

Highlights of your Health Care Coverage

Western Building Material Association

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

Effective date: 8/1/2007

MEDICAL PLAN		Your Choice - Plan 2 \$500/\$1,500/\$25/80/50%	
MEDICAL COST SHARE OPTIONS		HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
Individual Deductible PCY (Family Deductible 3x Individual)		\$500 PCY	Shared with In-Network Deductible
Coinsurance (Member's percentage of costs after deductible based on allowable charges)		80%	50%
Individual Out of Pocket Maximum PCY, Excludes Copay (No Family OOP Max)		\$1,500 PCY	Not Applicable
Office Visit Cost Share		\$25 Copay	Deductible/Coinsurance
COVERED SERVICES			
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION			
Preventive Office Visit (\$500 PCY)		Office Visit Cost Share	Not Covered
Immunizations (Shared with Exam Limit)		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	Deductible/Coinsurance
Inpatient Professional Services		Deductible/Coinsurance	Deductible/Coinsurance
Contraceptive Management (Unlimited)		\$25 Copay	Deductible/Coinsurance
DIAGNOSTIC SERVICE OPTIONS			
Other Professional Diagnostic Imaging and Laboratory Services		Deductible/Coinsurance	Deductible/Coinsurance
Professional Diagnostic Imaging and Laboratory Services - Including PAP/PSA, Preventive		Deductible/Coinsurance	Deductible/Coinsurance
Mammography		Waive Deductible, Subject to Coinsurance	Deductible/Coinsurance
FACILITY CARE OPTIONS			
Inpatient Facility		Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Surgery Facility		Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (60 days PCY)		Deductible/Coinsurance	Deductible/Coinsurance
EMERGENCY CARE OPTIONS			
Emergency Care (Waive copay if admitted, always subject to deductible and coinsurance.)		\$100 Copay, Deductible/Coinsurance	\$100 Copay, Subject to In-Network Deductible/Coinsurance
Ambulance Transportation		Deductible/Coinsurance	Same as In-Network Deductible/Coinsurance
Air Ambulance (Unlimited)		Deductible/Coinsurance	Same as In-Network Deductible/Coinsurance

PCY = Per calendar year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. 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 contact Customer Service.

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OTHER SERVICES	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
Acupuncture (12 visits PCY)	Office Visit Cost Share	Office Visit Cost Share
Chemical Dependency (\$13,500 per 24 Months)	Covered as Any Other Service	Deductible/Coinsurance
Home Health Care (130 visits PCY)	Deductible/Coinsurance	Deductible/Coinsurance
Hospice (Inpatient: 10 days; Respite: 240 hours; 6 month limit)	Deductible/Coinsurance	Deductible/Coinsurance
Manipulations (spinal and other) (12 visits PCY)	Office Visit Cost Share	Office Visit Cost Share
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro) and Orthotics (Orth) (MS: \$5,000 PCY; ME: \$5,000 PCY Shared with MS; Pro: \$5,000 PCY Shared with MS; Orth: \$300 PCY, Shared with ME)	Deductible/Coinsurance	Deductible/Coinsurance
Mental Health Inpatient Facility Care (14 days PCY)	Covered as Any Other Service	Covered as Any Other Service
Mental Health Outpatient Professional Care (20 visits PCY)	Covered as Any Other Service	Covered as Any Other Service
Rehab Inpatient Facility (30 days PCY)	Inpatient Cost Share	Inpatient Cost Share
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (45 visits PCY)	Covered as Any Other Service	Office Visit Cost Share
TMJ Disorders (Non Covered)	Not Covered	Not Covered
Transplants (\$250,000 per lifetime; combined inpatient and outpatient limit)	Covered as Any Other Service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 PCY)	Office Visit Cost Share	Deductible/Coinsurance
LIFETIME MAXIMUM	\$2,000,000	

PHARMACY PLAN

RETAIL \$15/\$25/\$45 MAILORDER \$30/\$50/\$90
Cost Share Category
Tier 1/ Tier 2/ Tier 3

OUTPATIENT PRESCRIPTION DRUGS

Retail Cost Shares Up to 30 day supply per prescription	\$15/\$25/\$45
Mail Cost Shares Up to 90 day supply per prescription	\$30/\$50/\$90
Individual Deductible PCY	\$0
Out-of-Network Non-participating retail and mail pharmacies	Cost Share, then 40% (to allowable)
Out of Pocket Max	Unlimited
Annual Benefit Max	Unlimited