsurance	Phase 3 is not covered.
Chiropractic Care			
Office Visits, Spinal Manipulations, and Adjustments	80% coinsurance	60% coinsurance	Medical Necessity will be reviewed after 25 visits.
X-Rays	80% coinsurance	60% coinsurance	
Clinical Trials (Routine Patient Costs)	80% coinsurance	60% coinsurance	
Dental Exam/Preventive Care - *only covered when not available through Dental Insurance.*	100% (Deductible waived)	100% (Deductible waived)	Includes cleanings and exams covered twice per calendar year. Bitewing x-rays covered once every 12 months. Full-mouth x-rays are not covered. Fluoride treatment for children under age 19 covered once every 12 months.
Dialysis	80% coinsurance	60% coinsurance	Prenotification is requested.
Durable Medical Equipment	80% coinsurance	60% coinsurance	Preauthorization is required for electric /motorized scooters or wheelchairs and pneumatic compression devices.
Glaucoma, Cataract Surgery and Lenses (one set)	80% coinsurance	60% coinsurance	
Hearing Aids	80% coinsurance	60% coinsurance	Limited to 1 per ear every 3 years up to $1,000. Over-the-counter/retail purchases are covered under Tier 1 benefits.
Home Health Care	80% coinsurance	60% coinsurance	Preauthorization is required.
Hospice			
Inpatient	80% coinsurance	60% coinsurance	Preauthorization is required for inpatient services. Respite care limited to 15 days inpatient and 15 days outpatient, maximum of 5 days per occurrence
Outpatient	80% coinsurance	60% coinsurance	
Family Bereavement Counseling	**Not Covered**		
Hospital			
Inpatient Treatment	80% coinsurance	60% coinsurance	Preauthorization is required for all inpatient services and for some outpatient procedures.
Outpatient Treatment	80% coinsurance	60% coinsurance	
Physician/Surgeon Services	80% coinsurance	60% coinsurance	
Imaging (CT, PET, MRI, & MRA)	80% coinsurance	60% coinsurance	Preauthorization is required for CT for non-orthopedic, MRI for non-orthopedic, and PET.

Coinsurance shown below is what Plan Pays and applies after deductible has been met, unless stated otherwise. Visits limits apply to In Network and Out of Network services combined.			
	In Network	**Out of Network**	**Limits**
Implants	80% coinsurance	60% coinsurance	Cochlear and bone anchored hearing aids are not covered.
Infertility	80% coinsurance	60% coinsurance	Coverage up to Diagnosis only, Treatment is excluded.
Injections/Infusions	80% coinsurance	60% coinsurance	Preauthorization is required for some injections/infusions. All are subject to review for medical necessity.
Mastectomy Bras	80% coinsurance	60% coinsurance	Limited to 2 per diagnosis.
Newborn Care	80% coinsurance	60% coinsurance	
Outpatient Diagnostic X-Ray and Lab	80% coinsurance	60% coinsurance	
Outpatient Emergency Services – Life Threatening/Accidental Injury	80% coinsurance, In Network deductible applies.		Preauthorization is required if admitted.
Outpatient Emergency Services – Non-Emergency	80% coinsurance, then $100 copay. In Network deductible applies.		Preauthorization is required if admitted. Copay is waived if admitted.
Physician Services: In-Office Setting			
Primary Care Office Visits	80% coinsurance	60% coinsurance	Virtual visits are covered as any other Office Visit.
Specialist Office Visits	80% coinsurance	60% coinsurance	
Labs, X-Rays, and Surgery	80% coinsurance	60% coinsurance	
Pregnancy Services			
Office Visit	80% coinsurance	60% coinsurance	**Cost sharing does not apply to certain services covered under *Preventive Care*.** Dependent daughter pregnancy is covered. Preauthorization is required for some maternity services.
Routine Prenatal and Postnatal Services	80% coinsurance	60% coinsurance	
Non-Routine Prenatal Services, Delivery and all Inpatient Care	80% coinsurance	60% coinsurance	
Breast Pump	Covered at 100% ACA requirement, no deductible applies	60% coinsurance	Over the counter breast pump purchase covered 100% (deductible does not apply) up to $500.
Pre-natal screening as defined under Women's Preventative Services of the Patient Protection and Affordable Care Act of 2010	No Charge	No Charge	
Preventative Care – Adult and Child			
Routine Physical Exam	No Charge	No Charge	School/sports physical for kids are covered.
Colonoscopies, Cologuard – must be age 45	No Charge	No Charge	Diagnostic colonoscopies are covered 100% after the Network deductible.
Mammograms, including 3D – *must be over age 40, unless Medically Necessary*	No Charge	No Charge	Diagnostic mammograms are covered 100% after the Network deductible. Automated Breast Ultrasound is included.
Pap Smears	No Charge	No Charge	
Prostate Exam – *must be over age 50, unless Medically Necessary*	No Charge	No Charge	
Routine Immunizations	No Charge	No Charge	
Private Duty Nursing	80% coinsurance	60% coinsurance	For outpatient care only if medically necessary.
Prosthetics, Orthotics, Supplies, and Surgical Dressings	80% coinsurance	60% coinsurance	Custom Molded Shoe inserts are covered and are limited to one per year. Orthopedic shoes are covered if part of a brace or for diabetics.

