TPM TRUST

Timber Products Manufacturers Trust Benefit Highlights
for
MEDICAL PLAN PACIFIC YEW

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 notied, or if the cost share is a copay.

MEDICAL COST SHARE OPTIONS

Benefit Highlights	In Network	Out of Network
Deductible		
Individual	$5,000	$10,000
Family (Embedded)	$10,000	$20,000
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	80%	40%
Out of Pocket Maximum **(Includes deductible, coinsurance, copay & pharmacy if applicable)**		
Individual	$6,650	$13,300
Family (Embedded)	$13,300	$26,600
Office Visit Cost Share	Deductible/Coinsurance	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	Deductible/Coinsurance	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	Deductible/Coinsurance	Deductible/Coinsurance
Other Professional Diagnostic Laboratory/Pathology	Deductible/Coinsurance	Deductible/Coinsurance
Diagnositic Mammography	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	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Room Physician	Deductible/Coinsurance	Deductible/Coinsurance
Ambulance Transportation (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
Air Ambulance (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.

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Benefit Highlights for MEDICAL PLAN PACIFIC YEW

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Benefit Highlights *(continued)*	In Network	Out of Network
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)	Deductible/Coinsurance	Deductible/Coinsurance
Chemical Dependency Inpatient Facility Care (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
Chemical Dependency Outpatient Professional Care (Unlimited)	Deductible/Coinsurance	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)	Deductible/Coinsurance	Deductible/Coinsurance
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro) and Orthotics (Orth) (MS: Unlimited; ME: Unlimited; Pro: Unlimited; Orth: $300 per calendar year (Unlimited Diabetes Related)	Deductible/Coinsurance	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	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	Deductible/Coinsurance
Transplants (Unlimited; $7,500 travel and lodging limits)	Deductible/Coinsurance	Deductible/Coinsurance
ALTERNATIVE CARE		
Acupuncture (12 visits per calendar year)	Deductible/Coinsurance	Deductible/Coinsurance
Manipulations (spinal & other) (24 visits per calendar year)	Deductible/Coinsurance	Deductible/Coinsurance
Nutritional Therapy (Unlimited)	Covered in Full	Deductible/Coinsurance
PHARMACY		
Prescription Drugs - Mail (generic/preferred/non-preferred) 90 Day Supply	Deductible/Coinsurance	Not Covered
Specialty Pharmacy (Mandatory)	Deductible/Coinsurance	Not Covered
Annual Plan Maximum	Unlimited	

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