2020-2021 Employee Benefits
Open Enrollment

Welcome to your open enrollment period for **Alaska Public Broadcasting Health Trust (APBHT).** Open enrollment is a once-a-year opportunity for you to customize your benefits for the next plan year, such as waiving coverage, adding or dropping dependents.

The Open Enrollment period for APBHT starts **Monday, November 16, 2020**, and ends **Friday, December 04, 2020**. Please take a few minutes to review this memo so you are aware of any changes and actions items you need to complete. Your next opportunity to make enrollment changes will not be until next year's open enrollment period, unless you have a qualifying event (i.e. marriage, birth, adoption, or loss of health coverage).

Making informed decisions for Open Enrollment

To help make informed decisions about your benefit options during the Open Enrollment period, review benefit summaries, plan costs and annual notifications. Below is a brief overview of what is changing this year, as well as action items you need to do. You can also review your benefit details by visiting APBHT's FlippingBook Open Enrollment Guide by visiting:

https://online.flippingbook.com/view/321485/

What's New or Changing?	Action Items
Medical, Rx: No changes to current benefits. **Dental:** No changes to current benefits. **Vision:** No changes to current benefits. **Basic Life/AD&D:** No changes to current benefits	**All Benefits:** All employees who waive coverage need to complete a waiver form. 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.

Please keep in mind there are typically changes to the premiums; please contact your HR Representative for detailed Benefits information.

Remember…

Open Enrollment is also the time to add/drop any dependents if necessary. Remember that the choices you make during open enrollment will take effect on **Friday, January 01, 2021**, and will remain in effect until **Friday, December 31, 2021**. Only qualifying events will allow you to make a change before that date.

Please submit all forms to your general manager or HR representative no later than Friday, December 04, 2020

Where to Go if You Have Questions:

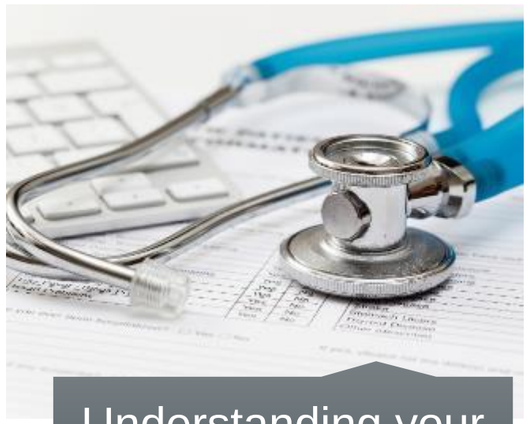
Should you have any questions about your benefits or questions in general, contact Kim Pigg, your plan administrator, or our Broker Partners Stephanie Rossland (907-777-0234) | Leslie Shelton (907-777-0223) with Wilson Albers.

2021 EMPLOYEE BENEFITS

Effective January 1, 2021 to December 31, 2021

Topics For Today

Open Enrollment



Understanding your Medical Coverage

Benefit Plans Overview & Eligibility

What’s Changing

Open Enrollment & Qualifying Events

Open Enrollment is your opportunity to:

- Make changes to your current benefit selections
- Confirm coverage for dependents
- Verify and update your beneficiary information

Please review your options carefully. When Open Enrollment ends, it will not be possible to make changes to your benefit choices until next year's open enrollment period without a Qualifying Event.

Examples of Qualifying Events
Marriage
Death
Birth
Divorce
Involuntary loss of coverage
Adoption

If you are unsure if your situation is considered a qualifying event, please contact Human Resources.

