ALASKA RAILROAD

2022 AT-A-GLANCE BENEFIT COMPARISON

Gold Essentials vs. Blue Essentials Plans

Compare Plans. This table shows the basic differences and similarities between the **Gold**, **Blue**, **Gold Essentials** and **Blue Essentials** plans.

- **Gold Essentials** is a Consumer Directed Health Plan (CDHP) that comes with a Health Savings Account (HSA).
- **Blue Essentials** is a Preferred Provider Plan (PPO).

Benefit or Plan Feature	Gold Essentials	Blue Essentials
Annual Deductible, in Network — for Individual and for Family	$1,400 Individual | $3,900 Family	$1,000 Individual | $3,000 Family
Out-of-Pocket Maximum, In Network — for Individual and for Family	$5,300 Individual | $12,900 Family	$3,500 Individual | $10,500 Family
Bi-weekly Premium costs	Lower	Higher
Includes Company-Funded Health Savings Account (HSA)	Yes	No
Includes Health Care Flexible Spending Account (FSA)	No	Yes
Your Coinsurance for Premera Preferred Providers	20%	20%
Out-of-Network Coinsurance counts toward Out-of-Pocket Maximum	No	No
4-Tier Prescription coverage	Better Managed	Better Managed
Prescription coverage subject to Deductible	Yes	No
Covers 100% of preventive medications	192 medicines	No
Requires Prior Authorization for certain procedures	Yes	Yes
Voluntary Medical Travel	Yes	Yes
Additional Emergency Room fee	No	Yes - $100
See a Specialist without a Referral	Yes	Yes
Nicotine Use Surcharge	Yes	Yes
Access to NurseLine advice 24/7	Yes	Yes
Access to Premera Mobile, website and online tools	Yes	Yes
Access to Doctor on Demand virtual medical care	$60 fee	No fee
Access to Coalition Health Care Center	No	$20 fee

ALASKA RAILROAD

2022 BENEFITS OPEN ENROLLMENT

for Essentials-covered Employees

Change or Enroll Nov. 16 - Dec. 15

Here is your once-a-year chance to Check your route

Open Window is your annual opportunity to:

- Change your current Health Care Plan. This year, you may select one of two Essentials plans (see next page for information)
- Add or drop the Optional Dental Plan
- Enroll new dependents not added during the year
- Enroll or re-enroll in a Flexible Spending Account

If you want to keep your current health care or life insurance coverage, and the same dependent coverage, you don't need to do anything. Your elections automatically renew for 2022.

To ***change*** your benefits or contribute to a Flexible Spending Account, you must act by completing the appropriate forms (in your enrollment packet), and returning them to Human Resources.

Waiving coverage for the first time for 2022?
Complete the *Employee Waiver of Health Plan Coverage Form* in your Open Enrollment packet.

Seasonal employees returning from layoff or employees returning from leave of absence:
If you are not on payroll effective Dec. 5, 2021, but you return to benefits-eligible employment in 2022, you must complete your enrollment within 31 days of returning to work.

Your Personalized ARRC Benefits Enrollment Information Form	Required ***only*** if you want to make changes for 2022. Indicate all of your benefit elections and dependent information on the form.
Health Savings Account (HSA) 2022 Election / Change Form	Required ***only*** if you are new to the Gold Essentials Plan for 2022, or if you want to change your current HSA voluntary contribution. You can contribute your own money to your HSA, up to IRS limits. You own this account — your balance is yours to keep, even when you retire or leave ARRC.
Health Care Flexible Spending Account (HCFSA) Enrollment / Change Form	You may contribute to the HCFSA if you choose the Blue Essentials Plan for medical. Return the form ***only*** if you want to contribute to the account in 2022.
Dependent Care Flexible Spending Account Enrollment / Change Form	Return the form ***only*** if you want to contribute to your Dependent Care FSA account in 2022.
Employee Waiver of Health Plan Coverage Form	Return the form ***only*** if you are waiving medical coverage for 2022.
Proof of Dependent Relationship to You	Return proof (e.g., birth certificate, marriage certificate) ***only*** if you are enrolling new family members for 2022.

