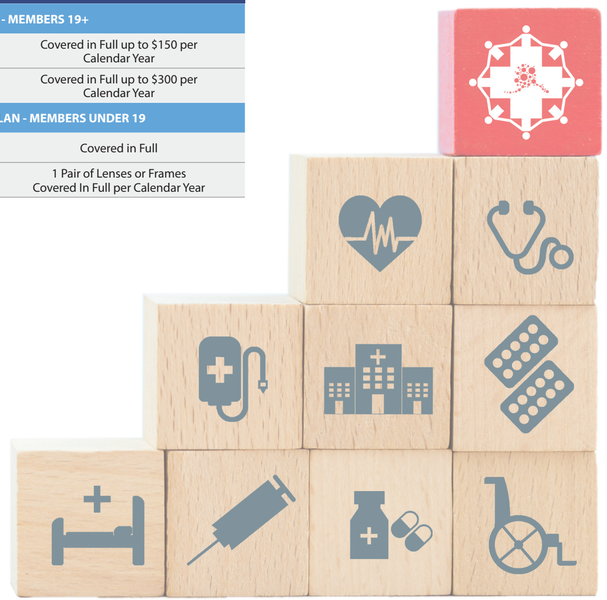
Family Dental Options	Foraker Base Plan	Denali Buy Up Plan
Deductible (only applies to Basic and Major)	$50	$50
Diagnostic & Preventive (Class I) (e.g. cleanings, oral exams, bitewing x-rays)	Covered in Full	Covered in Full
Basic (Class II) (e.g. fillings, periodontal maintenance, simple extractions)	Deductible, then 20%	Deductible, then 20%
Major (Class III) (e.g. crowns, dentures, bridges)	Deductible, then 50%	Deductible, then 50%
Maximum Allowance	$1,500	$2,000
Enhanced	Periodontal/ Endodontic in Major	Periodontal/ Endodontic in Basic
Preventive Waived (Class I) from Max Allowance	No	Yes
Orthodontia Coverage	No	Yes - $1,500 Lifetime

Embedded Vision Plan	
ADULT VISION PLAN - MEMBERS 19+	
Vision Exam	Covered in Full up to $150 per Calendar Year
Vision Hardware	Covered in Full up to $300 per Calendar Year
PEDIATRIC VISION PLAN - MEMBERS UNDER 19	
Vision Exam	Covered in Full
Vision Hardware	1 Pair of Lenses or Frames Covered In Full per Calendar Year



