



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

Plans Effective 2020

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 |
|---|--|------------------------|
| Deductible | | |
| Individual | \$750 | \$1,500 |
| Family | \$1,500 | \$3,000 |
| Coinsurance (Member's percentage of costs after deductible based on allowable charges) | 20% | 40% |
| Out of Pocket Maximum (Includes deductible, coinsurance, copay & pharmacy if applicable) | | |
| Individual | \$2,750 | \$5,500 |
| Family | \$5,500 | \$11,000 |
| Office Visit Cost Share | \$25 Copay, applies to the Out of Pocket Maximum | Deductible/Coinsurance |

COVERED SERVICES

PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION

| | | |
|--|-----------------|-------------|
| Preventive Office Visit (Unlimited) | Covered in Full | Not Covered |
| Immunizations (Unlimited) | Covered in Full | Not Covered |
| Health Education (HE) (Unlimited) | Covered in Full | Not Covered |
| Nicotine Dependency Programs (ND) (Unlimited) | Covered in Full | Not Covered |
| Diabetes Health Education (DE) (Unlimited) | Covered in Full | Not Covered |

PROFESSIONAL CARE

| | | |
|--|--|------------------------|
| Professional Office Visit Including Urgent Care | \$25 Copay, applies to the Out of Pocket Maximum | Deductible/Coinsurance |
| Inpatient Professional Services | Deductible/Coinsurance | Deductible/Coinsurance |
| Contraceptive Management (Unlimited) | Covered in Full | Deductible/Coinsurance |

DIAGNOSTIC SERVICE OPTIONS

| | | |
|---|--|------------------------|
| Preventive Professional Diagnostic Imaging & Laboratory Services - Including Mammogram and PAP/PSA | Covered in Full | Deductible/Coinsurance |
| Other Professional Diagnostic Imaging | First \$500 Waive Deductible, 100% (Covered in Full) then Deductible/Coinsurance | Deductible/Coinsurance |
| Other Professional Diagnostic Laboratory/Pathology | First \$500 Waive Deductible, 100% (Covered in Full) then Deductible/Coinsurance | Deductible/Coinsurance |
| Diagnostic Mammography | First \$500 Waive Deductible, 100% (Covered in Full) then Deductible/Coinsurance | Deductible/Coinsurance |

FACILITY CARE OPTIONS

| | | |
|--|------------------------|------------------------|
| Inpatient Facility | Deductible/Coinsurance | Deductible/Coinsurance |
| Outpatient Surgery Facility | Deductible/Coinsurance | Deductible/Coinsurance |
| Skilled Nursing Facility (60 Days Per Cal. Year) | Deductible/Coinsurance | Deductible/Coinsurance |
| Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum) | Deductible/Coinsurance | Deductible/Coinsurance |

EMERGENCY CARE OPTIONS

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

| Any deductible, copays, and coinsurance percentages shown are amounts for which you are responsible. | | |
|--|--|------------------------------|
| Benefit Highlights <i>(continued)</i> | In Network | Out of Network |
| EMERGENCY CARE OPTIONS | | |
| Emergency Room Physician | Covered in Full | Covered in Full |
| Ambulance Transportation (Unlimited) | Deductible/Coinsurance | Deductible/Coinsurance |
| Air Ambulance (Unlimited) | Deductible/Coinsurance | Deductible/Coinsurance |
| OTHER SERVICES | | |
| Allergy/Therapeutic Injections | Deductible/Coinsurance | Deductible/Coinsurance |
| Mental Health Inpatient Facility Care (Unlimited) | Covered as Any Other Service | Covered as Any Other Service |
| Mental Health Outpatient Professional Care (Unlimited) | \$25 Copay, applies to the Out of Pocket Maximum | Deductible/Coinsurance |
| Chemical Dependency Inpatient Facility Care (Unlimited) | Deductible/Coinsurance | Deductible/Coinsurance |
| Chemical Dependency Outpatient Professional Care (Unlimited) | \$25 Copay, applies to the Out of Pocket Maximum | Deductible/Coinsurance |
| Rehab Inpatient Facility (30 days per calendar year) | Deductible/Coinsurance | Deductible/Coinsurance |
| Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (45 Visits per calendar year) | \$25 Copay, applies to the Out of Pocket Maximum | Deductible/Coinsurance |
| Medical Supplies (MS), Equipment (ME), Prosthetics (Pro) (MS: Unlimited; ME: Unlimited; Pro: Unlimited) | Deductible/Coinsurance | Deductible/Coinsurance |
| Foot Orthotics, Orthopedic Shoes and Accessories (\$300 per calendar year (Unlimited Diabetes Related)) | Deductible/Coinsurance | Deductible/Coinsurance |
| Home Health Care (130 visits per calendar year) | Deductible/Coinsurance | Deductible/Coinsurance |
| Hospice (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum) | Deductible/Coinsurance | Deductible/Coinsurance |
| TMJ Disorders (Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service)) | Covered as Any Other Service | Covered as Any Other Service |
| Transplants (Unlimited; \$7,500 travel and lodging limits) | Covered as Any Other Service | Not Covered |
| ALTERNATIVE CARE | | |
| Acupuncture (12 visits per calendar year) | \$25 Copay, applies to the Out of Pocket Maximum | Deductible/Coinsurance |
| Manipulations (spinal & other) (24 visits per calendar year) | \$25 Copay, applies to the Out of Pocket Maximum | Deductible/Coinsurance |
| Nutritional Therapy (Unlimited) | Covered in Full | Deductible/Coinsurance |
| Annual Plan Maximum | Unlimited | |
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| <p>Balance billing may apply if a provider is not contracted with the Network. Members are responsible for amounts in excess of the allowable charge.</p> | | |



Timber Products Manufacturers Trust Benefit Highlights for PHARMACY BENEFIT PLAN - ESSENTIALS

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 (up to 30 day supply) | Mail Order (up to 90 day supply) |
|--|--|-------------------------------------|
| Deductible | | |
| Individual Per Calendar Year | \$0 | \$0 |
| Family Per Calendar Year | \$0 | \$0 |
| Specific Maintenance Generic Drugs | \$0 copay per prescription | \$0 copay per prescription |
| Tier 1 - Preferred Generic | \$10 copay per prescription | \$20 copay per prescription |
| Tier 2 - Preferred Brand | \$30 copay per prescription | \$60 copay per prescription |
| Tier 3 - Preferred Specialty* | \$50 copay per prescription | \$100 copay per prescription |
| Tier 4 - Non-Preferred | 30% up to \$250 per prescription | 30% up to \$500 per prescription |
| Out of Network Non-participating retail pharmacies | Cost Share, then 40% to Allowable | NOT COVERED |
| Out of Pocket Max | Pharmacy Copays Apply to the Medical OOP Max | Unlimited |
| Annual Benefit Max | Unlimited | Unlimited |

Drug List -- Essentials E4

* Specialty Drugs typically subject to 30 day supply limits

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