Refer to your Benefits Enrollment Information Form for Life and AD&D Insurance premiums. Contact HR immediately if you want to change life insurance elections. To increase life insurance, you must submit evidence of insurability and have it approved by Hartford by Dec. 15.

WHERE TO SEND YOUR OPEN WINDOW FORMS AND DOCUMENTATION

Email: HRBenefits@akrr.com

Mail/interoffice mail: Alaska Railroad Corporation
PO Box 107500, Anchorage, AK 99510-7500

Fax: 907-265-2542

Hand deliver: Human Resources/GOB 1st floor

Questions? 907-265-2220

DON'T MISS THE DECEMBER 15 DEADLINE

If you miss the deadline, you and your currently enrolled dependents will have the following benefits as of January 1, 2022:

- Your current medical and dental plan choices
- Your current life insurance and AD&D election(s)

You are not allowed to make changes during the year unless you have a qualified life event.

2022 Plan Benefits Recap

A refresher on the benefits offered to you — More details in the attached *At-a-Glance Essentials Plan Guide*.

Benefit	Benefit Choices
Medical and prescription drugs	Choose the Gold Essentials Plan or the Blue Essentials Plan. Both are administered by Premera Blue Cross Blue Shield of Alaska.
Dental	**Non-represented employees:** You are offered the ARRC Optional Dental Plan. **Union-represented employees:** Your union requires you to enroll in the Railroad Employees' National Dental Plan. You may supplement coverage with the ARRC Optional Dental Plan for an additional cost.
Vision & Hearing	Coverage is included with your medical plan.
Health Savings Account (HSA)	Only available if you choose the Gold Essentials Plan. ARRC contributes $500 to $1,500 to your HSA, depending on the number of your enrolled dependents. For year-round participants, ARRC contributes half in January and half in July. Contributions are prorated for employees who are new, seasonal or returning from layoff. Prorated amounts are listed in the *My Benefits Journal*.
Flexible Spending Accounts (FSAs)	**Health Care FSA:** Only available if you choose the Blue Essentials Plan. Contribution limit on enrollment forms. **Dependent Care FSA:** Contribute up to $5,000.
Life and AD&D Insurance	Several options are available, including Basic Life and AD&D, Standard coverage, Optional Life, and Dependent Life coverage for your spouse and children. You and ARRC share the premium cost for Basic Coverage, while you pay the full premium cost for the additional options.

Bi-Weekly Premium Costs

ARRC continues to pay for most of the bi-weekly cost for your health benefits.

Medical and Prescription Drugs

Gold Essentials Plan			Blue Essentials Plan*		
You	You + 1	You + 2 or more	You	You + 1	You + 2 or more
$50.75	$110.21	$137.37	$77.84	$175.86	$223.89

* Does not include ATDA's 2022 premium adjustment

Dental Coverage

PLAN	Railroad Employees' National Dental Plan	ARRC Optional Dental Plan		
GROUP	You and Your Family	You	You + 1	You + 2 or more
NON-REP	N/A	$5.84	$13.84	$18.22
UNION	Your union requires you to enroll in this plan. The cost for 2021 was **$29.39** per pay period. The 2022 rate is pending.	You may also enroll in optional coverage at the costs noted above.		

ALASKA RAILROAD

2022 BENEFIT GUIDE

At a Glance
Blue and Gold Essentials Plans

This *At-a-Glance Benefit Guide* provides an overview of medical, prescription drug, and dental benefits offered through the Essentials Plans for the plan year beginning January 1, 2022. *This guide is a summary only. If there is a discrepancy between this document and the plans' official plan documents, the plan documents will supersede it.*

Your Medical Plans

- **GOLD ESSENTIALS PLAN.** This Consumer-Directed Health Plan (HDHP) comes with a Health Savings Account (HSA), which you can use to pay eligible health care expenses. If you are eligible, the Alaska Railroad Corporation deposits money into your account and you can decide to contribute as well.
- **BLUE ESSENTIALS PLAN.** This is a Preferred Provider Plans (PPO).
- **COMPARE GOLD VS. BLUE ESSENTIALS PLANS.** Review the *At-a-Glance Benefit Comparison* table for details on plan differences and similarities.