Coinsurance shown below is what Plan Pays and applies after deductible has been met, unless stated otherwise. Visits limits apply to In Network and Out of Network services combined.			
	In Network	**Out of Network**	**Limits**
Psychiatric Services			
Residential Treatment	80% coinsurance	60% coinsurance	Preauthorization is required
Inpatient Treatment	80% coinsurance	60% coinsurance	
Partial Day Program	80% coinsurance	60% coinsurance	
Office Visits/Therapy	80% coinsurance	60% coinsurance	Virtual visits are covered as any other Office Visit.
Outpatient Physician	80% coinsurance	60% coinsurance	
Second Surgical Opinions	80% coinsurance	60% coinsurance	
Skilled Nursing Facility	80% coinsurance	60% coinsurance	Preauthorization is required. Limited to 90 days per calendar year.
Sleep Disorders/Apnea	80% coinsurance	60% coinsurance	Preauthorization is required. Coverage for sleep disorders if medically necessary.
Substance Abuse			
Residential Treatment	80% coinsurance	60% coinsurance	Preauthorization is required
Inpatient Treatment	80% coinsurance	60% coinsurance	
Partial Day Program	80% coinsurance	60% coinsurance	
Office Visits/Therapy	80% coinsurance	60% coinsurance	Virtual visits are covered as any other Office Visit.
Outpatient Physician	80% coinsurance	60% coinsurance	
Surgery	80% coinsurance	60% coinsurance	Preauthorization is required for all inpatient services and for some outpatient procedures.
Temporomandibular Treatment (TMJ)	**Not Covered**		
Therapy			
ABA Therapy	80% coinsurance	60% coinsurance	
Aquatic Therapy	80% coinsurance	60% coinsurance	
Chemotherapy/Radiation Treatment	80% coinsurance	60% coinsurance	Preauthorization is required.
Cognitive Therapy	80% coinsurance	60% coinsurance	
Massage Therapy	80% coinsurance	80% coinsurance	
Occupational Therapy	80% coinsurance	60% coinsurance	Physical therapy, Speech therapy, Occupational therapy limited to 30 visits combined per plan year. Medical Necessity will be reviewed after 30 visits combined.
Physical Therapy	80% coinsurance	60% coinsurance	
Post-cochlear implant aural therapy	80% coinsurance	60% coinsurance	
Pulmonary Therapy	80% coinsurance	60% coinsurance	
Respiratory Therapy	80% coinsurance	60% coinsurance	
Speech Therapy	80% coinsurance	60% coinsurance	Physical therapy, Speech therapy, Occupational therapy limited to 30 visits combined per plan year. Medical Necessity will be reviewed after 30 visits combined.
Vision Therapy	80% coinsurance	60% coinsurance	

Coinsurance shown below is what Plan Pays and applies after deductible has been met, unless stated otherwise. Visits limits apply to In Network and Out of Network services combined.			
	In Network	**Out of Network**	**Limits**
Transplants			
Recipient Expenses	**Transplant services covered under separate policy with Optum Managed Transplant Program**		Expenses not covered under the Optum Managed Transplant program may include: Services before/after transplant benefit period; Services not covered under the Optum Managed Transplant Program.
Donor Expenses			
Urgent Care	80% coinsurance	60% coinsurance	
Vision Exam Services **–** *only covered when not available through Vision Insurance.*	100% coinsurance, deductible waived	100% coinsurance, deductible waived	Routine vision care covered once per calendar year. Covered services include vision exam, refractions, and glaucoma testing.
Note: Children's Vision screening is covered under Preventive Care Services and is only to detect the presence of eye problems such as amblyopia. Preventive Care Vision Screening for children is not the same as a Vision Exam.			
Weight Loss	**Not Covered**		Only diagnostic and counseling services as provided for under *Preventive Care* are covered.
Wigs	80% coinsurance	80% coinsurance	Covered 1 per condition for burns, radiation and/or chemotherapy. Alopecia is excluded from coverage.
All Other Covered Services	80% coinsurance	60% coinsurance	

Prescription Drug Benefits
HDHP $2,000 – Family Plan

The out-of-pocket maximum is the maximum dollar amount that Participants are responsible for paying for covered services during a Calendar Year.

