



Timber Products Manufacturers Trust Benefit Highlights

**for
MEDICAL PLAN ROSEWOOD**

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
Deductible		
Individual	\$1,000	\$2,000
Family	\$2,000	\$4,000
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	30%	45%
Out of Pocket Maximum (Includes deductible, coinsurance, copay & pharmacy if applicable)		
Individual	\$4,000	\$8,000
Family	\$8,000	\$16,000
Office Visit Cost Share	\$35 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	Deductible/Coinsurance
Immunizations (Unlimited)	Covered in Full	Deductible/Coinsurance
Health Education (HE) (Unlimited)	Covered in Full	Deductible/Coinsurance
Nicotine Dependency Programs (ND) (Unlimited)	Covered in Full	Deductible/Coinsurance
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Deductible/Coinsurance

PROFESSIONAL CARE

Professional Office Visit	\$35 Copay, applies to the Out of Pocket Maximum	Deductible/Coinsurance
Urgent Care	\$35 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
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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 ROSEWOOD**

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)	\$35 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)	\$35 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)	\$35 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 (180 days per calendar year)	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)	\$35 Copay, applies to the Out of Pocket Maximum	Deductible/Coinsurance
Manipulations (spinal & other) (24 visits per calendar year)	\$35 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 - 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		
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
Out of Network		
Non-participating retail pharmacies	Tier copay, plus 40%	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 -- 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.

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