Gold Essentials Plan Highlights

If you select the **Gold Essentials** Plan, your bi-weekly premiums are lower than the Blue Essentials Plan, but your deductible and coinsurance are higher. (Reminder: The "deductible" is the amount you pay before ARRC starts sharing costs with you with what is called "coinsurance.") Here are some key features of the **Gold Essentials** Plan:

	Premera In-Network Preferred and Participating Providers	Out-of-Network Providers
Annual Deductible	$1,400 individual | $3,900 family	$1,400 individual | $3,900 family
Annual Out-of-Pocket Maximum	$5,300 individual | $12,900 family	unlimited individual | unlimited family
Your Coinsurance	20% Preferred Provider 40% Participating Provider	50% plus charges over the plan's Medicare allowed amount
Prescription Drugs	See Prescription Drug section on pages 6-7	

MEETING THE GOLD ESSENTIALS PLAN DEDUCTIBLE

You pay the entire amount of your doctor visits, medical procedures, some lab tests, and most prescriptions until you meet the annual **in-network** deductible. However, you can use funds in your Health Savings Account to help pay your annual deductible.

(Gold Essentials Highlights continued next page)

Gold Essentials Plan Highlights continued

For those enrolled in family coverage, the deductible applies to your entire family. When your family meets the deductible, coinsurance kicks in. For example, if the collective medical plan expenses of a family of four add up to $3,900, you have met the annual deductible. Alternatively, if only one person has $3,900 of expenses, then the family deductible has also been met.

MEETING THE GOLD ESSENTIALS ANNUAL OUT-OF-POCKET MAXIMUM

The plan's out-of-pocket maximum is the most you have to pay during the calendar year for eligible **in-network** health care services. Once you reach the maximum, the plan pays 100% of qualified expenses for the rest of the year. *There is no out-of-pocket maximum for **out-of-network** expenses.*

The individual **in-network** out-of-pocket maximum is $5,300. (Note: If you enroll in family coverage, once one of your covered family members meets the $5,300 individual maximum, the plan pays 100% of his/her qualified medical costs for the rest of the year.) The family **in-network** out-of-pocket maximum is $12,900. Once attained, the plan pays 100% of qualified medical costs for care for all family members for the rest of the year.

GOLD ESSENTIALS HEALTH SAVINGS ACCOUNT (HSA)

Because the **Gold Esssentials** Plan is a Consumer Directed Health Plan, it comes with a tax-free HSA to help you pay the costs of eligible health care expenses. Once you complete your form, the Alaska Railroad Corporation sets up the account on your behalf and automatically contributes the amount noted in the table below (based on your family coverage election). For year-round employees ARRC contributes half of its share in January and half in July. The amounts are prorated for seasonal employees. See your bargaining unit agreement for the prorated schedule.

As long as you qualify to make contributions as determined by IRS guidelines, you can contribute your own money to your HSA each pay period, too. You choose the amount you want to contribute, up to the annual IRS limit. You can increase, decrease, or stop your voluntary contributions at any time during the year. For 2022, the IRS has the following limits on how much can be contributed to an HSA:

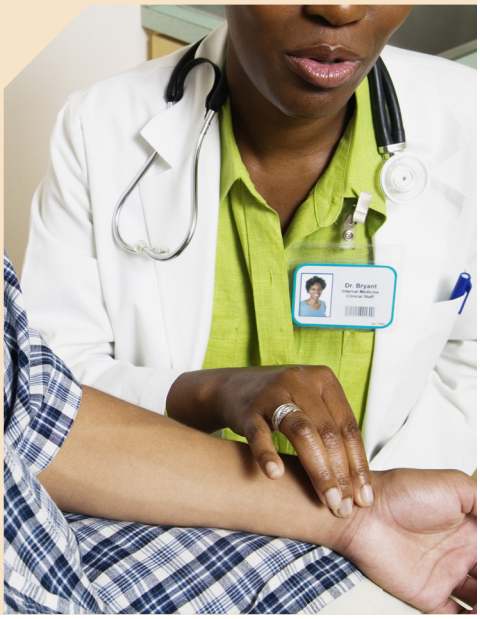
	ARRC Automatic HSA Contribution	Your Voluntary HSA Contribution	2022 Maximum HSA Contribution
You only	$500	Up to $3,150	$3,650
You +1	$1,000	Up to $6,300	$7,300
You + 2 or more	$1,500	Up to $5,800	$7,300

