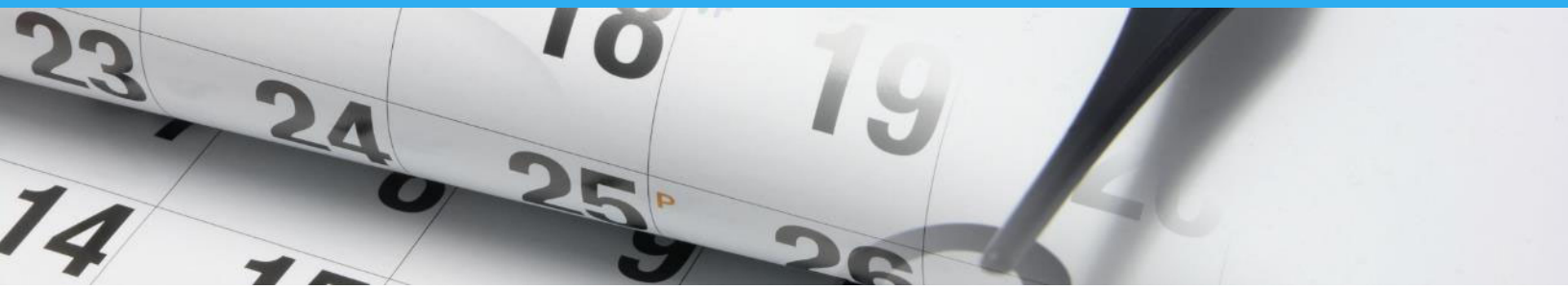
A guide to *Your* Benefits

Alaska Public Broadcasting Health Trust

Plan Year 2020

Effective January 1, 2020 to December 31, 2020

Who Is Eligible & When Can I Enroll?



Your Benefits Package

Your benefits needs change as your life changes. Make sure your current plan selections are still the best choices for you and your family. Please review this guide to learn about the benefit options available to you, so you can make informed decisions about your health care. When you make smart, well-informed decisions, you reduce your out-of-pocket health care costs, and help control the rising cost of health care premiums.

Who Is Eligible?

Before you get started, be sure to understand who may be covered on the benefit plan.

To determine the benefits for which you may be eligible, please refer to the benefits eligibility requirements table. You are eligible to participate in these plans upon meeting each plan's eligibility requirements. You also have the option to enroll your eligible dependents in some of these plans.

Eligible dependents may include:

- Lawful spouse or domestic partner
- Children: Child under 26 years of age, Natural or legally adopted, or Minor or foster child for whom you or your spouse has legal guardianship

You must sign up your eligible dependent for insurance coverage—their enrollment is not automatic.

When Can I Make Benefit Elections?

There are three enrollment opportunities for benefits:

1. **When you are initially eligible for coverage.** You have a certain number of days from the date you are eligible for coverage to submit your enrollment.
2. **Special enrollment opportunity.** This is a limited enrollment period that opens if you have lost other coverage due to a reason beyond your control, or you have a qualified family status change.

   Examples of qualified family status changes that allow you to change some of your benefits during the year include:

   - Marriage or divorce
   - Death of your dependent child or spouse
   - Change in your or your spouse's employment status that results in loss or gain of coverage
   - Birth, adoption, or change in the custody of your child

3. **Annual open enrollment.** APBHT open enrollment is November 18 to December 13. This is the time of year to add or delete coverage for any eligible dependents. If you do not enroll an eligible spouse or child now, you may only add that person on the company's plan during next year's open enrollment period or a special enrollment opportunity.

Benefits Eligibility

Benefit Plan	Eligibility	Probationary Period
	You are eligible to enroll if you are an Employee working	**You are eligible to enroll on the**
Refer to previous page for Dependents eligibility		
Medical, Rx, Vision	at least 30 hours per week	First of the month after 30 days
Dental	at least 30 hours per week	First of the month after 30 days
No Dependents eligibility – Employee only benefit(s)		
Life/AD&D	at least 30 hours per week	First of the month after 30 days

What's New or Changing?

1. **Medical, Rx, Vision**: No changes to current benefits.
2. **Dental**: No changes to current benefits.
3. **Life/AD&D**: No changes to current benefits.

Action Items:

- **All Benefits**: It is not necessary to complete new enrollment forms during open enrollment unless you are making changes to your benefits, and/or adding or dropping dependents.

Medical Benefits At-A-Glance

We offer a medical insurance plan through **Premera Blue Cross Blue Shield of Alaska**.

The table below provides an overview of key coverage features for health benefits. This is only a partial list of the covered benefits. For a complete list of covered services, please refer to the Medical Plan benefit summaries provided by your Employer. Any coinsurance percentages shown are amounts for which you're responsible.

Plan Features (In-Network Services)		**HP HSA Aggregate $2,000/20%/$3,500 Essentials**
		You Pay:
Annual Deductible PCY	Individual	$2,000
	Family	$4,000
Out-of-Pocket Maximum PCY *	Individual	$3,500
	Family	$7,000
Office Visit		In Network Deductible, then 20% Preferred / 40% Participating
Specialist Visit		In Network Deductible, then 20% Preferred / 40% Participating
Urgent Care Visit		In Network Deductible, then 20% Preferred / 40% Participating
Emergency Care		In Network Deductible, then 20% Preferred
Preventive Services **		Covered In Full
Laboratory Services **Imaging – Basic** **Imaging – Major (MRI, CT, PET)**		In Network Deductible, then 20% Preferred / 40% Participating
Inpatient Hospital/Surgery		In Network Deductible, then 20% Preferred / 40% Participating

* Includes deductible

** Preventive Office Visit, Immunizations, Preventive Laboratory Screens, Preventive Imaging, Preventive Routine Mammography

Prescription Drugs Benefits At-A-Glance

When you enroll in a medical plan, you receive comprehensive prescription drugs as well.

