



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

**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  | \$3,000  | \$6,000                |
| Family  | \$6,000  | \$12,000               |
| <b>Coinsurance</b> (Member's percentage of costs after deductible based on allowable charges)   | 30%  | 45%                    |
| <b>Out of Pocket Maximum</b> (Includes deductible, coinsurance, copay & pharmacy if applicable) |  |                        |
| Individual  | \$6,350  | \$12,700               |
| Family  | \$12,700   | \$25,400               |
| <b>Office Visit Cost Share</b>  | \$35 Copay, applies to the Out of Pocket Maximum | 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> | \$35 Copay, applies to the Out of Pocket Maximum | 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>  | First \$500 Waive Deductible, 100% (Covered in Full) then Deductible/Coinsurance | Deductible/Coinsurance |
| <b>Other Professional Diagnostic Laboratory/Pathology</b>   | First \$500 Waive Deductible, 100% (Covered in Full) then Deductible/Coinsurance | Deductible/Coinsurance |
| <b>Diagnostic Mammography</b>   | First \$500 Waive Deductible, 100% (Covered in Full) then 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 the 6 month lifetime maximum) | Deductible/Coinsurance | Deductible/Coinsurance |

**EMERGENCY CARE OPTIONS**

|   |  |  |
|---|--|--|
| <b>Emergency Care (Waive copay if admitted to inpatient facility)</b> | \$200 Copay for ER Facility; not subject to Deductible/Coinsurance | \$200 Copay for ER Facility; not subject to Deductible/Coinsurance |
|---|--|--|

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**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 BIRCH**

Any deductible, copays, and coinsurance percentages shown are amounts for which you are responsible.

| Benefit Highlights <i>(continued)</i>  | In Network                                       | Out of Network               |
|--|--|------------------------------|
| <b>EMERGENCY CARE OPTIONS</b>  |  |                              |
| <b>Emergency Room Physician</b>  | Covered in Full                                  | Covered in Full              |
| <b>Ambulance Transportation (Unlimited)</b>  | Deductible/Coinsurance                           | Deductible/Coinsurance       |
| <b>Air Ambulance (Unlimited)</b>   | Deductible/Coinsurance                           | Deductible/Coinsurance       |
| <b>OTHER SERVICES</b>  |  |                              |
| <b>Allergy/Therapeutic Injections</b>  | Deductible/Coinsurance                           | Deductible/Coinsurance       |
| <b>Mental Health Inpatient Facility Care (Unlimited)</b>   | Covered as Any Other Service                     | Covered as Any Other Service |
| <b>Mental Health Outpatient Professional Care (Unlimited)</b>  | \$35 Copay, applies to the Out of Pocket Maximum | Deductible/Coinsurance       |
| <b>Chemical Dependency Inpatient Facility Care (Unlimited)</b>   | Deductible/Coinsurance                           | Deductible/Coinsurance       |
| <b>Chemical Dependency Outpatient Professional Care (Unlimited)</b>  | \$35 Copay, applies to the Out of Pocket Maximum | Deductible/Coinsurance       |
| <b>Rehab Inpatient Facility (30 days per calendar year)</b>  | Deductible/Coinsurance                           | Deductible/Coinsurance       |
| <b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac &amp; Pulmonary Rehab.; and Chronic Pain (45 Visits per calendar year)</b> | \$35 Copay, applies to the Out of Pocket Maximum | Deductible/Coinsurance       |
| <b>Medical Supplies (MS), Equipment (ME), Prosthetics (Pro) (MS: Unlimited; ME: Unlimited; Pro: Unlimited)</b>   | Deductible/Coinsurance                           | Deductible/Coinsurance       |
| <b>Foot Orthotics, Orthopedic Shoes and Accessories (\$300 per calendar year (Unlimited Diabetes Related))</b>   | Deductible/Coinsurance                           | Deductible/Coinsurance       |
| <b>Home Health Care (130 visits per calendar year)</b>   | Deductible/Coinsurance                           | Deductible/Coinsurance       |
| <b>Hospice (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)</b>   | Deductible/Coinsurance                           | Deductible/Coinsurance       |
| <b>TMJ Disorders (Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service))</b>   | Covered as Any Other Service                     | Covered as Any Other Service |
| <b>Transplants (Unlimited; \$7,500 travel and lodging limits)</b>  | Covered as Any Other Service                     | Not Covered                  |
| <b>ALTERNATIVE CARE</b>  |  |                              |
| <b>Acupuncture (12 visits per calendar year)</b>   | \$35 Copay, applies to the Out of Pocket Maximum | Deductible/Coinsurance       |
| <b>Manipulations (spinal &amp; other) (24 visits per calendar year)</b>  | \$35 Copay, applies to the Out of Pocket Maximum | Deductible/Coinsurance       |
| <b>Nutritional Therapy (Unlimited)</b>   | Covered in Full                                  | Deductible/Coinsurance       |
| <b>Annual Plan Maximum</b>   | Unlimited  |                              |

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## Timber Products Manufacturers Trust Benefit Highlights for PHARMACY BENEFIT PLAN Rx 6

**TPM utilizes a National Network**

Below is a brief overview of what you can expect to pay for a prescription drug, depending on which "tier" category it falls under in the Preferred Drug List for your plan when you're an In-Network Pharmacy. For more information on your pharmacy benefits, including Out-of-Network benefits, see your benefit booklet. To find out what tier applies to a specific medication, see our Preferred Drug List in your pharmacy packet.

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| Prescription   | Retail Pharmacy<br>(up to 30 day supply)     | Mail Order<br>(up to 90 day supply) |
|--|--|-------------------------------------|
| <b>Deductible</b>  |  |                                     |
| Individual Per Calendar Year                                 | \$0  | \$0                                 |
| Family Per Calendar Year                                     | \$0  | \$0                                 |
| <b>Specific Maintenance Generic Drugs</b>                    | \$0 copay per prescription                   | \$0 copay per prescription          |
| <b>Tier 1 - Generic Drug</b>                                 | \$10 copay per prescription                  | \$20 copay per prescription         |
| <b>Tier 2 - Preferred Brand Drug</b>                         | \$30 copay per prescription                  | \$60 copay per prescription         |
| <b>Tier 3 - Non-Preferred Brand Drug</b>                     | \$50 copay per prescription                  | \$100 copay per prescription        |
| <b>Tier 4 - Specialty Drug</b>                               | \$100  | \$100 - LIMITED TO A 30 DAY SUPPLY  |
| <b>Out of Network</b><br>Non-participating retail pharmacies | NOT COVERED                                  | NOT COVERED                         |
| <b>Out of Pocket Max</b>                                     | Pharmacy Copays Apply to the Medical OOP Max | Unlimited                           |
| <b>Annual Benefit Max</b>                                    | Unlimited                                    | Unlimited                           |

**Drug List -- Preferred B4**

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