NOTE: If you are age 55 to 65, you can also make a "catch-up" election of $1,000 each year.

Each year the balance in your HSA rolls over and can earn interest. And, the account is yours even if you retire or leave ARRC for any reason.

The IRS determines which expenses are eligible for reimbursement from your HSA. The list can change at times. For a complete list of qualified expenses see IRS Publication 502. In addition to paying for doctor visits, prescriptions and lab tests, here are examples of services you can use your HSA balance to pay:

- Deductibles and out-of-pocket expenses
- Copays
- Diagnostic devices
- Hearing exams, aids and batteries
- Dental expenses
- Substance abuse treatment
- Vision expenses
- Fertility enhancement
- Breast pumps and supplies
- Weight loss programs
- Vision correction surgery
- Adult orthodontics



Blue Essentials Plan Highlights

If you select the **Blue Essentials** Plan, your bi-weekly premiums are higher than the Gold Essentials Plan, but your deductible and coinsurance are lower. (The "deductible" is the amount you pay before ARRC starts sharing costs with you with what is called "coinsurance.") Here are some key features of the **Blue Essentials** Plan:

	Premera In-Network Preferred and Participating Providers	Out-of-Network Providers
Annual Deductible	$1,000 individual | $3,000 family	$1,000 individual | $3,000 family
Annual Out-of-Pocket Maximum	$3,500 individual | $10,500 family	unlimited individual | unlimited family
Your Coinsurance	20% Preferred Provider 40% Participating Provider	50% plus charges over the plan's Medicare allowed amount
Prescription Drugs	See Prescription Drug section on pages 6-7	

MEETING THE BLUE ESSENTIALS PLAN DEDUCTIBLE

An annual **in-network** deductible applies for most services (e.g., doctor visits, medical procedures and some lab tests). Once you meet the deductible, you and the plan share costs through coinsurance. Also, separate copays are required for your hospital admissions ($250 per admission) and emergency room visits ($100 per visit). These separate copays do ***not*** count toward your annual medical deductible.

For those enrolled in family coverage, the annual deductible applies to your entire family. When your family meets the deductible, coinsurance kicks in. For example, if the collective medical expenses of a family of four add up to $3,000, you have met the annual family deductible. However, if one person in the family meets the individual deductible amount of $1,000, coinsurance will kick in for his/her qualified medical costs.

MEETING THE BLUE ESSENTIALS ANNUAL OUT-OF-POCKET MAXIMUM

The **Blue Essentials** Plan's out-of-pocket maximum is the most you have to pay during the calendar year for **in-network** health care services. Once you reach the maximum, the plan pays 100% of the qualified expenses for the rest of the year. *There is no out-of-pocket maximum for* ***out-of-network*** *expenses.*

The individual in-network out-of-pocket maximum is $3,500. The family in-network out-of-pocket maximum is $10,500. Once attained, the plan pays 100% of qualified medical costs for care for all family members for the rest of the year. However, take note that once one of your covered family members meets the $3,500 individual maximum, the plan pays 100% of his/her qualified medical costs for the rest of the year.

Be Smart—and Informed—When Using Your Medical Plan

It Pays to Go In-Network!

You'll keep money in your pocket if you use Premera **in-network** providers (physicians, hospitals and providers of other health care services). The chart on the next page compares how you and the plans share costs, based on the provider's affiliation with Premera.