The table below provides an overview of key coverage features for prescription drugs benefits. This is only a partial list of the covered benefits. For a complete list of covered services, please refer to the Medical Plan benefit summaries provided by your Employer. Any coinsurance percentages shown are amounts for which you're responsible.

Plan Features (In-Network Services)	**HP HSA Aggregate $2,000/20%/$3,500 Essentials**
	You Pay:
Prescription Drugs - Retail	After Deductible is met $15/$30/$50/30%; Coinsurance is waived
Prescription Drugs - Mail	After deductible is met $37.50/$75/$50/30%; Coinsurance is waived
Specialty Pharmacy	Retail: after deductible is met: $15/$30/$50/30%; coinsurance is waived. Mail: after medical deductible is met: $37.50/$75/$50/30%; coinsurance is waived.
Drug List	E4 Essentials Formulary
Supply Limit Per Fill	Retail: up to 90 days Mail Order: up to 90 days Specialty: up to 30 days

Did You Know?

Generic Prescription Medications are FDA approved and contain the same Active Pharmaceutical Ingredients as the brand-name counterpart. Generics are also a better cost savings for you and can cost 20%-60% less!

Medical Benefits At-A-Glance

These are supplemental benefits included with your Medical plan.

The table below provides an overview of key coverage features for health benefits. This is only a partial list of the covered benefits. For a complete list of covered services, please refer to the Medical Plan benefit summaries provided by your Employer. Any coinsurance percentages shown are amounts for which you're responsible.

Plan Features (In-Network Services)	**HP HSA Aggregate $2,000/20%/$3,500 Essentials**
	You Pay:
Pediatric Vision Exam 1 PCY under age 19	In Network Deductible, then 20% Preferred
Pediatric Eyewear Under age 19: one pair of glasses PCY (frames & lenses). 12-month supply of contacts PCY, in lieu of glasses (frames & lenses)	Covered in Full
Routine Vision Exam 1 PCY	Covered in Full
Vision Hardware $200 PCY	Covered in Full

Medical Benefits At-A-Glance

Teladoc – Virtual Care

'Visit' a doctor – wherever and whenever you need to. Teladoc virtual care gives members immediate and convenient access to care when needed. Members can avoid long drive times and wait times they might experience at an urgent care or emergency room. Teladoc is not meant to replace a member's relationship with their Primary Care Provider (PCP) or to replace all in-person, face-to-face visits. It is an expansion of our service delivery options.

- Common conditions handled by virtual care providers: cold and flu symptoms, nasal congestion, sinus problems, bronchitis, respiratory infections, allergies, and ear infections.
- Get care via phone call, online video, or other online media as easily as walking into an office and getting care face-to-face.
- Receive care virtually from your own doctor or from a doctor at our national provider service, Teladoc. Teladoc board-certified physicians offer consultation similar to what a patient gets in a face-to-face office visit. Physicians can send a prescription to the member's preferred pharmacy, if it is medically necessary. Teladoc can send records of the consultation by fax or electronic medical record transfer to your primary care doctor for continuity of care with a local doctor.

For more information, visit the Teladoc website at www.teladoc.com/premeraAK.

Premera's 24-Hour Nurse Line

Registered Nurses are trained to offer advice, guidance and support to members and their families. RNs are trained to ask the right questions to make a recommendation about when or where a member should seek treatment for an injury or illness. RNs also have access to high-quality health resources and will listen to members' concerns, answer questions, and offer advice about many health-related topics.

- Free and confidential service
- Available 24 hours a day, 7 days a week
- Available in English, Spanish and 140+ additional languages
- The contact number can be found on the back of your ID card

Premera Medical Travel Support

Premera understands the price of medical care may be lower outside of Alaska and offers Medical Travel Support. With approval, this feature helps you obtain care at in-network hospitals and surgical centers across the United States.

- Member and one companion; pre-authorization required
- Air: 1 round-trip per episode
- Surface transportation & parking: $35/day
- Ferry transportation: $50 per person each way
- Lodging: $50/day per person
- Travel: in-network deductible, then 0%
- Medical procedures: covered as any other service

Contact Premera at 800-364-2994 to learn more.

Talkspace: Therapy as Close as Your Phone

Premera believes behavioral health is critical to their member's overall health and well-being. Research shows that addressing people's behavioral health needs helps to maintain better health overall, with fewer emergency room visits and inpatient admissions.

Talkspace is available by live, face-to-face video appointments and text messaging. Text messaging means a therapist will respond quickly, usually in less than a day. Talkspace provides access to 5,000 licensed therapists by video and text messaging regardless of date, location, or time of day. Virtual behavioral health therapy sessions will have the same cost shares as equivalent to face-to-face visits, as described in your benefit plan.

Here's how to access Talkspace:

- Sign up for Talkspace at talkspace.com/premera.
- You will then be shown the 3 best matches for your needs, and you will choose a therapist.
- Once you've selected your therapist, you can start messaging with their therapist right away. Please know, Talkspace is not a live chat where an immediate response will happen from your therapist.