When the individual and/or family out-of-pocket expenses reach the out-of-pocket maximum, the Plan will pay 100% of the Allowable Expenses for the remainder of the Calendar Year. No family member will be charged more than the individual out-of-pocket maximum.

Coinsurance is the amount specified in the Summary of Benefits that the Plan pays for certain covered services after the In Network deductible has been met**.**

NOTE: Walgreens is NOT a covered pharmacy.

Covered Prescription Drug Expenses:	Plan Pays at Preferred Pharmacy[1]	Non-Participating Pharmacy	Limits[2]
Pharmacy Option: Limit of 30-day supply			
Coinsurance per prescription or refill, for generic	80% coinsurance	Not Covered	See Prescription Drug Benefits section
Coinsurance per prescription or refill, for formulary name brands[3]	80% coinsurance	Not Covered	See Prescription Drug Benefits section
Mail Order Option: Limit of 90-day supply			
Coinsurance per prescription or refill, for generic	80% coinsurance	Not Covered	See Prescription Drug Benefits section
Coinsurance per prescription or refill, for formulary name brands[4]	80% coinsurance	Not Covered	See Prescription Drug Benefits section
Specialty Drug Option: Limit of 30-day supply			
Copayment per prescription or refill	Managed by RxAlly through MedOne		See Prescription Drug Benefits section

1 100% payment by Plan after Copayment.
2 These limits are in addition to all other Plan exclusions, limitations and provisions set forth in this Plan. Please review the Plan carefully to determine benefits available.
3 Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated “dispense as written” or similar indication.
4 Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated “dispense as written” or similar indication.

Additional specific benefit coverage and limitations:

Alopecia – Excluded

Autism – Autism Spectrum Disorders Treatment – when medical necessity is met.

Preventive / Routine Autism Screening:		
From Age 0 To 7		
• Maximum Visits Per Calendar Year	$36,000	$36,000
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)
From Age 7 To 14		
• Maximum Visits Per Calendar Year	$25,000	$25,000
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)
From Age 14 To 21		
• Maximum Visits Per Calendar Year	$12,500	$12,500
• Paid By Plan After Deductible	100% (Deductible Waived)	100% (Deductible Waived)

Note about above table for Autism: Mental Health Parity says no limits allowed on treatment for ASD as it's treated as any other medical condition.

Biofeedback - Excluded

Dental Screenings are covered if coverage is not available through dental insurance. Includes cleanings, x-rays and fluoride.

Dental Services include: The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than once occurring while eating or chewing), including implants. Treatment must be completed within 12 months of the Injury except when medical and/or dental conditions preclude completion or treatment within this time period. Inpatient or Outpatient Hospital charges including professional services for x-ray, lab, and anesthesia while in the Hospital if Medically Necessary. Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

Diabetic training/counseling – covered for self-management education & nutritional programs for diabetics.

Elective Abortions – Exclusions Abortions: Unless a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term.

Extractions of wisdom teeth (soft bony complete impacted teeth) – Oral Surgery includes Excision of partially or completely impacted teeth only when there is a medical condition (such as hemophilia) that requires hospitalization.

Foot Disorders (Bunions, plantar fasciitis, flat feet) – Excluded Foot Care (Podiatry): Routine foot care. Excluded – Palliative foot care.

Genetic Counseling & Testing – Excluded – Genetic Counseling regardless of purpose.

Hearing Aids, including over-the-counter – OTC are covered at Tier 1 only.

Hearing exams – Covered benefit.

Implantable Hormone Pellets – Excluded

Sterilization – Sterilizations paid 100% in and out of network. Exclusions – Reversal of sterilization.

Treatment for Impotence & Penile Implants – Exclusion: Sexual Function: Diagnostic Services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits Section in this SPD) in connection with treatment for male or female impotence.

SPD language:

Gender Affirming Care. *The Plan covers the following gender-affirming services when ordered by a Provider or Physician.*

- *Psychotherapy.*

Exclusions - Sex Transformation: surgery, drugs, medicines, for or leading to, sex transformation surgery.

Standard language covered Medical Benefits:

Prosthetics, Orthotics, Supplies and Surgical Dressings. *Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices but excluding orthopedic shoes and other supportive devices for the feet, except as specifically stated in the Summary of Benefits.*

Standard language in Exclusions:

Orthopedic Shoes. *For orthopedic shoes, unless they are for diabetes or unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet.*

Group elects no Hazardous Hobby exclusion.

