



Timber Products Manufacturers Trust Benefit Highlights
for
MEDICAL PLAN LOCUST

Plans Effective 2025

TPM Trust plans utilize the Cigna Open Access Plus (OAP) 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 |
|---|--|------------------------|
| 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 | \$25 Copay, applies to the Out of Pocket Maximum | Deductible/Coinsurance |
| 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 |
| Diagnostic 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 treatment paid at the In Network level

| | | |
|---|--|--|
| 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.



**Benefit Highlights
for
MEDICAL PLAN LOCUST**

| Any deductible, copays, and coinsurance percentages shown are amounts for which you are responsible. | | |
|---|--|------------------------------|
| Benefit Highlights <i>(continued)</i> | In Network | Out of Network |
| EMERGENCY CARE OPTIONS Emergency treatment paid at the In Network level | | |
| 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 |
| Outpatient Therapy Services: Includes Physical, Speech, Occupational, Cognitive and Massage Therapy and Pulmonary Rehab (45 days per calendar year) | \$25 Copay, applies to the Out of Pocket Maximum | Deductible/Coinsurance |
| Outpatient Cardiac Rehabilitation (36 days 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 (Unlimited Diabetes Related)) | Deductible/Coinsurance | Deductible/Coinsurance |
| Home Health Care (130 visits per calendar year) | Deductible/Coinsurance | Deductible/Coinsurance |
| Hospice | 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; \$10,000 travel and lodging limits) | Covered as Any Other Service | Not Covered |
| ALTERNATIVE CARE | | |
| Acupuncture (12 days per calendar year) | \$25 Copay, applies to the Out of Pocket Maximum | Deductible/Coinsurance |
| Manipulations (spinal & other) (24 days 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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| <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.

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| Prescription | Retail Pharmacy (up to 30 day supply) | Mail Order (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 - Generic | \$10 copay per prescription | \$20 copay per prescription |
| Tier 2 - Preferred Brand | \$30 copay per prescription | \$60 copay per prescription |
| Tier 3 - Non-preferred Brand | 30% up to \$250 per prescription | 30% up to \$500 per prescription |
| Out of Network Non-participating retail pharmacies | NOT COVERED | NOT COVERED |
| Out of Pocket Max | Pharmacy Copays Apply to the Medical OOP Max | Pharmacy Copays Apply to the Medical OOP Max |
| Annual Benefit Max | Unlimited | Unlimited |

Drug List - Standard 3 Tier

Specialty Drugs subject to 30 day supply limits

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