



**Timber Products Manufacturers Trust Benefit Highlights  
for  
MEDICAL PLAN HOLLY**

**TPM utilizes a National Network**

Any deductible, copays, and coinsurance percentages shown are amounts for which you are responsible. Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

**MEDICAL COST SHARE OPTIONS**

Benefit Highlights	In Network	Out of Network
<b>Deductible</b>		
Individual	\$1,500	\$3,000
Family (Aggregate)	\$3,000	\$6,000
<b>Coinsurance</b> (Member's percentage of costs after deductible based on allowable charges)	0%	0%
<b>Out of Pocket Maximum</b> (Includes deductible, coinsurance, copay & pharmacy if applicable)		
Individual	\$1,500	\$3,000
Family (Aggregate)	\$3,000	\$6,000
<b>Office Visit Cost Share</b>	Deductible/Coinsurance	Deductible/Coinsurance

**COVERED SERVICES**

**PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION**

<b>Preventive Office Visit</b> (Unlimited)	Covered in Full	Not Covered
<b>Immunizations</b> (Unlimited)	Covered in Full	Not Covered
<b>Health Education (HE)</b> (Unlimited)	Covered in Full	Not Covered
<b>Nicotine Dependency Programs (ND)</b> (Unlimited)	Covered in Full	Not Covered
<b>Diabetes Health Education (DE)</b> (Unlimited)	Covered in Full	Not Covered

**PROFESSIONAL CARE**

<b>Professional Office Visit Including Urgent Care</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Inpatient Professional Services</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Contraceptive Management</b> (Unlimited)	Covered in Full	Deductible/Coinsurance

**DIAGNOSTIC SERVICE OPTIONS**

<b>Preventive Professional Diagnostic Imaging &amp; Laboratory Services - Including Mammogram and PAP/PSA</b>	Covered in Full	Deductible/Coinsurance
<b>Other Professional Diagnostic Imaging</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Other Professional Diagnostic</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Diagnostic Mammography</b>	Deductible/Coinsurance	Deductible/Coinsurance

**FACILITY CARE OPTIONS**

<b>Inpatient Facility</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Outpatient Surgery Facility</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Skilled Nursing Facility (60 Days Per Cal. Year)</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Hospice Inpatient Facility</b> (10 days Inpatient; within	Deductible/Coinsurance	Deductible/Coinsurance

**EMERGENCY CARE OPTIONS**

<b>Emergency Care</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Emergency Room Physician</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Ambulance Transportation</b> (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Air Ambulance</b> (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance

This is not a complete explanation of covered services, exclusions, limitations, reductions, or the terms under which the program may be continued in force. This benefit summary is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions, please refer to your Summary Plan Description or contact Customer Service.

Balance billing may apply if a provider is not contracted with the Network. Members are responsible for amounts in excess of the allowable charge.



**Benefit Highlights  
for  
MEDICAL PLAN HOLLY**

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Benefit Highlights <i>(continued)</i>	In Network	Out of Network
<b>OTHER SERVICES</b>		
<b>Allergy/Therapeutic Injections</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Mental Health Inpatient Facility Care</b> (Unlimited)	Covered as Any Other Service	Covered as Any Other Service
<b>Mental Health Outpatient Professional Care</b> (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Chemical Dependency Inpatient Facility Care</b> (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Chemical Dependency Outpatient Professional Care</b> (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Rehab Inpatient Facility</b> (30 days per calendar year)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac &amp; Pulmonary Rehab.; and Chronic Pain</b> (45 Visits per calendar year)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Medical Supplies (MS), Equipment (ME), Prosthetics (Pro) and Orthotics (Orth)</b> (MS: Unlimited; ME: Unlimited; Pro: Unlimited; Orth: \$300 per calendar year (Unlimited Diabetes Related))	Deductible/Coinsurance	Deductible/Coinsurance
<b>Medical Supplies (MS), Equipment (ME), Prosthetics (Pro)</b> (MS: Unlimited; ME: Unlimited; Pro: Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Foot Orthotics, Orthopedic Shoes and Accessories</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Hospice</b> (Hospice Home Visits: Unlimited; Respite: 240)	Deductible/Coinsurance	Deductible/Coinsurance
<b>TMJ Disorders</b> (Unlimited (Medical and Dental))	Covered as Any Other Service	Deductible/Coinsurance
<b>Transplants</b> (Unlimited; \$7,500 travel and lodging)	Deductible/Coinsurance	Deductible/Coinsurance
<b>ALTERNATIVE CARE</b>		
<b>Acupuncture</b> (12 visits per calendar year)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Manipulations (spinal &amp; other)</b> (24 visits per calendar year)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Nutritional Therapy</b> (Unlimited)	Covered in Full	Deductible/Coinsurance
<b>PHARMACY</b>		
<b>Prescription Drugs - Mail (generic/preferred/non-specialty)</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Specialty Pharmacy (Mandatory)</b>	Deductible/Coinsurance	Not Covered
<b>Annual Plan Maximum</b>	Unlimited	
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