Employees Eligibility

Medical, Rx, Vision

- If you are working at least 30 hours per week
- On the First of the month after 30 days

Dental

- If you are working at least 30 hours per week
- On the First of the month after 30 days

Basic Life/AD&D

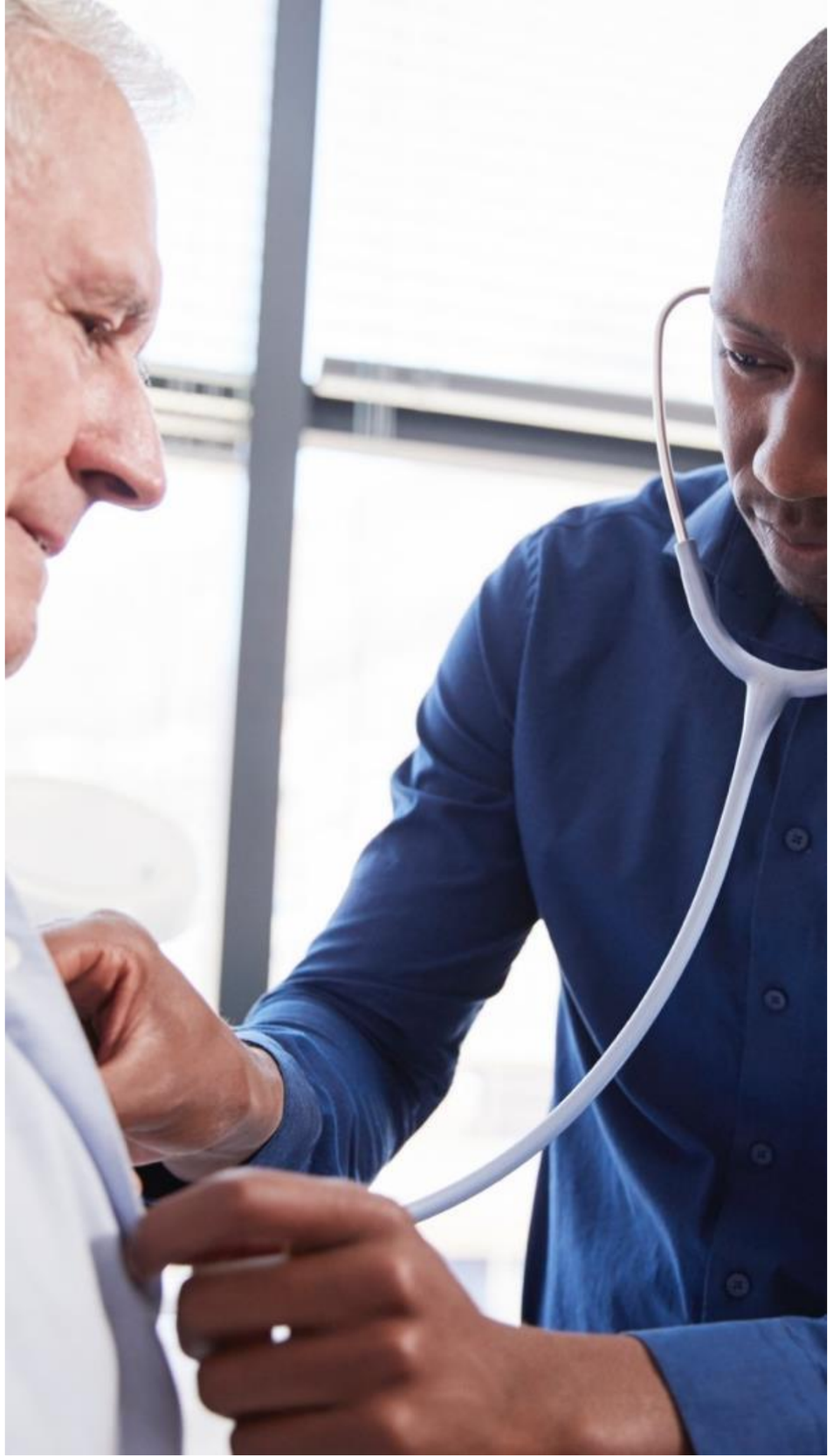
- If you are working at least 30 hours per week
- On the First of the month after 30 days

Dependents Eligibility

- Lawful Spouse or Domestic Partner
- Dependent child under 26 years of age, who is:
  - Natural or legally adopted
  - Minor or foster child for whom you or your spouse has legal guardianship

What's New For 2021?