All Plan Summary

**preferred in-network benefits shown*

Medical Plan Options	Fairweather $250 PPO	LeConte $500 PPO	Matanuska $1,500 PPO	Tustumena $3,000 PPO	Aurora $3,000 HSA	Columbia $5,000 HSA
MEDICAL COST SHARES						
Individual Deductible (2x Family)	$250	$500	$1,500	$3,000	$3,000	$5,000
Coinsurance	20%	20%	20%	30%	20%	30%
Individual Out-of-Pocket Maximum (2x Family)	$2,000	$3,500	$5,000	$8,000	$6,000	$7,000
Office Visit - Non Specialist and Specialist	Non-Specialist: $25 Specialist: $50	Non-Specialist: $35 Specialist: $70	Non-Specialist: $40 Specialist: $80	Non-Specialist: $50 Specialist: $100	Deductible, then 20%	Deductible, then 30%
PREVENTIVE CARE & HEALTH EDUCATION						
Preventive Care (Immunizations, Preventative Office Visits, Health Education)	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
PROFESSIONAL CARE						
Professional Office Visit	Non-Specialist: $25 Specialist: $50	Non-Specialist: $35 Specialist: $70	Non-Specialist: $40 Specialist: $80	Non-Specialist: $50 Specialist: $100	Deductible, then 20%	Deductible, then 30%
Virtual Care	Covered in Full	Covered in full	Covered in full	Deductible, then 30%	Deductible, then 20%	Deductible, then 30%
DIAGNOSTIC SERVICES						
Preventive X-Ray and Labs - Including Mammogram, PAP & PSA	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Basic Diagnostic X-Ray and Labs	Deductible waived, then 20%	Deductible waived, then 20%	Deductible waived, then 20%	Deductible, then 30%	Deductible, then 20%	Deductible, then 30%
Major Diagnostic Imaging (MRI, CT, PET)	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 30%	Deductible, then 20%	Deductible, then 30%
FACILITY CARE						
Includes Inpatient, Skilled Nursing, and Outpatient Surgery Facilities	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 30%	Deductible, then 20%	Deductible, then 30%
EMERGENCY CARE						
Emergency Care	$300, Deductible, then 20%	$300, Deductible, then 20%	$300, Deductible, then 20%	$300, Deductible, then 30%	Deductible, then 20%	Deductible, then 30%
OTHER SERVICES						
Mental Health + Chemical Dependency Inpatient Facility Care	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 30%	Deductible, then 20%	Deductible, then 30%
Mental Health + Chemical Dependency Office Visit	Non-Specialist: $25	Non-Specialist: $35	Non-Specialist: $40	Non-Specialist: $50	Deductible, then 20%	Deductible, then 30%
Maternity	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 30%	Deductible, then 20%	Deductible, then 30%
Rehab Inpatient Facility 30 days PCY	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 30%	Deductible, then 20%	Deductible, then 30%
Rehab Outpatient Care - (Occupational Therapy, Physical Therapy, Massage Therapy, etc..) 45 visits PCY	Specialist: $50	Specialist: $70	Specialist: $80	Specialist: $100	Deductible, then 20%	Deductible, then 30%
ALTERNATIVE CARE						
Manipulations - Spinal and other (12 visits PCY)	Non-Specialist: $25	Non-Specialist: $35	Non-Specialist: $40	Non-Specialist: $50	Deductible, then 20%	Deductible, then 30%
Acupuncture (12 visits PCY)	Non-Specialist: $25	Non-Specialist: $35	Non-Specialist: $40	Non-Specialist: $50	Deductible, then 20%	Deductible, then 30%
Naturopathic	Non-Specialist: $25	Non-Specialist: $35	Non-Specialist: $40	Non-Specialist: $50	Deductible, then 20%	Deductible, then 30%
PHARMACY						
Formulary	Preferred B4	Preferred B4	Preferred B4	E4 Essentials	Open A1	E1 Essentials
Tier 1	Deductible waived, then 10%	Deductible waived, then 10%	Deductible waived, then 10%	Deductible waived, then 10%	Deductible, then 20%	Deductible, then 30%
Tier 2	Deductible waived, then 20%	Deductible waived, then 20%	Deductible waived, then 20%	Deductible waived, then 20%	Deductible, then 20%	Deductible, then 30%
Tier 3	Deductible waived, then 30%	Deductible waived, then 30%	Deductible waived, then 30%	Deductible waived, then 10% with a $250 per script maximum	Deductible, then 20%	Deductible, then 30%
Tier 4	Deductible waived, then 10% with a $250 per script maximum	Deductible waived, then 10% with a $250 per script maximum	Deductible waived, then 10% with a $250 per script maximum	Deductible waived, then 30%	Deductible, then 20%	Deductible, then 30%

**PCY = Per Calendar Year*

Plan Summary

**preferred in-network benefits shown*

Medical Plan Options	2021 TONGASS $0 PPO
MEDICAL COST SHARES	
Individual Deductible (2x Family)	$0 PCY
Coinsurance	20%
Individual Out-of-Pocket Maximum (2x Family)	$1,500 PCY
Office Visit - Non Specialist and Specialist	$25 Non Specialist; $50 Specialist, applies to the OOP Max
PREVENTIVE CARE & HEALTH EDUCATION	
Preventive Care (Immunizations, Preventative Office Visits, Health Education)	Covered in Full
PROFESSIONAL CARE	
Professional Office Visit (includes Telemedicine)	$25 Non Specialist; $50 Specialist, applies to the OOP Max
Virtual Care	Covered in Full
DIAGNOSTIC SERVICES	
Preventive X-Ray and Labs - Including Mammogram, PAP & PSA	Covered in Full
Basic Diagnostic X-Ray and Labs	Deductible waived, then 20%
Major Diagnostic Imaging (MRI, CT, PET)	Deductible waived, then 20%
FACILITY CARE	
Includes Inpatient, Skilled Nursing, and Outpatient Surgery Facilities	Deductible waived, then 20%
EMERGENCY CARE	
Emergency Care	$300 Copay applies to the OOP Max, then Deductible waived, then 20%
OTHER SERVICES	
Mental Health + Chemical Dependency Inpatient Facility Care	Deductible waived, then 20%
Mental Health + Chemical Dependency Office Visit	$25 Non Specialist, applies to the OOP Max
Maternity	Covered in Full
Rehab Inpatient Facility 30 days PCY	Deductible waived, then 20%
Rehab Outpatient Care - (Occupational Therapy, Physical Therapy, Massage Therapy, etc..) 45 visits PCY	$50 Specialist, applies to the OOP Max
ALTERNATIVE CARE	
Manipulations - Spinal and other (12 visits PCY)	$25 Non Specialist, applies to the OOP Max
Acupuncture (12 visits PCY)	$25 Non Specialist, applies to the OOP Max
Naturopathic	$25 Non Specialist, applies to the OOP Max
PHARMACY	
Formulary	Preferred B4
Tier 1	Deductible waived, then 10%
Tier 2	Deductible waived, then 20%
Tier 3	Deductible waived, then 30%
Tier 4	Deductible waived, then 10% with a $250 per script maximum

*PCY = Per Calendar Year