AmericanHealth
American Health Holding Inc

Recommended Precertification List

American Health's precertification is a determination of medical necessity only, and does not involve matters of claimpayment, eligibility, coverage and the type and/or availability of benefits.

The establishment and construct of a precertification list is solely the responsibility of customer and/or the applicable plan sponsor (and not American Health). The design and implementation of a precertification list should be made only after obtaining the advice of customer's legal and benefit professionals, to include customer's full review of applicable health and welfare benefit plan terms and conditions as well as any applicable laws (for example, the Employee Retirement Income Security Act of 1974, and the Health Parity and Addiction Equity Act of 2008, as amended). American Health will have no responsibility for reviewing applicable plan documents, advising customer with respect to its precertification list or for customer's compliance with applicable laws related to the same. No representation or warranty is given with respect to this document, which is offered as-is.

Precertification requirements should be implemented only for those services listed within the Summary Plan Description as requiring prenotification or precertification and not defined as excluded

All Inpatient Admissions

- Acute
- Long-Term Acute Care
- Rehabilitation
- Mental Health / Substance Use Disorder
- Transplant
- Skilled Nursing Facility
- Residential Treatment Facility
- Obstetric – Prenotification only (precertification only required if days exceed Federal mandate)

Precertification for Inpatient and Outpatient procedures that could be considered Experimental /Investigational

Outpatient and Physician- Surgery

- Prenotification for the following:
  - Biopsies (excluding skin)
  - Vascular Access Devices for the Infusion of Chemotherapy (e.g. PICC and Central Lines)
  - Thyroidectomy, Partial or Complete
  - Open Prostatectomy
  - Creation and Revision of Arteriovenous Fistula (AV Fistula) or Vessel to Vessel Cannula for Dialysis
  - Oophorectomy, unilateral and bilateral
- Precertification for the following:
  - Back Surgeries and hardware related to surgery
  - Osteochondral Allograft, knee
  - Hysterectomy (including prophylactic)
  - Autologous chondrocyte implantation, Carticel
  - Transplant (excluding cornea)

- Balloon sinuplasty
- Sleep apnea related surgeries, limited to:
  - Radiofrequency ablation (Coblation, Somnoplasty)
  - Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
- Potentially Cosmetic Procedures, including but not limited to:
  - Abdominoplasty
  - Blepharoplasty
  - Cervicoplasty (neck lift)
  - Facial skin lesions (Photo therapy, laser therapy - excluding MOHS)
  - Hernia repair, abdominal and incisional (only when associated with a cosmetic procedure)
  - IDET (thermal intradiscal procedures)
  - Liposuction/lipectomy
  - Mammoplasty, augmentation and reduction (including removal of implant)
  - Mastectomy (including gynecomastia and prophylactic)
  - Morbid obesity procedures
  - Orthognathic procedures (e.g. Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
  - Otoplasty
  - Panniculectomy
  - Rhinoplasty
  - Rhytidectomy
  - Scar revisions
  - Septoplasty
  - Varicose vein surgery/sclerotherapy

Outpatient and Physician – Diagnostic Services

- Prenotification for the following:
  - CT for non-orthopedic
  - MRI for non-orthopedic
- Precertification for the following:
  - PET
  - Capsule endoscopy
  - Genetic Testing (including BRCA)
  - Sleep Study

Outpatient and Physician – Continuing Care Services

- Prenotification for the following:
  - Dialysis
- Precertification for the following:
  - Chemotherapy (including oral)
  - Radiation Therapy
  - Oncology and transplant related injections, infusions and treatments (e.g. CAR-T, endocrine andimmunotherapy), excluding supportive drugs (e.g. antiemetic and antihistamine)
  - Hyperbaric Oxygen
  - Home Health Care
  - Durable Medical Equipment, limited to electric/motorized scooters or wheelchairs and pneumaticcompression devices

Specialty Pharmacy Advocacy

Precertification for the following is available under Specialty Pharmacy Advocacy and notUtilization Management Outpatient

- All medications processed through the medical benefit which cost $2,000 or more per drug per month(excluding acute oncology or transplant treatments). When requested, this program can support precertification of medications processed through the PBM, (e.g. maintenance chemotherapy)

Note: Summary of Benefits and the above list are not inclusive of all benefits and limitations. Refer to the Plan Document for complete details.

TrueNorth Companies

Julie Estenson Director of Human Resources 2/3/2025

Approved by Name and Title Date

Julie Estenson

Printed name

Once the Schedule of Benefits is finalized and signed, that gives Consociate the right to start building the plan in the system for claims processing.