Emergency Care vs. Urgent Care

Go to Urgent Care

- Moderate fever
- Colds, cough or flu
- Bruises and abrasions
- Cuts and minor lacerations
- Minor burns and skin irritations
- Eye, ear, or skin infections
- Sprains or strains
- Possible fractures
- Urinary tract infections
- Respiratory infections

OR

Go to the Emergency Room

- Heart attack or stroke
- Chest pain
- Shortness of breath
- Severe abdominal pain
- Loss of consciousness
- Head injury or other major trauma
- Major burns
- One-sided weakness or numbness
- Open fractures
- Severe bleeding
- Intense pain
- Poisoning or suspected overdose

Did you know most ER visits are unnecessary? Use them only in a true emergency—like any situation where life, limb, and vision are threatened. Otherwise, call your doctor, your nurse line, or go to an Urgent Care clinic. You'll save a lot of money and time.

Your primary care is the best place to start when you're sick or hurt. They know your health history, including any underlying conditions you may have. when you visit your doctor for an illness injury, they can make informed choices about your treatment and necessary tests. If your condition isn't life-threating but needs to be taken care of right away, then urgent care may be the right choice for you. And, in most situations, you'll find that you save time and money by going to urgent care instead of an emergency room.

Emergency rooms are the best place for treating severe and life-threatening conditions. They have the widest range of services for emergency after-hours care, including diagnostic tests and access to specialists. That specialized care also makes it the most expensive type of care. And you'll probably have to wait a long time to get treated.

The important thing to remember is to use your best judgment when choosing your Facility when determining where to seek care. If you visit an Urgent Care Facility that is Out-of-Network, you could be faced with a Balance Bill situation.

Some medical situations could be life-threatening, such as chest pain or severe bleeding – seconds count. In those circumstances you should call 911 or the local Emergency Medical Services for immediate assistance. For more information on when to call 911 in a medical emergency, please see these guidelines developed by the American College of Emergency Physicians. http://www.emergencycareforyou.org/Emergency-101/When-To-Call-911/

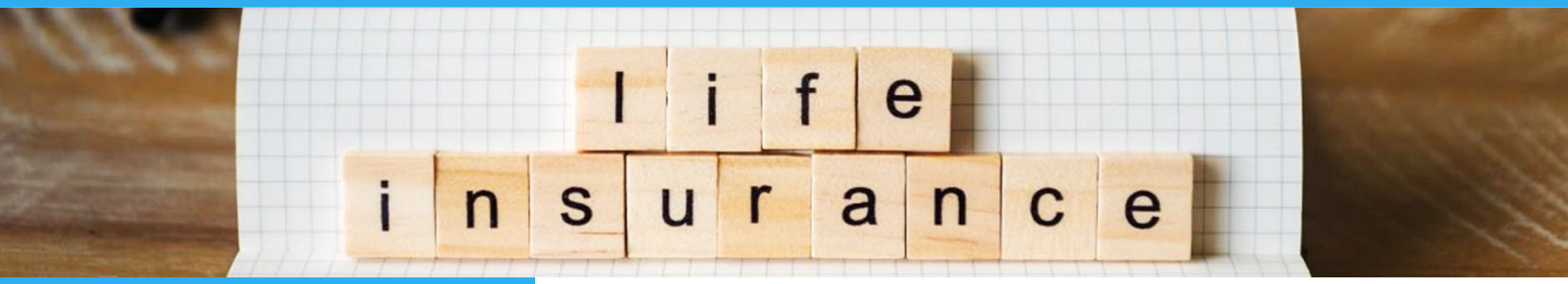
Dental Benefits At-A-Glance

We offer a dental insurance plan through **Premera Blue Cross Blue Shield of Alaska**.

The table below provides an overview of key coverage features for dental benefits. This is only a partial list of the covered benefits. For a complete list of covered services, please refer to the Dental Plan benefit summaries provided by your Employer. Any coinsurance percentages shown are amounts for which you're responsible.

Plan Features (In-Network Services)	**Dental Optima 1500**
	You Pay:
Deductible	$50 Per Individual / $150 Per Family
Preventive Services Exams, cleanings, x-rays	0% Deductible waived
Basic Services Fillings, simple extractions	20%
Endodontics Root canals	20%
Periodontics Gum treatment	20%
Major Services Crowns, inlays, onlays, bridges and dentures	50%
Calendar Year Maximum	$1,500 per person each calendar year applies to Basic & Major Services

Life and AD&D Insurance



Be sure to name a Beneficiary

Your beneficiary will receive the benefit paid by your life insurance policy in the event of your death. Your beneficiary is the person(s) who will receive your life insurance benefits when you die. Your beneficiary can be a person or multiple people, charitable institutions or your estate. Once named, your beneficiary remains on file until you make a change. Without clear direction on file, your family could end up fighting for your death benefit in court. This can take time and money, and it's the last thing your loved ones will want to deal with after your death.

Life and accidental death and dismemberment (AD&D) insurance is an important element of your income protection planning, especially for those who depend on you for financial security. For your peace of mind, we provide basic life and AD&D insurance to all benefits-eligible employees **at no cost**.

We automatically provides basic life and AD&D insurance through **Symetra** to all benefits-eligible employees at no cost. If you die as a result of an accident, your beneficiary would receive both the life benefit and the AD&D benefit.

- **Employee Life/AD&D benefit**:
  - **Class 1:** 1x annual earnings up to $100,000
  - **Class 2:** $20,000
  - **Class 3:** $5,000

Please check with your station manager to see which class you are covered under.