Coverage Limits for Out-of-Network Care

Premera has set a maximum allowable charge that the **Gold Esssentials** and **Blue Essentials** Plans will cover for out-of-network services (up to 125% of the Medicare-allowed charge). In most cases, an out-of-network provider's charges are much higher than the plan's allowed amount. If you use an out-of-network provider, your out-of-pocket costs will be significantly greater, because you are responsible for paying your deductible, a higher coinsurance, and any charges that exceed the allowed amount.

1 Preferred Provider (in-network)	2 Participating Provider (in-network)	3 Non-contracted Provider (out-of-network)
Providers agree to Premera's discounted fees. **Your lowest out-of-pocket expense!**	Providers agree to limit their fees to Premera's allowable charges for given services.	These providers do not have a contract or agreement with Premera. **This is your most expensive option!**
After you meet your deductible, you pay 20% coinsurance. Your share of coinsurance counts toward meeting your annual out-of-pocket maximum.	After you meet your deductible, you pay 40% coinsurance. Your share of coinsurance counts toward meeting your annual out-of-pocket maximum.	After you meet your deductible, **you and the plan share in the allowed amount for a given service. You pay 50% and the plan pays 50%.** You are also responsible for any charges over the plan's allowed amount for a given service. Allowable amount is calculated based on 125% of Medicare. Expenses you pay will NOT count toward your annual out-of-pocket maximum.

To find providers that are Preferred or Participating, visit www.premera.com and click on "Find a Doctor." If a provider isn't listed, that means he or she is an out-of-network provider.

If there is no in-network provider within 50 miles of your home, contact Premera before seeking non-emergency care from an out-of-network provider. You can also contact Premera to determine if the procedure(s) you need qualify for out-of-state travel to save both yourself and ARRC money.

UNDERSTAND THESE KEY TERMS

Deductible – The fixed amount you must spend for health care before your medical plan starts paying. You must meet a new deductible each year. Once you meet it, you are only responsible for paying copays and coinsurance.

Coinsurance – The portion of a provider's fee that you must pay after you meet the deductible. You pay coinsurance plus any deductibles until you meet your in-network out-of-pocket maximum. For example, if the plan's allowed amount for an in-network office visit is $100, coinsurance payment of 20% is $20 if you've met your deductible. Your medical plan pays the rest.

Annual Out-of-Pocket (OOP) Maximum – This is your "safety net" for health care expenses. It's the most your medical plan requires you to pay toward in-network health care costs per year. After the OOP is met, your plan pays 100% of in-network charges.

Travel and Technology Options

Voluntary Surgical Services (including Medical Travel) Benefit coming in 2022

If you need surgery, explore the **Surgery Plus** voluntary benefit that provides pre-planned, non-emergency surgical services. Many inpatient and outpatient procedures are eligible for this program. ARRC will waive the **Blue** Plan's deductible. In addition, ARRC will waive the coinsurance under both the **Gold Essentials** and **Blue Essentials** plans, if you take advantage of the program.

Surgery Plus travel partners will make air and ground travel as well as lodging reservations for you and a companion. The program covers your travel expenses such as round-trip airfare, surface transportation, and lodging up to applicable IRS limits.

For a list of approved procedures and providers, call **Surgery Plus** at **833-512-1172**, or visit the **Surgery Plus** online portal at ARRC.SurgeryPlus.com.

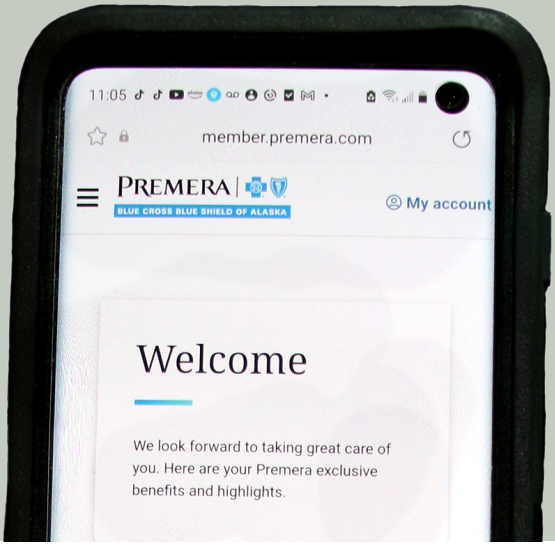
Doctor on Demand Virtual Medical Care

You and your eligible dependents can get immediate, convenient access to care — consultations, diagnoses and prescriptions — by phone or online video, whenever and wherever you need it from **Doctor on Demand**.