Medical, Rx	• No changes to current benefits
Dental	• No changes to current benefits
Basic Life/AD&D	• No changes to current benefits



Medical Benefits

Medical Plan Features

(This is what you pay for In-Network Services)

Carrier	Premera Blue Cross Blue Shield of Alaska
Plan Name	**HP HSA Aggregate $2,000/20%/$3,500 Essentials**
Annual Deductible PCY (Individual/Family)	$2,000 / $4,000
Coinsurance	20% Preferred / 40% Participating
Out-of-Pocket Maximum PCY (Individual/Family)	$3,500 / $7,000
Office Visit **Specialist Visit** **Urgent Care Visit**	In Network Deductible, then 20% Preferred / 40% Participating
Virtual Care – Telemedicine (General Medical)	In Network Deductible, then 20% Preferred
Emergency Care	In Network Deductible, then 20% Preferred

Prescription Drugs Plan Features

(This is what you pay for In-Network Services)

Carrier	Premera Blue Cross Blue Shield of Alaska
Prescription Drug Deductible	Medical Deductible
Retail (preferred generic / preferred brand / preferred specialty / non-preferred)	After Deductible is met $15/$30/$50/30%; Coinsurance is waived
Mail Order (preferred generic / preferred brand / preferred specialty / non-preferred)	After deductible is met $37.50/$75/$50/30%; Coinsurance is waived
Supply Limit Per Fill	Retail: up to 90 days Mail Order: up to 90 days Specialty: up to 30 days
Drug List	E1 Essentials Formulary No Tiers

Supplemental Benefits with Medical plan

(This is what you pay for In-Network Services)

Vision Exam 1 PCY	In Network Deductible, then 20% Preferred
Eyewear $200 PCY	Covered in Full
Pediatric Vision Exam 1 PCY under age 19	Covered in Full
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

Health Savings Accounts (HSAs)

- Savings account you can take with you.
- Contributions are pre-tax.
- Must participate in Qualified High Deductible Plan (QHDP) & any additional insurance plan must also be HSA qualified.
- You are not claimed as a dependent by another person.
- 20% penalty for Non-qualified expenses.
- Additional $1,000 “catch up” contribution for participants 55 years or older.

2020 HSA Contribution Limits			
	IRS Maximum	Employer Contribution	Employee Maximum
Employee Only	$3,550	$0	$3,550
Employee & Family	$7,100	$0	$7,100
Additional “catch-up” if 55 or older	$1,000	n/a	$1,000

2021 HSA Contribution Limits			
	IRS Maximum	Employer Contribution	Employee Maximum
Employee Only	$3,600	$0	$3,600
Employee & Family	$7,200	$0	$7,200
Additional “catch-up” if 55 or older	$1,000	n/a	$1,000

Additional Benefits

Included with your Medical plan

Go Mobile

Keep your health plan information right in your pocket – get easy, convenient, on-the-go access to the health plan info you need. Download the Premera mobile app today.

Access Digital ID card

View claims

Get care

Find care

Access Medicine Cabinet

www.premeramember.com/ak

Download on the App Store

GET IT ON Google Play

Premera Online Resources

Your Benefits

Find a Doctor

24-Hour NurseLine

Teladoc

Premera text alerts

Medical Transportation Benefits

myCare Alaksa

Member discounts

Preventive health

Behavioral health

Pharmacy

Coverage anywhere

Find a Doctor

PREMERA

Find a doctor you'll love. Or, see if yours is in the network.

FIND A DOCTOR

- Look for the network name on your ID card when you search using the provider tool.
- Log in to your secure account and we'll automatically serve up in-network providers when you do a provider search.
- Save money by using in-network healthcare providers.

Log in for your personal plan details.

LOG IN

Don't have a secure account yet? Take a minute to **create** one today. Then you can:

- View personalized benefit information
- Search doctors and clinics in your network
- Track your claims and deductible
- Email customer service securely
- Find the best price on prescription drugs
- And more!

Preventive Care Services

Preventive vs. Diagnostic:
Know the difference and communicate with your Providers

When received from a Preferred Provider, authorized preventive services cost nothing to you and are covered in full as preventive health services according to healthcare reform law. Utilize your benefits for a healthier life.

Remember, you are ultimately responsible for your own health and healthcare costs.

Preventive Care Services

Pregnancy

Know your benefits for a healthy pregnancy, postpartum care, and breast pump coverage.