Health Savings Accounts (HSAs)

A Health Savings Account (HSA) is a tax-exempt account established by employees covered under their employer's Qualified High Deductible Health Plan (QHDHP) to pay or reimburse for certain qualified medical expenses.

In order to enroll in an HSA, you must be enrolled in a QHDHP. Your company offers a QHDHP option which allows employees to contribute to an HSA.

Keep in Mind

- The Health Savings Account (HSA) is only available if you participate in the HSA Plan. The money is yours, is held in an investment account and is portable; it goes with you to be used for qualified medical expenses if you terminate employment or when you retire.
- If you are enrolled in the HSA Plan, you may not participate in a general Healthcare Flexible Spending Account (FSA). However, you can participate in the limited Healthcare FSA for dental and vision, as well as medical expenses once you have met your deductible.
- If you are enrolled in the HSA Plan, you may still participate in the Dependent Day Care Flexible Spending Account (FSA).
- Withdrawals from HSAs for qualified medical expenses are tax-free. If you withdraw money for any reason other than qualified medical expenses, you must pay income tax and a 20% IRS tax penalty.
- You must have a balance in your account to make a withdrawal.
- The maximum you can contribute to an HSA in one year is set by the IRS (in 2018, $3,450 for single coverage and $6,900 for family coverage. In 2019, $3,500 for single coverage and $7,000 for family coverage. In 2020, $3,550 for single coverage and $7,100 for family coverage.). If you are age 55 or older, you can contribute an additional catchup contribution of $1,000. It is your responsibility to make sure your HSA contributions, including any employer or incentive contributions, do not go over the IRS maximum.

2020 Premiums Costs

The following tables show the **monthly** amounts you will pay for coverage under each plan.

2020 HEALTH & DENTAL MONTHLY RATES				
Health Plan 01/01/2020 (Active Employees)	**Employee Only***	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
Medical *	$972.48	$2,405.72	$2,044.73	$3,171.54
Dental *	$56.09	$114.77	$119.06	$183.95
Administration Fee	$15.00	$15.00	$15.00	$15.00
Total	**$1,043.57**	**$2,535.49**	**$2,178.79**	**$3,370.49**
Life	$0.180 / $1,000			
AD&D	$0.024 / $1,000			
COBRA Services	$1.00	$1.00	$1.00	$1.00
COBRA Services Annual Set-up Fee	$200 annual fee, divided equally among participants at the beginning of year			
* Employer is required to pay at least 75% of Employee Only Coverage				

2020 COBRA RATES				
Health Plan 01/01/2020	**Employee Only***	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
Medical and Dental	$1,049.14	$2,570.90	$2,207.06	$3,422.60
Medical Only	$991.93	$2,453.83	$2,085.62	$3,234.97
Dental Only	$57.21	$117.07	$121.44	$187.63

EE employee only
ES employee plus spouse only
EC no spouse, but one or more children
EF spouse plus one or more children

2019 Premiums Costs

The following tables show the **monthly** amounts you will pay for coverage under each plan.

2019 HEALTH & DENTAL MONTHLY RATES				
Health Plan 01/01/2019 (Active Employees)	**Employee Only***	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
Medical *	$942.55	$2,331.69	$1,981.80	$3,073.94
Dental *	$56.09	$114.77	$119.06	$183.96
Total	**$998.64**	**$2,446.46**	**$2,100.86**	**$3,257.90**
* Employer is required to pay at least 75% of Employee Only Coverage				

2019 COBRA RATES				
Health Plan 01/01/2019	**Employee Only***	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
Medical and Dental	$1,018.61	$2,495.39	$2,142.88	$3,323.06
Medical Only	$961.40	$2,378.32	$2,021.44	$3,135.42
Dental Only	$57.21	$117.07	$121.44	$187.64

EE employee only
ES employee plus spouse only
EC no spouse, but one or more children
EF spouse plus one or more children

Tips & Definitions

1. Make sure you're getting the most value for your health care dollar with these helpful tips.

2. **Use doctors in your network.** Pay the lowest cost for care by using doctors, clinics, hospitals, and pharmacies in your health plan's network. When you go out-of-network, your insurer covers less of the cost.

3. **Use your preventive care benefits.** Many health plans pay for preventive care visits. Getting regular exams, screenings, and immunizations can save you a lot of money in the long run by catching problems early or preventing them altogether.

4. **Choose the right type of care.** Urgent care, an online doctor visit, or call to a nurse line might help – saving you a trip to the emergency room. When you need care, knowing your options can save you time.

5. **Ask your doctor for generic drugs.** Generic drugs are safe and effective. They're FDA-approved and contain the same active ingredients as the brand-name versions. Generics cost much less and work just the same.

6. **Use your health plan's support programs.** Check to see if your health plan includes programs like help to quit smoking, fitness discounts, health assessments and other ways to be healthier or save money.

Copay: A fixed fee that members must pay for their use of specific medical services covered by the plan.

Deductible: The amount you pay out of your own pocket each year before your insurance begins picking up most costs of health care.

Coinsurance: An insurance policy provision under which the carrier and the member share costs incurred after the deductible is met according to a certain formula.

Example: Members pay an in-network coinsurance of 20% and carrier pays 80%, after deductible is met.