Doctor on Demand physcians can diagnose, recommend treatment and prescribe medication when appropriate for many non-urgent medical care issues. Common conditions that **Doctor on Demand** doctors can address include sinus problems, respiratory infections, allergies, urinary tract infections, cold and flu symptoms and other non-emergency illnesses.

Beginning January 1, 2022, the cost for the **Gold Essentials** Plan will be $60 per visit until you meet the plan deductible; then, you pay 20% coinsurance until you meet the annual out-of-pocket in-network maximum. The per-visit cost is waived for the **Blue Essentials** Plan.

For more information or to create an account, call **800-997-6196** or visit **www.doctorondemand.com**



Go Mobile and Online with Premera

Premera offers resources to help you make informed health care decisions and keep track of services you need.

Get **Premera Mobile.** With this smart phone app, you can find a doctor, have a one-touch connection to the NurseLine and customer service, and email proof of coverage to your provider. The free app is available for most smart phones.

Go paperless: Get your explanations of benefits and other documents electronically, while also lowering ARRC plan administrative expenses.

Stay on the Right Track and Save Money with Wellness

You can save money by taking steps to improve your wellness.

Quitting Nicotine Can Pay

If you use nicotine, you'll pay a $25 per pay period surcharge for your medical benefits – $650 a year – deducted on an after-tax basis. You don't have to pay this fee if you:

- Have not used nicotine during the 90 days before you enroll.
- Don't intend to use nicotine in the future.

Be sure to note your nicotine use attestation on your personalized ***ARRC Benefits Enrollment Information Form***. Also, there may be exceptions if your physician indicates that stopping the use of nicotine products would be detrimental to your health. Refer to ***My Benefits Journal*** for more details.

Preventive Care Screenings: Make your appointment for 2022 today!

Both the Gold and Blue Plans pay 100% of preventive care when you visit a Premera "Preferred" or "Participating" network provider, even if you haven't met your deductible. Here's a short list of covered services:

- Diagnostic tests, such as for blood pressure, diabetes and cholesterol
- Age-appropriate check-ups
- Women's health services and healthy pregnancy care
- Immunizations and flu shots
- Cancer screenings, such as mammograms, colonoscopies, prostate exams and Pap tests
- Screening for depression

Your Prescription Drug Coverage – Essentials Pharmacy Plan

Both the **Gold Essentials** and **Blue Essentials** Plans provide prescription drug benefits. For 2022, ARRC and Premera will continue to use the Essentials Pharmacy Plan formulary. This is an innovative new prescription plan.

The Essentials formulary does not cover some drugs. These are low-value, high-cost drugs, drugs that have lower-cost alternatives (including over-the-counter options), competing brands, and drugs that are considered to be priced at unacceptably high levels.

The formulary consists of four "tiers," or levels of coverage, as noted in the table at the top of page 7. There is at least one drug within each drug class, and your doctor will have options to prescribe new preferred generic, preferred brand and preferred specialty medications.

The formulary also includes some non-preferred medications that are available at a higher cost.

To find drugs included in the Essentials formulary, go to www.premera.com and select Covered Drugs under the Pharmacy heading at the bottom of the page. In the "Search for a Drug" drop-down menu, select E4 for the Blue Essentials Plan or E1 for the Gold Essentials Plan.