Pregnancy care

Kids' health

Your health plan is available from getting infant feeding support through your child's 26th birthday.

Care for kids

Women's health

Find out when to get your mammogram, Pap test, and more.

Women's health benefits

Men's health

A primary care provider can help with preventive care, injuries, and other concerns.

Men's health benefits

Mental health

Learn more about therapy, eating disorders, and substance abuse help.

Mental health benefits

Colon cancer screenings

Review your colonoscopy coverage before your appointment.

Colonoscopy and FIT tests

Premera 24-Hour Nurseline

Registered nurses are available to answer your questions on any medical issue, including making the right choices on when to seek help and where to go.

- Free and Confidential Service
- Available 24 Hours a Day, 7 Days a Week
- Available in English, Spanish and 140+ additional languages

Available 24/7 at 800-841-8343
(number also available on the back of your ID card)

Talkspace: Therapy as Close as Your Phone

Available

- by live, face-to-face video appointments
- by text messaging (response in less than a day)

Access

- Access to 5,000 licensed therapists
- Regardless of date, location or time of day

Cost

- Same cost shares as equivalent to face-to-face visits

Sign up!

- www.talkspace.com/Premera

Please know, Talkspace is not a live chat where an immediate response will happen from your therapist.

Medical Travel Support

With approval, this feature helps you obtain care at in-network hospitals and surgical centers across the United States.

Air	1 round-trip per episode
Surface Transportation & Parking	$35 per day
Ferry Transportation	$50 per person each way
Lodging	$50 per 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!

myCare Alaska

No need to go into a medical office

Ask general or urgent medical questions

Available 7 days a week, 8 a.m. to 8 p.m. (AKST)

See how easy it is to connect. Register and say hi!

Get started at mycarealaska.com

myCare Alaska
provided by Premera

Chat With a Doctor Like You'd Chat With a Friend

Premera Designated Centers of Excellence

What's included?

- Access to three of the most common specialty procedures
  - Total joint replacements (knee and hip)
  - Spine surgeries
  - Gynecological procedures
- Bundled payment
- Air travel for you and a companion
- Black car services from airport to hotel
- Dedicated care coordination expert

Premera makes it easy

- Medical travel expert available
- Travel arrangements assistance

Premera Designated Center of Excellence (PDCOE)

- Virginia Mason Medical Center in Seattle

Call Premera Customer Service to begin your coordination of travel at 800-508-4722