Out-of-Pocket Maximum: The highest or total amount your health insurance requires you to pay towards the cost of your health care during the benefit year, including copays, deductibles and coinsurance. Once met, claims are paid at 100% of usual and customary charges for the rest of the benefit year.

Usual, Customary and Reasonable Charges (UCR): The calculation by a health care plan of what they determine is the appropriate fee to pay for a specific health care service.

Balance Billed: Defined as the difference between what the carrier will cover as determined by Usual, Customary and Reasonable Charges, and what your Provider charges. You may be responsible for paying this difference if you do not use a preferred provider.

Preferred Provider: The physicians, hospitals, and other health care providers who have contracted with the carrier and provide care at negotiated prices. Due to the agreement in the contract, you will receive discounts and are not responsible for amounts above the allowable charges (UCR).

Contacts Information

Please contact the appropriate provider listed below to learn more about a specific benefit plan or contact HR if you have any questions.

Benefits	Provider	Phone Number	Website
Medical, Rx, Vision	Premera Blue Cross Blue Shield of Alaska	1-800-508-4722	www.premera.com
Dental	Premera Blue Cross Blue Shield of Alaska	1-800-508-4722	www.premera.com
Life/AD&D	Symetra	1-800-796-3872	www.symetra.com

THE WILSON AGENCY
AN ALERA GROUP COMPANY

The Wilson Agency, our employee benefits consultant, is available to assist you should you have claims or service issues you are unable to resolve by contacting the insurance carrier directly. If you have questions or problems that you feel are not being addressed properly by our insurance carriers' customer service departments, please give The Wilson Agency a call at 907-277-1616.

Enrollment Checklist

Remember that the choices you make during open enrollment will take effect on **January 1, 2020** and remain in effect until **December 31, 2020**. Only qualifying events will allow you to make a change before that date.

- ❑ Review enrollment materials
- ❑ Review all available plans and options to see which is best for you
- ❑ Consider the coverage you may be eligible for
- ❑ Review contributions
- ❑ Make sure you have all required information available
- ❑ Review accuracy of enrollment information
- ❑ Updated your beneficiary information
- ❑ Submit information before deadline

Notes

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

PO Box 91059
Seattle, WA 98111-9159
www.premera.com

MEMBER ENROLLMENT AND CHANGE APPLICATION

1. GROUP INFORMATION (to be completed by the group)

Group ID	Group name	Employee class/subgroup (as applicable)	Employee Date of Hire / /
Enrollment Reason	If COBRA, indicate number of months eligible for coverage: ☐ 18 months ☐ 29 months ☐ 36 months	Date of enrollment details ☐ Same as hire date ☐ Other date / /	Plan start date / /

2. EMPLOYEE INFORMATION (employee to complete sections 2 through 4)

Employee name (Last) (First)	Contact phone ( )	Contact email (*Required)
Mailing address City State ZIP		

3. ENROLLMENT INFORMATION

Plan choice (as applicable)

NOTE:** Please indicate names as you would like it to appear on the ID card. **ID card names are limited to 26 characters and spaces.

Add	Drop	Relationship to Employee	Last Name	First Name	Social Security No. (*Required)	Date of Birth	Gender M	Gender F	Benefit Selection Medical/Vision	Benefit Selection Dental
☐	☐	Self				/ /	☐	☐	☐	☐
☐	☐					/ /	☐	☐	☐	☐
☐	☐					/ /	☐	☐	☐	☐
☐	☐					/ /	☐	☐	☐	☐
☐	☐					/ /	☐	☐	☐	☐
☐	☐					/ /	☐	☐	☐	☐

If any dependent has a different mailing address, please attach that information. Additional information attached? ☐ No ☐ Yes

If any child over the dependent age limit is applying for coverage due to disability, please complete and attach the ***Request for Certification of Disabled Dependent*** form.

Please complete and attach the ***Other Coverage Questionnaire*** form if any applicant has other current health coverage, including Medicare or Premera, which will remain in effect when your Premera coverage begins. If the form is not included, then it is assumed that no other coverage is in effect.

In applying for enrollment as indicated on this application, I declare that all of the information on this form is true and complete to the best of my knowledge. I also declare that each person I am requesting enrollment for is eligible for coverage. I have also read and understand the provisions as stated in section 5 of this document. The changes on this form supersede all previous forms submitted.

Employee signature_____ Date signed ____ / ____ / ____

***Please note:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.*

4. PLEASE READ

PREMERA PRIVACY POLICY

We may collect, use, or disclose personal information about you, such as health information, your address, telephone number or Social Security number. We may exchange this information with healthcare providers, insurance companies, or other sources to conduct our routine business operations. Examples are deciding if you qualify for coverage; paying claims; coordinating benefits with other healthcare plans; or conducting care management, case management, or quality reviews. We may also collect, use or release your personal information as required or permitted by law.

To safeguard your privacy and make sure we keep your information remains confidential, we train all employees on our written confidentiality policy and procedures. If a disclosure of your personal information is not related to a routine business function, we will remove anything that could be used to easily identify you, unless we have your prior approval to release such information.

You have the right to ask to look at or change your records retained by us. To view or print copies of our detailed Privacy Notice and other forms, please visit our web site at premera.com. To have forms mailed to you, please call the number below.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or dependents because of other health care coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 60 days after your other coverage ended (60 days if the prior coverage was through Medicaid or CHIP). Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 60 days after the marriage, birth, adoption, or placement for adoption, unless a different time limit has been specified in your benefit booklet.

