

Summary of Benefits

(Benefit Coverage Plans A and B)

	Benefit	Benefit Coverage Plan A		Benefit Coverage Plan B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Dental Care (Aetna)	Yearly deductible	None	\$50/individual; \$150/family	None	\$50/individual; \$150/family
	Maximum yearly benefit	\$1,200	\$1,200	\$1,200	\$1,200
	Orthodontia maximum	\$1,000 per course of treatment separated by two years	\$1,000 per course of treatment separated by two years	\$1,000 per course of treatment separated by two years	\$1,000 per course of treatment separated by two years
	Diagnostic and preventive services	No cost	Paid at 80% of usual and prevailing fee	No cost	Paid at 80% of usual and prevailing fee
	Basic restorative services, endodontics, periodontics, maintenance of prosthodontics, and oral surgery	Paid at 80% of fee schedule	Paid at 80% of usual and prevailing fee	Paid at 80% of fee schedule	Paid at 80% of usual and prevailing fee
	Major restorative services, installation of prosthodontics, and orthodontics	Paid at 50% of fee schedule	Paid at 50% of usual and prevailing fee	Paid at 50% of fee schedule	Paid at 50% of usual and prevailing fee
Prescription Drugs (ESI)	Yearly deductible	None	None	None	None
	Maximum network out-of-pocket cost (doesn't include clinical pharmacy program penalties)	\$6,350 Individual; \$12,700 Family	None	\$6,350 Individual \$12,700 Family	None
	Prescription drugs at retail pharmacy (up to a 34-day supply)	Tier 1: \$0 Generic Tier 2: \$10 Preferred Tier 3: \$20 Non-preferred	Reimbursed at contracted amount minus applicable in-network copayment	Tier 1: \$7 Generic Tier 2: \$20 Preferred Tier 3: \$35 Non-preferred	Reimbursed at contracted amount minus applicable in-network copayment
	Mail-order prescription drug program (mandatory for all maintenance prescription medications for up to a 90-day supply)	Tier 1: \$0 Generic Tier 2: \$20 Preferred Tier 3: \$40 Non-preferred	Not applicable	Tier 1: \$15 Generic Tier 2: \$40 Preferred Tier 3: \$70 Non-preferred	Not applicable