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

DENTAL PLAN	**DENTAL OPTIMA - $50/$150 20/20/50% $1500**	
COVERED SERVICES		
Individual/Family Deductible PCY	$50 PCY / $150 PCY	Shared with In-Network Lifetime Maximum
Diagnostic/Preventive -initial & routine oral exams -cleanings -fluoride treatments -routine dental x-rays -sealants -space maintainers	20%	Shared with In-Network Lifetime Maximum
Basic -oral surgery -fillings -periodontal scaling -periodontal maintenance -full mouth debridement -repair & recementing of crowns, inlays, bridgework & dentures -endodontic (root canal) treatment -emergency palliative treatment -general anesthesia	20%	Shared with In-Network Lifetime Maximum
Major -inlays, onlays & crowns -dentures & fixed bridges -replacement of crowns, inlays, bridgework & dentures	50%	Shared with In-Network Lifetime Maximum
Annual Maximum	$1500	Shared with In-Network Lifetime Maximum
TMJ	Not Covered	Not Covered

Diagnostic and Preventive Care Services aren't subject to the calendar year deductible. 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.