*REQUIRED SOCIAL SECURITY NUMBER AND CONTACT EMAIL ADDRESS

Under the Affordable Care Act (ACA), all health plans must provide an IRS Form 1095-B to fully insured members starting in 2016. You'll need Form 1095-B to help file your taxes, much like your W-2.

If you have any questions about the information included in this notice, please call us at 1-800-508-4722.

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

P.O. Box 240609
Anchorage, AK 99524

Other Coverage Questionnaire

Customer Service: 800-508-4722
Hearing Impaired: 800-842-5357

Dear Subscriber:

To avoid any further delay processing your claim(s), we need your help! We appreciate your assistance in providing this information, and thank you for your cooperation. Please complete and return this form by mail or call Customer Service at 1-800-508-4722 within 45 days of the postmark date. When we receive the completed form, we will process your claim within 15 days.

Subscriber Name and Address

_____

_____

_____

Date _____

Member ID _____

Group Number _____

Service Date(s) _____

Claim Number _____

When you or your dependents have other health coverage, the information requested below will enable us to coordinate payment of your claim(s) with your other carrier(s). Please refer to the back of this form for answers to the most often asked coordination of benefits questions. If you require assistance in completing this form, please contact your employer or our Customer Service Department.

OTHER INSURANCE INFORMATION

Do you or any family members have any of the following:

1. Coverage with us (other than listed above)? ☐ **No** ☐ **Yes** If Yes, please complete the following line.

SUBSCRIBER NAME	DATE OF BIRTH MONTH DAY YEAR	SUBSCRIBER ID NUMBER	GROUP NUMBER

2. Medicare coverage ☐ **No** ☐ **Yes** If Yes, please complete the following sections. If there is more than one member with Medicare Coverage, use a separate piece of paper. **Please include a copy of your Medicare card(s) for each Medicare recipient.**

NAME OF FAMILY MEMBER WITH MEDICARE COVERAGE		MEDICARE ID NUMBER	PART A EFF. DATE / /	PART B EFF. DATE / /	PART D EFF. DATE / /
RETIREMENT DATE / /	ARE YOU ENTITLED TO MEDICARE DUE TO ONE OF THE FOLLOWING: ☐ DISABILITY ☐ KIDNEY FAILURE	DATES REQUIRED IF DISABILITY OR KIDNEY FAILURE CHECKED:	DATE OF ENTITLEMENT / /	FIRST DIALYSIS TREATMENT / /	KIDNEY TRANSPLANT / /
Are you entitled to Medicare for more than one reason? If so, give the reasons for your dual entitlement.					

3. Other medical, dental, prescription drug, or vision coverage? ☐ **No** ☐ **Yes**

If Yes, please complete the following sections. If more than one policy, please attach additional paper.

IF ANOTHER HEALTH INSURANCE PLAN PAYS FIRST, SEND US A COPY OF THEIR EXPLANATION OF BENEFITS.

OTHER INSURANCE COMPANY:

COMPANY NAME		
STREET ADDRESS		
CITY	STATE	ZIP CODE
TELEPHONE NUMBER ( )		
EFFECTIVE DATE OF COVERAGE		

NAME OF POLICYHOLDER	DATE OF BIRTH MONTH DAY YEAR
RELATIONSHIP TO OUR SUBSCRIBER	
IS POLICY A GROUP COVERAGE? ☐ NO ☐ YES IS COVERAGE AN INDIVIDUAL POLICY? ☐ NO ☐ YES	IS THIS COBRA COVERAGE? ☐ NO ☐ YES
POLICY ID # (SOCIAL SECURITY #, MEMBER #, ETC.)	
GROUP #	
EMPLOYER: ARE YOU RETIRED? ☐ NO ☐ YES	
ABOVE POLICY IS FOR: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION DRUGS	
ABOVE POLICY COVERS: ☐ SUBSCRIBER ☐ SPOUSE ☐ DEPENDENT CHILDREN	

(OVER)

4. If parents are divorced or legally separated, the following information is needed to determine which coverage will process claims first for dependent children.

CHILD'S NAME FIRST	LAST	NAME OF PERSON WITH CUSTODY	RELATIONSHIP TO CHILD LISTED	NAME OF PERSON WITH FINANCIAL RESPONSIBILITY FOR HEALTH COVERAGE ACCORDING TO DIVORCE DECREE	RELATIONSHIP TO CHILD	**NAME OF OTHER COVERAGE PROVIDED***

* If this is different from the Other Insurance Company listed in Question Number 3, please list all other coverage information (e.g., telephone number, name of policyholder, ID Number, Group Number, etc.) on a separate sheet.

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

SIGNATURE OF SUBSCRIBER OR SPOUSE

X

Questions and Answers to Help You Understand Coordination of Benefits (COB)

What is Coordination of Benefits (COB)?

COB is two or more health care companies working together to share the cost of health care expenses.

Why do we coordinate benefits?

Insurance regulations allow health care companies to coordinate benefits. These regulations allow us to keep your cost of health care coverage as low as possible by avoiding payment of more than the total charge of bills submitted. These rules identify one plan as "primary" (the company that pays first) and the other plan as "secondary" (the company that pays second.)

Who do I submit my bill(s) to first?

