



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

**Plans Effective 2021**

**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	\$500	\$1,000
Family	\$1,000	\$2,000
<b>Coinsurance</b> (Member's percentage of costs after deductible based on allowable charges)	20%	40%
<b>Out of Pocket Maximum</b> (Includes deductible, coinsurance, copay & pharmacy if applicable)		
Individual	\$2,500	\$5,000
Family	\$5,000	\$10,000
<b>Office Visit Cost Share</b>	\$30 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>	\$30 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>	\$250 Copay for ER Facility; not subject to Deductible/Coinsurance	\$250 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 TAMARACK**

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Benefit Highlights <i>(continued)</i>	In Network	Out of Network
<b>EMERGENCY CARE OPTIONS</b>		
Emergency Room Physician	Covered in Full	Covered in Full
Ambulance Transportation (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
Air Ambulance (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
<b>OTHER SERVICES</b>		
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)	\$30 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)	\$30 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)	\$30 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
<b>ALTERNATIVE CARE</b>		
Acupuncture (12 visits per calendar year)	\$30 Copay, applies to the Out of Pocket Maximum	Deductible/Coinsurance
Manipulations (spinal & other) (24 visits per calendar year)	\$30 Copay, applies to the Out of Pocket Maximum	Deductible/Coinsurance
Nutritional Therapy (Unlimited)	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 - 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)
<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 - Preferred Generic</b>	\$10 copay per prescription	\$20 copay per prescription
<b>Tier 2 - Preferred Brand</b>	\$30 copay per prescription	\$60 copay per prescription
<b>Tier 3 - Preferred Specialty*</b>	\$50 copay per prescription	\$50 copay per prescription
<b>Tier 4 - Non-Preferred</b>	30% up to \$250 per prescription	30% up to \$250 per prescription
<b>Out of Network</b> 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

\* Specialty Drugs subject to 30 day supply limits

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