



**Timber Products Manufacturers Trust Benefit Highlights  
for**

**MEDICAL PLAN GRAND FIR**

**Plans Effective 2023**

**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	\$2,000	\$4,000
Family	\$4,000	\$8,000
<b>Coinsurance</b> (Member's percentage of costs after deductible based on allowable charges)	30%	50%
<b>Out of Pocket Maximum</b> (Includes deductible, coinsurance, copay & pharmacy if applicable)		
Individual	\$6,850	N/A
Family	\$13,700	N/A
<b>Office Visit Cost Share</b>	Non-Specialist: \$25 Copay; Specialist: \$40 Copay	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>	Non-Specialist: \$25 Copay; Specialist: \$40 Copay	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 Laboratory/Pathology</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 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, then Deductible/Coinsurance	\$250 Copay for ER Facility, then 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 GRAND FIR**

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>	Deductible/Coinsurance	Deductible/Coinsurance
<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>	Non-Specialist: \$25 Copay; Specialist: \$40 Copay	Deductible/Coinsurance
<b>Chemical Dependency Inpatient Facility Care (Unlimited)</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Chemical Dependency Outpatient Professional Care (Unlimited)</b>	Non-Specialist: \$25 Copay; Specialist: \$40 Copay	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 (25 Visits per calendar year)</b>	Non-Specialist: \$25 Copay; Specialist: \$40 Copay	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>	Non-Specialist: \$25 Copay; Specialist: \$40 Copay	Deductible/Coinsurance
<b>Manipulations (spinal &amp; other) (12 visits per calendar year)</b>	Non-Specialist: \$25 Copay; Specialist: \$40 Copay	Deductible/Coinsurance
<b>Nutritional Therapy (Unlimited)</b>	Covered in Full	Deductible/Coinsurance
<b>Annual Plan Maximum</b>	Unlimited	

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.



## 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.

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

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	Cost Share, then 40% to Allowable	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 -- Essentials E4**

**\* Specialty Drugs subject to 30 day supply limits**

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

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 highlight 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.