- If the patient is our Subscriber, submit to us first and the other plan second.
- If the patient is the spouse of our Subscriber, submit to the other plan first and to us second.
- If the patient is a dependent child, submit to the plan of the parent whose birthday falls **earliest in the year**. Example: mother's birth date is May 5th and father's birth date is November 9, submit to the **mother's** plan first.
- If the parents of the patient are divorced or legally separated, submit first to the plan of the parent with financial responsibility for health care coverage according to the divorce decree. If not stated in the divorce decree, submit bill(s) in the following order:

  A. To the plan of the parent with custody;
  B. To the plan of the spouse of the parent with custody;
  C. To the plan of the natural parent without custody; or
  D. To the plan of the spouse of the parent without custody.

- If you have two coverages with us, submit each bill with both Subscriber and Group identification numbers.
- If Medicare is your primary carrier, submit your bill(s) to us with a copy of the Medicare Explanation of Benefits.
- If you are the Subscriber of more than one health care coverage, the coverage which has been effective the longest is primary. Submit your bill(s) to that carrier first.
- Retiree Plans may require any non-retiree coverage to be primary.

How do we coordinate benefits?

- When we receive your bill(s), we determine which health care company will process your bill(s) first.
- If you submit your bill(s) with a copy of your other health care company's denial or an Explanation of Benefits, we will use this information to process your bill(s) promptly.
- If we do not receive this information with your bill(s), we contact your other health care company to obtain the information needed to process your bill(s). We always call those companies that coordinate over the telephone. This enables us to process your bill(s) promptly.

When do I receive an "Other Coverage Questionnaire"?

- When we have conflicting, incomplete or outdated information, you will receive a questionnaire.
- When your other coverage cancels, we need new coverage information.

IMPORTANT REMINDERS

- When we request COB information, please return the form by the date indicated to assure prompt processing of your bill(s).
- Always keep your health care providers (doctor, dentist, etc.) updated with your correct health care coverage information.

3800 Centerpoint Dr., Suite 940
Anchorage, AK 99503-8934

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

AFFIDAVIT OF DOMESTIC PARTNERSHIP - ALASKA

1. DOMESTIC PARTNERS

A. I, _____ certify that I, and _____
(print name of employee) *(print name of domestic partner)*

are domestic partners, and we:

1. currently share the same regular and permanent residence, and
2. have a close personal relationship, and
3. are jointly responsible for "basic living expenses," as defined below, and
4. are not married to anyone, and
5. are each eighteen (18) years of age or older, and
6. are not related by blood closer than would bar marriage in the State of Alaska, and
7. were mentally competent to consent to contract when our domestic partnership began, and
8. are each other's sole domestic partner and are responsible for each other's common welfare.

B. "Basic living expenses" means the cost of basic food, shelter, and any other expenses of a domestic partner. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.

2. EMPLOYEE

A. I understand that this Affidavit shall be terminated upon the death of my domestic partner or by a change of circumstance attested to in this Affidavit.

B. I agree to notify the Business Office if there is any change of circumstances attested to in this Affidavit within thirty (30) days of the change.

C. After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed within _____ as determined by the Group, but in no case less than 90 days, after a request for termination of domestic partnership has been filed with the Business Office.

3. AGREEMENT

A. We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization or if otherwise required by law.

B. We understand that this declaration of responsibility for our common welfare may have legal implications under Alaska law.

C. We understand that a civil action may be brought against us for any losses, including reasonable attorney's fees, because of a false statement contained in this Affidavit of Domestic Partnership.

D. We also certify under penalty of perjury, under the laws of the state of Alaska, that the foregoing is true and correct.

E. I, the undersigned Employee, understand that willful falsification of information on this Affidavit may lead to disciplinary action, up to and including discharge from employment.

Signature of Employee	Signature of Domestic Partner
Address	Address
City, State, ZIP	City, State, ZIP
Employing Unit (Department)	Department (if an Employee)
Signed at	Date

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

An Independent Licensee of the Blue Cross Blue Shield Association

Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross Blue Shield of Alaska. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-508-4722 (TTY: 800-842-5357).

Español (Spanish): Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross Blue Shield of Alaska. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-508-4722 (TTY: 800-842-5357).

中文 (Chinese): 本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross Blue Shield of Alaska 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-508-4722 (TTY: 800-842-5357)。

Tiếng Việt (Vietnamese): Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross Blue Shield of Alaska. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-508-4722 (TTY: 800-842-5357).

Tagalog (Tagalog): Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross Blue Shield of Alaska. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-508-4722 (TTY: 800-842-5357).

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Waiver of Coverage

1. EMPLOYEE INFORMATION

Group/employer name		Group number	
Employee name	Employee date of birth	Gender ☐ Male ☐ Female	Number of hours worked per week

2. WAIVER CONFIRMATION

This is to confirm that I decline to participate in the Premera Blue Cross Blue Shield of Alaska program offered through my employer's group health plan as follows.

☐ I do not wish to enroll **myself**. I have other Group coverage as follows:
- ☐ CHAMPUS/Tricare
- ☐ Medicare as primary, at the request of the Medicare enrollee
- ☐ Another group health plan through my spouse or parent. Name of spouse's/parent's employer: _____

☐ I do not wish to enroll **myself**. I have other Individual coverage.

☐ I do not wish to enroll **myself**. I do not have other health coverage.

☐ I do not wish to enroll my ☐ **spouse** ☐ **children.*** They have other Group coverage.

☐ I do not wish to enroll my ☐ **spouse** ☐ **children.*** They have other Individual coverage.

☐ I do not wish to enroll my ☐ **spouse** ☐ **children.*** They have coverage through Medicaid/CHIP or other state-sponsored coverage.