Where To Seek Care

Use Virtual Care

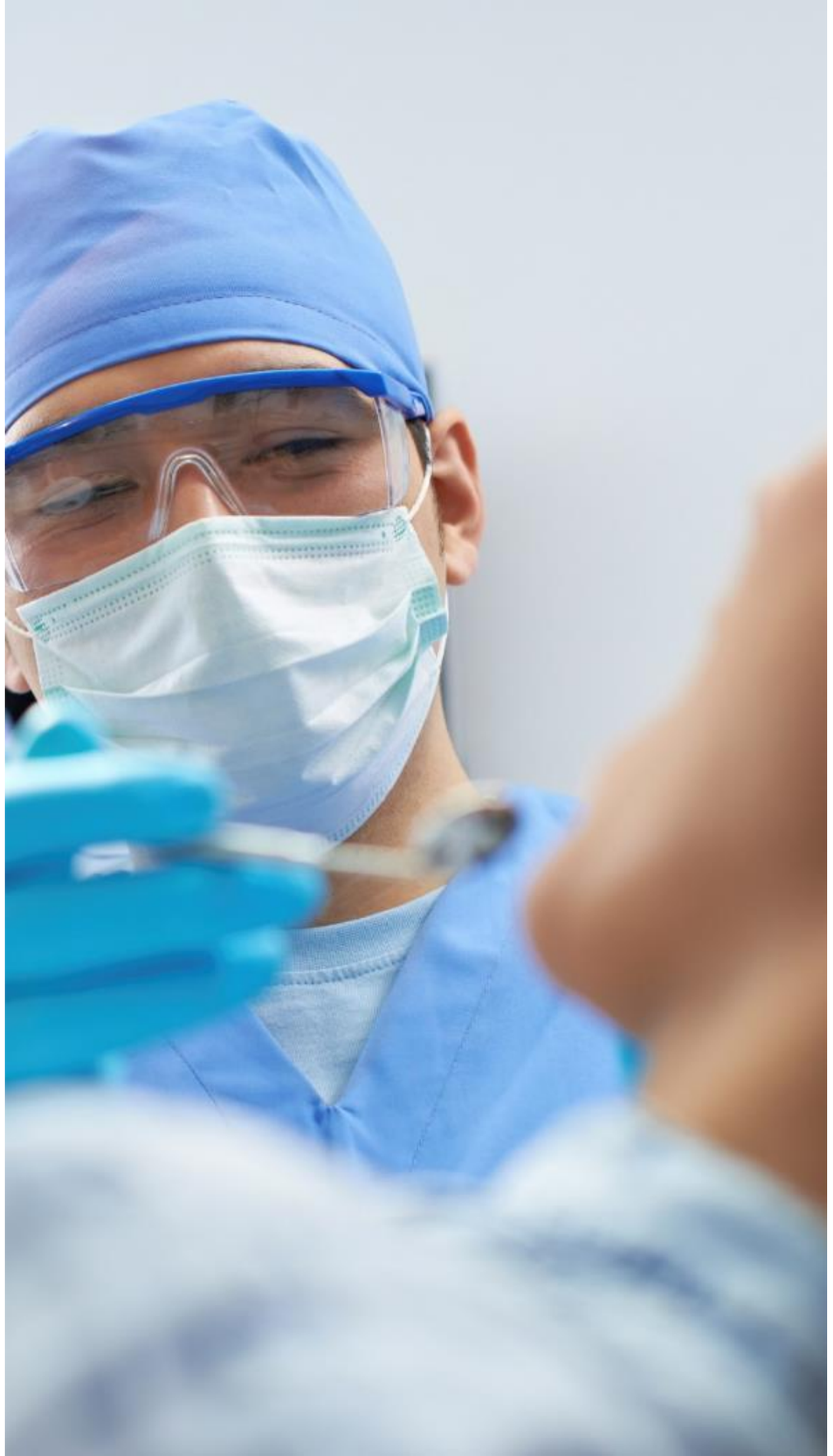
- Cold and fly symptoms
- Nasal congestion
- Sinus problems
- Bronchitis
- Respiratory problems
- Allergies
- Ear infections
- Nausea
- Skin infections and acne

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

Go to Emergency Care

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



Dental Benefits

Dental Plan Features

(This is what you pay for In-Network Services)

Carrier	Premera Blue Cross Blue Shield of Alaska
Plan Name	**Dental Optima 1500**
Deductible	$50 Per Individual / $150 Per Family
Preventive Services	0%
Basic Services	20%
Major Services	50%
Calendar Year Maximum	Up to $1,500 per person each calendar year applies to Basic & Major Services

Basic Life/AD&D Benefits

Life and AD&D Benefits

Protect those you love from the unexpected!

	Carrier	Symetra
	Amount	Class 1: 1x annual earnings up to $100,000 Class 2: $20,000 Class 3: $5,000
	Cost	No cost to you

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

Be sure to choose a beneficiary to receive benefits in the event of your death – and remember to update your beneficiary when life event changes

Other Benefits

BenefitHub – Perks Portal

Enjoy discounts, rewards and perks on thousands of brands you love in a variety of categories:

- Travel
- Auto
- Electronics
- Apparel
- Local Deals
- Education
- Entertainment
- Restaurants
- Health and Wellness
- Beauty and Spa
- Tickets
- Sports & Outdoors

It's easy to access and start saving!

1. Go to www.apbht.benefithub.com
2. Create your account by entering your email address
3. Follow the prompts
4. Start exploring your savings offerings

Questions? Call 1-866-664-4621 or email customercare@benefithub.com

Premiums Costs

Contacts

Resources/Contact Information

Benefit	Provider	Phone	Website / Email
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
Basic Life/AD&D	Symetra	1-800-796-3872	www.symetra.com

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).

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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.

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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: November 13, 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 2021 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 March 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.