



**Timber Products Manufacturers Trust Benefit Highlights**

for

**MEDICAL PLAN BUCKTHORN**

**Plans Effective 2025**

**TPM Trust plans utilize the BlueCard PPO 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)	20%	40%
<b>Out of Pocket Maximum</b> (Includes deductible, coinsurance, copay & pharmacy if applicable)		
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
<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	Deductible/Coinsurance
<b>Immunizations</b> (Unlimited)	Covered in Full	Deductible/Coinsurance
<b>Health Education (HE)</b> (Unlimited)	Covered in Full	Deductible/Coinsurance
<b>Nicotine Dependency Programs (ND)</b> (Unlimited)	Covered in Full	Deductible/Coinsurance
<b>Diabetes Health Education (DE)</b> (Unlimited)	Covered in Full	Deductible/Coinsurance

**PROFESSIONAL CARE**

<b>Professional Office Visit</b>	\$30 Copay, applies to the Out of Pocket Maximum	Deductible/Coinsurance
<b>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**

Emergency treatment paid at the In Network level

<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
---	--	--

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 BUCKTHORN**

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> Emergency treatment paid at the In Network level		
<b>Emergency Room Physician</b>	Covered in Full	Covered in Full
<b>Ambulance Transportation</b> (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Air Ambulance</b> (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
<b>OTHER SERVICES</b>		
<b>Allergy/Therapeutic Injections</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Mental Health Inpatient Facility Care</b> (Unlimited)	Covered as Any Other Service	Covered as Any Other Service
<b>Mental Health Outpatient Professional Care</b> (Unlimited)	\$30 Copay, applies to the Out of Pocket Maximum	Deductible/Coinsurance
<b>Chemical Dependency Inpatient Facility Care</b> (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Chemical Dependency Outpatient Professional Care</b> (Unlimited)	\$30 Copay, applies to the Out of Pocket Maximum	Deductible/Coinsurance
<b>Rehab Inpatient Facility</b> (30 days per calendar year)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac &amp; Pulmonary Rehab.; and Chronic Pain</b> (45 Visits per calendar year)	\$30 Copay, applies to the Out of Pocket Maximum	Deductible/Coinsurance
<b>Medical Supplies (MS), Equipment (ME), Prosthetics (Pro)</b> (MS: Unlimited; ME: Unlimited; Pro: Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Foot Orthotics, Orthopedic Shoes and Accessories</b> (\$300 per calendar year (Unlimited Diabetes Related))	Deductible/Coinsurance	Deductible/Coinsurance
<b>Home Health Care</b> (130 visits per calendar year)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Hospice</b> (180 days per calendar year)	Deductible/Coinsurance	Deductible/Coinsurance
<b>TMJ Disorders</b> (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
<b>Transplants</b> (Unlimited; \$7,500 travel and lodging limits)	Covered as Any Other Service	Not Covered
<b>ALTERNATIVE CARE</b>		
<b>Acupuncture</b> (12 visits per calendar year)	\$30 Copay, applies to the Out of Pocket Maximum	Deductible/Coinsurance
<b>Manipulations (spinal &amp; other)</b> (24 visits per calendar year)	\$30 Copay, applies to the Out of Pocket Maximum	Deductible/Coinsurance
<b>Nutritional Therapy</b> (Unlimited)	Covered in Full	Deductible/Coinsurance
<b>Annual Plan Maximum</b>	Unlimited	
<p>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.</p>		
<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.

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>		
Generic	30% up to \$250 per prescription	30% up to \$250 per prescription
Brand	30% up to \$250 per prescription	30% up to \$500 per prescription
Specialty	N/A	30% up to \$250 per prescription
<b>Out of Network</b>		
Non-participating retail pharmacies	Tier copay, plus 40%	NOT COVERED
<b>Out of Pocket Max</b>	Pharmacy Copays Apply to the Medical OOP Max	Pharmacy Copays Apply to the Medical OOP Max
<b>Annual Benefit Max</b>	Unlimited	Unlimited

**Drug List -- Essentials E4**

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

The Participant may be required to pay the difference between a Brand-Name Drug and the generic equivalent in addition to the Copayment and/or Coinsurance if the Participant chooses a Brand-Name Drug when a Generic Drug is available. The amount the Participant pays for the difference between a Brand-Name Drug and the generic equivalent does not apply to the Out of Pocket Amount and will continue to be imposed after the Out of Pocket Amount is met.

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.