☐ I do not wish to enroll my ☐ **spouse** ☐ **children.*** They do not have other health coverage.

*Please list the names of specific children you wish to waive if you are not enrolling all of them: _____

_____

3. EVIDENCE OF OTHER GROUP COVERAGE

Are you an employee of a small group employer (2-99 employees)? *If unknown, check with your Group Benefits Administrator to verify.*

☐ No, go to Section 4 ☐ Yes, please provide the following:

If you have declined due to having **other Group coverage for yourself**, attach one of the following to provide evidence of that other coverage.

☐ Copy of your insurance ID card from the other group coverage

☐ Copy of an Explanation of Benefits (EOB) for yourself from the other group coverage

4. EMPLOYEE SIGNATURE

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage (or receive a request to enroll from a state agency administering Medicaid or CHIP) and we must receive your enrollment application within 60 days after your other coverage ended. Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 60 days after the marriage, birth, adoption, or placement for adoption, unless a different time limit has been specified in your benefit booklet.

By signing below, you understand that you will be unable to obtain coverage under your employer's group health plan until the next open enrollment period, unless you and/or your dependents qualify for enrollment under the special enrollment rules described above.

Please note: *A person who, with intent to injure, defraud, or deceive, knowingly makes a false or fraudulent statement or representation in or with reference to an application for insurance may be prosecuted under state law.*

X	Date

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

An Independent Licensee of the Blue Cross Blue Shield Association

Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross Blue Shield of Alaska. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-508-4722 (TTY: 800-842-5357).

Español (Spanish): Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross Blue Shield of Alaska. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-508-4722 (TTY: 800-842-5357).

中文 (Chinese): 本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross Blue Shield of Alaska 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-508-4722 (TTY: 800-842-5357)。

Tiếng Việt (Vietnamese): Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross Blue Shield of Alaska. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-508-4722 (TTY: 800-842-5357).

Tagalog (Tagalog): Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross Blue Shield of Alaska. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-508-4722 (TTY: 800-842-5357).

SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: Benefits Division | PO Box 34690 | Seattle, WA 98124-1690
Phone 1-800-426-7784 | TTY/TDD 1-800-833-6388

CHANGE OF BENEFICIARY DESIGNATION

Please attach to original enrollment form

POLICY # _____

EMPLOYER/POLICYHOLDER NAME _____

EMPLOYEE INFORMATION

NAME **PHONE NUMBER**

STREET ADDRESS **CITY** **STATE** **ZIP CODE**

PRIMARY BENEFICIARY(IES):

NAME **DATE OF BIRTH**

ADDRESS

RELATIONSHIP **BENEFIT PERCENT**

NAME **DATE OF BIRTH**

ADDRESS

RELATIONSHIP **BENEFIT PERCENT**

CONTINGENT BENEFICIARY(IES):

NAME **DATE OF BIRTH**

ADDRESS

RELATIONSHIP **BENEFIT PERCENT**

NAME **DATE OF BIRTH**

ADDRESS

RELATIONSHIP **BENEFIT PERCENT**

DEFINITIONS

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

EMPLOYEE SIGNATURE **DATE SIGNED**

ALASKA PUBLIC BROADCASTING HEALTH TRUST

TO: Participant in Alaska Public Broadcasting Health Trust Plan

FROM: Kim Pigg, Administrative Manager

DATE: January 1, 2020

RE: Employee Benefit Plan Summary Plan Description and Employee Notifications

The Summary Plan Description is an important document that tells participants what the plan provides and how it operates. The employee notifications provide additional important information that affects your health plan. Please review these important documents.

You can access these documents online at: http://030c78c.netsolhost.com/healthtrust.html

At the above listed website you will find the following documents for the 2020 Alaska Public Broadcasting Health Trust Benefit plan documents and notification:

- SPD Wrap Document
- Medical Plan Booklet
- Dental Booklet
- Life Certificate – Class 1
- Life Certificate – Class 2
- Life Certificate – Class 3
- Employee Notification Document

Additional documents may be added to this website in the future. Future years Summary Plan Description, plan documents, and notifications will be added to the above website by the 15th of June each year. You will only be required to sign receipt of these documents in upcoming years only if the plan changes and/or there are significant modifications to the plan components or notifications.

If requested, a hard copy of any of these documents can be provided to you at no charge.

If you have any questions about these documents, please contact me at:

Kim Pigg
Alaska Public Broadcasting Health Trust
135 Cordova Street
Anchorage, AK 99501
Phone: (907) 277-6300 ext. 6002
Email: kim@akpb.org

RECEIPT OF
ALASKA PUBLIC BROADCASTING HEALTH TRUST
SUMMARY PLAN DESCRIPTION WRAP DOCUMENTS AND
EMPLOYEE NOTIFICATIONS

My signature below verifies that I have received notification of the Alaska Public Broadcasting Health Trust Summary Plan Description WRAP Documents and Employee Notifications.

I have reviewed these documents and understand it is my sole responsibility to understand my coverage and rights.

_____

Employee's Name (Print)

_____ _____

Employee's Signature Date

_____

Employee's Participating Station/Organization

Please return to:

Kim Pigg
Alaska Public Broadcasting Health Trust
PO Box 200009
Anchorage, Alaska 99520

Or by email to kim@akpb.org

Or by fax at 907-277-6350

It is recommended that you provide copy of the signed form to your station manager/human resource manager for inclusion in your personnel file and/or with your health plan records as well as retaining a copy for your own files.