TPM TRUST

Timber Products Manufacturers Trust Benefit Highlights for MEDICAL PLAN LOCUST

Plans Effective 2024

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	$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
Diagnositic 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)	$250 Copay for ER Facility; not subject to Deductible/Coinsurance	$250 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.

TPM TRUST

Benefit Highlights for MEDICAL PLAN LOCUST

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

Benefit Highlights *(continued)*	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 (Unlimitied 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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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	Mail Order
	(up to 30 day supply)	**(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	$50 copay per prescription
Tier 4 - Non-Preferred	30% up to $250 per prescription	30% up to $250 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 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.

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