PREFERRED GENERIC	PREFERRED BRAND	PREFERRED SPECIALTY	NON-PREFERRED
The formulary's lowest cost drugs have the same active ingredients – with the same quality, strength, effectiveness, and purity – as their brand name versions.	These are certain brand name drugs that do not yet have a generic equivalent. Your share of the cost is higher when compared to Preferred Generics.	These are certain drugs used to treat complex health conditions.	While included in the Essentials formulary, these drugs have preferred equivalents at a lower cost. **You pay the highest share of the cost for these drugs.**

GOLD ESSENTIALS PLAN PRESCRIPTION DRUG COVERAGE

The **Gold Essentials** Plan covers 100% of the cost of 192 preventive maintenance drugs — the list is available. For all other prescriptions, you pay the full cost until you meet your medical plan deductible; then you pay 20% of the cost until you reach the annual in-network out-of-pocket maximum.

BLUE ESSENTIALS PLAN PRESCRIPTION DRUG COVERAGE

Under the **Blue Essentials** Plan, your share of the cost is based on the drug's formulary tier. Here's what you can expect to pay at the pharmacy for a prescription (30-day to 90-day supply):

Essentials Formulary Tier	Retail	Mail Order
Generic Drugs	30-day or 90-day supply: You pay $10	N/A
Preferred Brand Name Drugs	30-day supply: You pay 20% of the drug's cost, not to exceed $75 per prescription	90-day supply: You pay 20%, not to exceed $75 per prescription
Preferred Specialty Drugs	N/A	30-day supply: You pay 30%, not to exceed $150 per prescription
Non-Preferred Drugs	30-day supply: You pay 50% of the drug's cost, not to exceed $150 per prescription	90-day supply: You pay 50%, not to exceed $150 per prescription

ADDITIONAL PRESCRIPTION DRUG COVERAGE CONSIDERATIONS

While **Gold Esentials** and **Blue Essentials** Plans cover prescription drugs differently, there are these common considerations:

- **STEP THERAPY** — Some conditions, like arthritis, high blood pressure and allergies, require long-term medications. Step therapy is a way to start with medications at the lowest cost and lowest risk "step," gradually "stepping up" to more expensive—and sometimes more risky—drugs, if necessary. If you're starting a long-term medication that requires step therapy, we encourage you to learn as much as you can about your condition and medications so that you're an active participant in managing your care.
- **"DISPENSE AS WRITTEN"** — If your doctor writes this on a prescription, your pharmacist cannot substitute a generic drug, even if one is available. You'll pay the coinsurance and the difference in cost between the generic drug and brand name drug.
- **SPECIALTY DRUGS** — These are medications that typically cost more and treat complex conditions that require special handling and monitoring. If your doctor prescribes a specialty drug, you must fill that prescription through the specialty pharmacy — Accredo. If your prescription falls into the specialty category, you will receive a letter from Premera instructing you to use the specialty pharmacy.
- **MAIL ORDER** — You may buy many prescriptions through the mail order program, which is usually less than retail cost.

About Your Dental Coverage

Non-represented employees: You may enroll yourself and eligible family members in **ARRC's Optional Dental Plan**.

Union-represented employees: Your union requires you to enroll in the **Railroad Employees' National Dental Plan**, offered to railroads throughout the U.S. and administered by Aetna. Premium deductions begin on your date of hire; benefits begin after 12 months of cumulative service. ***PLEASE NOTE:*** *Dependents ages 19-24 must be full-time students to qualify for coverage. Contact Human Resources to cancel coverage if your young adult dependents are not full-time students.* You may also enroll in the ARRC Optional Dental Plan. If you do so, you will be covered by the two dental plans, with your National Dental coverage serving as the primary plan. Below is a summary of Dental Plan Benefits:

	Railroad Employees' National Dental Plan	Optional Dental Plan
Administered by	Aetna	Premera
Annual Deductible	$50 per person | $100 per family	None
Annual Maximum Benefit Per Person	$1,500	$2,000
Preventive Care	100% of charges allowed by plan; includes sealants in permanent teeth of dependents up to age 19	100% of charges allowed by plan; includes sealants in permanent teeth of dependents up to age 19
Routine Services	80% of charges allowed by plan	90% of charges allowed by plan
Major Services	50% of charges allowed by plan	50% of charges allowed by plan
Orthodontia (Children Only)	50% of charges allowed by plan $1,000 maximum every five years	50% of charges allowed by plan $2,000 lifetime maximum